Jefferson Health Plans

2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Stelara - 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 continuation?

☐ Yes - Go to 2 ☐ No - Go to 3

Q2. Is there documentation of improvement in symptoms?

☐ Yes ☐ No

Q3. Is Stelara being prescribed by or in consultation with a dermatologist, rheumatologist, or gastroenterologist?

☐ Yes ☐ No

Q4. Is there documentation of tuberculosis (TB) testing that is negative for latent tuberculosis infection OR positive for latent tuberculosis with documentation that treatment is completed or is receiving treatment for latent tuberculosis?

☐ Yes ☐ No

Q5. Is the patient being treated with live vaccines?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q6. Does the patient have any active, serious infections?

☐ Yes ☐ No

Q7. Does the patient have a confirmed diagnosis of moderate to severe plaque psoriasis and is a candidate for phototherapy or systemic therapy?
If No, go to 12.

☐ Yes ☐ No

Q8. Is the patient 6 to 17 years of age?

☐ Yes ☐ No

Q9. Is there documentation of an inadequate response, intolerance, or contraindication to Enbrel?

☐ Yes ☐ No

Q10. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q11. Is there documentation of an inadequate response, intolerance, or contraindication to TWO of the following: Enbrel, Humira, Skyrizi, Otezla?

☐ Yes ☐ No

Q12. Does the patient have a confirmed diagnosis of active psoriatic arthritis?
If No, go to 15.

☐ Yes ☐ No

Q13. Is the patient 6 years of age or older?

☐ Yes ☐ No

Q14. Is there documentation of an inadequate response, intolerance, or contraindication to two of the following: Enbrel, Humira, Xeljanz, Xeljanz XR, Otezla, Skyrizi?

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Patient Name:	**Prescriber Name:**

☐ Yes ☐ No

Q15. Does the patient have a confirmed diagnosis of moderately to severely active Crohn's disease?
If No, go to 18.

☐ Yes ☐ No

Q16. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q17. Is there documentation of an inadequate response, intolerance, or contraindication to Humira and Skyrizi?

☐ Yes ☐ No

Q18. Does the patient have a confirmed diagnosis of moderately to severely active Ulcerative Colitis?

☐ Yes ☐ No

Q19. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q20. Is there documentation of an inadequate response, intolerance, or contraindication to Humira and Xeljanz or Xeljanz XR?

☐ Yes ☐ No

Q21. Additional Information:

Q22. Requested Duration:

☐ 12 months ☐ Other

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Patient Name:	**Prescriber Name:**

Prescriber Signature Date

2024 Medicare Prior Authorization Request