Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Taltz - 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 reauthorization request? If YES, go to 2. If NO, go to 3.

☐ Yes ☐ No

Q2. Is there confirmation of continued positive clinical response since starting Taltz?

☐ Yes ☐ No

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

☐ Yes ☐ No

Q4. Is there a confirmation of tuberculosis (TB) screening results and treatment plan for active or latent infection?

☐ Yes ☐ No

Q5. Does the patient have a confirmed diagnosis of moderate to severe plaque psoriasis (PsO)?

☐ Yes ☐ No

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Member Name:	**Prescriber Name:**

Q6. Is the patient 6 to 17 years of age?

☐ Yes ☐ No

Q7. Is there documentation of an inadequate response, intolerance, or contraindication to Enbrel?

☐ Yes ☐ No

Q8. Is the patient 18 years of age or older?

☐ Yes ☐ No

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

☐ Yes ☐ No

Q10. Does the patient have a confirmed diagnosis of active psoriatic arthritis (PsA)?

☐ Yes ☐ No

Q11. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q12. Is there documentation of inadequate response, intolerance, or contraindication to Enbrel, Humira, Otezla, Rinvoq, Skyrizi, OR Xeljanz/Xeljanz XR?

☐ Yes ☐ No

Q13. Does the patient have a confirmed diagnosis of active ankylosing spondylitis (AS)?

☐ Yes ☐ No

Q14. Is the patient 18 years of age or older?

☐ Yes ☐ No

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Member Name:	**Prescriber Name:**

Q15. Is there documentation of inadequate response, intolerance, or contraindication to Enbrel, Humira, Rinvoq, or Xeljanz/Xeljanz XR?

☐ Yes ☐ No

Q16. Does the patient have a confirmed diagnosis of non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation?

☐ Yes ☐ No

Q17. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q18. Is there documentation of inadequate response, intolerance, or contraindication to Rinvoq?

☐ Yes ☐ No

Q19. Requested Duration:

☐ 12 Months ☐ Other:

Q20. Additional Information:

_____ _____

Prescriber Signature Date

v2025