



**MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM**

Skyrizi - 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: <input type="checkbox"/> 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 Drug (DMARD) or a targeted synthetic DMARD?

☐ Yes

☐ No

Q2. Is the drug prescribed by or in consultation with an appropriate specialist such as a dermatologist, rheumatologist, or gastroenterologist?

☐ Yes

☐ No

Q3. Is this a reauthorization request? If YES, go to 4. If NO, go to 5.

☐ Yes

☐ No

Q4. Has the prescriber provided confirmation of a positive clinical response?

☐ Yes

☐ No

Q5. Are chart notes attached documenting a diagnosis of moderately to severely active plaque psoriasis? If YES, go to 6. If NO, go to 7.

☐ Yes

☐ No



**MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM**

Skyrizi - 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:
<p>Q6. Is there a documentation of inadequate response, intolerance or contraindication to at least 1 of the following: methotrexate, UVB therapy, or acitretin?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q7. Are chart notes attached documenting a diagnosis of moderately to severely active Crohn's disease? If YES, go to 8. If NO, go to 9.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q8. Is there documentation of inadequate response, intolerance, or contraindication to one of the following: corticosteroids, methotrexate, 6-mercaptopurine, azathioprine?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q9. Are chart notes attached documenting an FDA-approved diagnosis not otherwise excluded from part D?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q10. Requested Duration:</p> <p><input type="checkbox"/> 12 Months <input type="checkbox"/> Other:</p>	
<p>Q11. Additional Information:</p>	

Prescriber Signature

Date

v2026