Jefferson Health Plans

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: □ 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. Is this a renewal request? If YES, go to 2. If NO, go to 3

☐ Yes ☐ No

Q2. For RENEWALS: Has the prescriber provided confirmation of a positive clinical response?

☐ Yes ☐ No

Q3. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q4. Does the patient have a confirmed diagnosis of moderately to severely active plaque psoriasis? Please attach clinical documentation.

☐ Yes ☐ No

Q5. Is there a documented history of inadequate response, intolerance or contraindication to methotrexate or UVB therapy (alone or in combination with other medications) or acitretin? Attach documentation

☐ Yes ☐ No

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

☐ Yes ☐ No

Q7. Is there a documented history of inadequate response, intolerance or contraindication to at least one DMARD?

☐ Yes ☐ No

Q8. Does the patient have a confirmed diagnosis of moderately to severely active Crohn's disease? Please attach clinical documentation.

☐ Yes ☐ No

Q9. Is there documentation of inadequate response, intolerance, or contraindication to one of the following: corticosteroids, methotrexate, or azathioprine?

☐ Yes ☐ No

Q10. Does recent tuberculin testing show that the patient is negative for latent tuberculosis infection? Please attach documentation of recent testing.

☐ Yes ☐ No

Q11. Is there documentation that the patient has completed treatment (or is receiving treatment) for latent tuberculosis? Please attach documentation of treatment.

☐ Yes ☐ No

Q12. Does the patient have any other active, serious infection?

☐ Yes ☐ No

Q13. Is there confirmation that live vaccines will be avoided immediately prior to and during Skyrizi therapy?

☐ Yes ☐ No

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Q14. Is the drug prescribed by or in consultation with a dermatologist, rheumatologist, or gastroenterologist?

☐ Yes ☐ No

Q15. Requested Duration:

☐ 12 Months ☐ Other:

Q16. Additional Information:

Prescriber Signature

Date

v2025