Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Adalimumab

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 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 the requested drug?

☐ Yes ☐ No

Q3. Does the patient have a diagnosis of rheumatoid arthritis?

☐ Yes ☐ No

Q4. Has the patient had an inadequate response, intolerance, or contraindication to a trial of at least one disease modifying anti-rheumatic drug (DMARD) (e.g., methotrexate, hydroxychloroquine, sulfasalazine, azathioprine)? If yes, go to 22.

☐ Yes ☐ No

Q5. Does the patient have a diagnosis of psoriatic arthritis (PsA)? if yes, got to 22.

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☐ Yes ☐ No

Q6. Does the patient have a diagnosis of plaque psoriasis (PsO)?

☐ Yes ☐ No

Q7. Is the disease moderate to severe?

☐ Yes ☐ No

Q8. Is the patient a candidate for systemic therapy or phototherapy and had an inadequate response, intolerance, or contraindication to methotrexate OR ultraviolet-B (UVB) therapy OR acitretin? If yes, go to 22.

☐ Yes ☐ No

Q9. Does the patient have limited disease and has had an inadequate response, intolerance, or contraindication to one topical steroid (high to very high potency) AND calcipotriene 0.005% cream? If YES, go to 22.

☐ Yes ☐ No

Q10. Does the patient have a diagnosis of polyarticular juvenile idiopathic arthritis (JIA)?

☐ Yes ☐ No

Q11. Has the patient had an inadequate response, intolerance, or contraindication to one disease modifying anti-rheumatic drug (DMARD) (e.g., methotrexate)? If YES, go to 22.

☐ Yes ☐ No

Q12. Does the patient have a diagnosis of Crohn's disease?

☐ Yes ☐ No

Q13. Has the patient had an inadequate response, intolerance, or contraindication to one of the following therapies: corticosteroids, azathioprine, 6-mercaptopurine, methotrexate or lost response to or intolerant to infliximab? If YES, go to 22.

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☐ Yes ☐ No

Q14. Does the patient have a diagnosis of ulcerative colitis?

☐ Yes ☐ No

Q15. Has the patient had an inadequate response, intolerance, or contraindication to one of the following: corticosteroids or a DMARD (e.g., azathioprine, 6-mercaptopurine (6-MP))? If YES, go to 22.

☐ Yes ☐ No

Q16. Does the patient have the diagnosis of hidradenitis suppurativa?

☐ Yes ☐ No

Q17. Has the patient had an inadequate response, intolerance, or contraindication to at least 2 of the following therapies: A) topical antibiotics (e.g., clindamycin), B) oral antibiotics (e.g., doxycycline, minocycline, amoxicillin-clavulanic acid, clindamycin, rifampin, dapsone), and C) intralesional triamcinolone injections? If YES, go to 22.

☐ Yes ☐ No

Q18. Does the patient have the diagnosis of uveitis?

☐ Yes ☐ No

Q19. Has the patient had an inadequate response, intolerance, or contraindication to at least one of the following: A) oral or topical glucocorticoids (prednisone, methylprednisolone, prednisolone), B) immunosuppressive agents (e.g., azathioprine, methotrexate, cyclosporine), or C) periocular or intraocular injection (triamcinolone)?

☐ Yes ☐ No

Q20. Does the patient have a diagnosis of ankylosing spondylitis (AS) or active non-radiographic axial spondyloarthritis (nr-axSpA), adult?

☐ Yes ☐ No

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Q21. Does the patient have a documented history of an inadequate response, intolerance, or contraindication to at least 2 nonsteroidal anti-inflammatory drugs (NSAIDs)?

☐ Yes ☐ No

Q22. Is the patient within the age group listed in the FDA labeling for the requested adalimumab agent and indication?

☐ Yes ☐ No

Q23. Is the requested drug being prescribed by or in consultation with a rheumatologist, dermatologist, gastroenterologist, or ophthalmologist?

☐ Yes ☐ No

Q24. Has the patient been evaluated for active or latent tuberculosis (TB) infection with a tuberculin skin test prior to the initiation of therapy?

☐ Yes ☐ No

Q25. Was the tuberculin skin test negative?

☐ Yes ☐ No

Q26. Has the patient received appropriate prophylaxis in accordance with Centers for Disease Control and Prevention (CDC) guidelines?

☐ Yes ☐ No

Q27. Is the request for a formulary adalimumab agent?

☐ Yes ☐ No

Q28. Is there documentation of inadequate response, intolerance, or contraindication to all formulary adalimumab agents indicated for the patient's diagnosis?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

_____ _____

Prescriber Signature Date

v2025