Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Ustekinumab - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Member Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare Advantage	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Will the patient be taking this drug concomitantly with another biologic Disease Modifying Anti-Rheumatic Drugs (DMARDs) or a targeted synthetic DMARD?

☐ Yes ☐ No

Q2. Is this a request for reauthorization? If YES, go to 3. If NO, go to 4.

☐ Yes ☐ No

Q3. Is there confirmation of positive clinical response?

☐ Yes ☐ No

Q4. Is the drug being prescribed by or in consultation with an appropriate specialist such as a dermatologist, rheumatologist, or gastroenterologist?

☐ Yes ☐ No

Q5. Are chart notes attached documenting a diagnosis of moderate to severe plaque psoriasis and is a candidate for phototherapy or systemic therapy? If YES, go to 6. If NO, go to 7.

☐ Yes ☐ No

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Member Name:	**Prescriber Name:**

Q6. Is there documentation of an inadequate response, intolerance, or contraindication to 1 of the following: methotrexate, ultraviolet-B (UVB) therapy, or acitretin?

☐ Yes ☐ No

Q7. Are chart notes attached documenting an FDA-approved diagnosis not otherwise excluded from part D?

☐ Yes ☐ No

Q8. Requested Duration:

☐ 12 Months ☐ Other:

Q9. Additional Information:

_____ _____

Prescriber Signature Date

v2026