Jefferson Health Plans

2024 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Tremfya

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: ☐ 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 an initial request?

☐ Yes - Go to 2

☐ No - For Moderate to severe Plaque psoriasis (PsO), go to 18. For Active Psoriatic arthritis (PsA), go to 19.

Q2. Does the patient have one of the following diagnoses: Moderate to severe Plaque psoriasis (PsO) or Active Psoriatic arthritis (PsA)?

☐ Yes - For PsO, go to 3. For PsA, go to 7. ☐ No

Q3. Has the patient previously received a biologic or targeted synthetic drug (e.g., Sotyktu, Otezla) indicated for the treatment of moderate to severe plaque psoriasis?

☐ Yes ☐ No

Q4. Are chart notes or medical records attached showing crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected?

☐ Yes ☐ No

Jefferson Health Plans

2024 PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Tremfya

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:**

Q5. Are chart notes or medical records attached showing at least 10% of the body surface area (BSA) is affected?

☐ Yes ☐ No

Q6. Are chart notes or medical records attached showing at least 3% of body surface area (BSA) is affected and the member meets any of the following criteria with chart notes or medical records attached:
A) Member has had an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin including response to therapy.
B) Documentation that member has a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin?

☐ Yes ☐ No

Q7. Has the patient previously received a biologic or targeted synthetic drug (e.g., Rinvoq, Otezla) indicated for active psoriatic arthritis with chart notes, medical record documentation, or claims history supporting previous medications tried?

☐ Yes ☐ No

Q8. Does the patient have severe disease?

☐ Yes ☐ No

Q9. Does the patient have mild to moderate disease?

☐ Yes ☐ No

Q10. Has the patient had an inadequate response to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine) administered at an adequate dose and duration with chart notes or medical records including response to therapy?

☐ Yes ☐ No

Jefferson Health Plans

2024 PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Tremfya

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:**

Q11. Is there documentation that member has an intolerance, contraindication, or has a clinical reason to avoid to methotrexate or leflunomide, or another conventional synthetic drug (e.g., sulfasalazine).

☐ Yes ☐ No

Q12. Does the patient have enthesitis or predominantly axial disease?

☐ Yes ☐ No

Q13. Has the patient been evaluated for active or latent tuberculosis (TB) infection with a tuberculosis skin test [PPD], an interferon-release assay [IGRA], or a chest x-ray) within 6 months of initiating therapy for persons who are naïve to biologic drugs or targeted synthetic drugs associated with an increased risk of TB?

☐ Yes ☐ No

Q14. Was the PPD, IGRA, or chest x-ray positive for TB?

☐ Yes ☐ No

Q15. Does testing confirm there is no active disease?

☐ Yes ☐ No

Q16. For latent TB, will the patient receive TB treatment prior to initiation of the requested drug?

☐ Yes ☐ No

Q17. Will the requested medication be used concomitantly with any other biologic drug or targeted synthetic drug?

☐ Yes ☐ No

Q18. For continuation of therapy for PsO, has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition with one of the following:

Jefferson Health Plans

2024 PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Tremfya

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:**

A) Chart notes or medical records documenting reduction in body surface area (BSA) affected from baseline.
B) Chart notes or medical records showing improvement in signs and symptoms from baseline (e.g., itching, redness, flaking, scaling, burning, cracking, pain)?

☐ Yes ☐ No

Q19. For continuation of therapy for PsA, has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline (chart notes or medical records attached):
A) Number of swollen joints
B) Number of tender joints
C) Dactylitis
D) Enthesitis
E) Axial disease
F) Skin and/or nail involvement

☐ Yes ☐ No

Q20. Additional Information:

Prescriber Signature

Date

2024 Prior Authorization Request