Jefferson Health Plans

2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Otezla - 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.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare	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. Is this a request for reauthorization?

☐ Yes ☐ No

Q2. FOR reauthorization: Has the prescriber provided confirmation of a positive clinical response?

☐ Yes ☐ No

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

☐ Yes ☐ No

Q4. Is the patient 6 years of age or older for treatment of plaque psoriasis OR 18 years or older for treatment of psoriatic arthritis or Behcet's Disease?

☐ Yes ☐ No

Q5. Does the patient have a confirmed diagnosis of plaque psoriasis? Please attach clinical documentation.

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q6. Does the patient have a confirmed diagnosis of active psoriatic arthritis? Please attach clinical documentation.

☐ Yes ☐ No

Q7. Does the patient have a confirmed diagnosis of oral ulcers associated with Behcet's Disease? Please attach clinical documentation.

☐ Yes ☐ No

Q8. Is there a documented history of inadequate response, intolerance, or contraindication to at least one DMARD indicated for the diagnosis?

☐ Yes ☐ No

Q9. Is there a documented history of inadequate response, intolerance, or contraindication to colchicine?

☐ Yes ☐ No

Q10. Requested Duration:

☐ 12 Months ☐ Other:

Q11. Additional Information:

Prescriber Signature

Date

2024 Medicare Prior Authorization Request