



PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Taltz

Fax back to: (833) 605-4407

Phone: (215) 991-4300

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.

Patient Name:	Prescriber Name:
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: <input type="checkbox"/> Exchange - PA	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 the 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. Is this a reauthorization request? If YES, go to 2. If NO, go to 3.

Yes

No

Q2. Is there confirmation of continued positive clinical response since starting Taltz?

Yes

No

Q3. Is the medication prescribed by or in consultation with a dermatologist or rheumatologist?

Yes

No

Q4. Is there a confirmation of tuberculosis (TB) screening results and treatment plan for active or latent infection?

Yes

No

Q5. Does the patient have a confirmed diagnosis of moderate to severe plaque psoriasis (PsO)?

Yes

No



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Patient Name:	Prescriber Name:
Q6. Is the patient 6 to 17 years of age? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. Is there documentation of an inadequate response, intolerance, or contraindication to Enbrel and Otezla? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. Is the patient 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Is there documentation of an inadequate response, intolerance, or contraindication to two of the following: Enbrel, an adalimumab containing product, Otezla, Skyrizi? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q10. Does the patient have a confirmed diagnosis of active psoriatic arthritis (PsA)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q11. Is the patient 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q12. Is there documentation of inadequate response, intolerance, or contraindication to two of the following: Enbrel, an adalimumab containing product, Otezla, Rinvoq, Skyrizi, Xeljanz/Xeljanz XR? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q13. Does the patient have a confirmed diagnosis of active ankylosing spondylitis (AS)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q14. Is the patient 18 years of age or older?	



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Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q15. Is there documentation of inadequate response, intolerance, or contraindication to two of the following: Enbrel, an adalimumab containing product, Rinvoq, or Xeljanz/Xeljanz XR?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q16. Does the patient have a confirmed diagnosis of non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q17. Is the patient 18 years of age or older?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q18. Is there documentation of inadequate response, intolerance, or contraindication to Rinvoq and an adalimumab containing product?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q19. Additional Information:	

Prescriber Signature

Date

v2025