



2024 MEDICARE 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.

Form with fields for Patient Name, Prescriber Name, Member Number, Date of Birth, Line of Business, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, State Lic ID, and Specialty/facility name.

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.

Form with fields for Drug Name, Strength, and 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?

Yes - Go to 2

No - Go to 3

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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Patient Name:	Prescriber Name:
Q6. Does the patient have a confirmed diagnosis of active psoriatic arthritis? Please attach clinical documentation. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. Is there a documented history of inadequate response, intolerance or contraindication to at least one DMARD? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. Does the patient have a confirmed diagnosis of moderately to severely active Crohn's disease? Please attach clinical documentation. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Is there documentation of inadequate response, intolerance or contraindication to one of the following: corticosteroids, methotrexate or azathioprine? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q10. Does recent tuberculin testing show that the patient is negative for latent tuberculosis infection? Please attach documentation of recent testing. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q11. Is there documentation that the patient has completed treatment (or is receiving treatment) for latent tuberculosis? Please attach documentation of treatment. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q12. Does the patient have any other active, serious infection? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q13. Is there confirmation that live vaccines will be avoided immediately prior to and during Skyrizi therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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Patient Name:	Prescriber Name:
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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

2024 Medicare Prior Authorization Request