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. Will the patient be taking adalimumab concomitantly with another biologic Disease Modifying Anti-Rheumatic Drug (DMARD) or a targeted synthetic DMARD?

☐ Yes ☐ No

Q2. Is this a reauthorization request? If YES, go to 3. If NO, go to 4.

☐ Yes ☐ No

Q3. Is there confirmation of continued positive clinical response since starting the requested drug?

☐ Yes ☐ No

Q4. Are chart notes attached documenting a diagnosis of rheumatoid arthritis (RA) or juvenile idiopathic arthritis (JIA)?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q5. Has the patient had an inadequate response, intolerance, or contraindication to a trial of at least one conventional DMARD (e.g., methotrexate, hydroxychloroquine, leflunomide, sulfasalazine)?

☐ Yes ☐ No

Q6. Are chart notes attached documenting a diagnosis of moderate to severe plaque psoriasis (PsO) and the patient is a candidate for systemic therapy or phototherapy?

☐ Yes ☐ No

Q7. Has the patient had an inadequate response, intolerance or contraindication to 1 of the following: methotrexate, ultraviolet-B (UVB) therapy, or acitretin? If YES, go to 17.

☐ Yes ☐ No

Q8. Are chart notes attached documenting a diagnosis of Crohn's disease?

☐ Yes ☐ No

Q9. Has the patient had an inadequate response, intolerance, or contraindication to one of the following therapies: corticosteroids, methotrexate, 6-mercaptopurine, azathioprine? If YES, go to 17.

☐ Yes ☐ No

Q10. Are chart notes attached documenting a diagnosis of hidradenitis suppurativa?

☐ Yes ☐ No

Q11. Has the patient had an inadequate response, intolerance, or contraindication to at least one oral antibiotic (e.g., doxycycline, minocycline, amoxicillin-clavulanic acid, clindamycin, rifampin, dapsone)? If YES, go to 17.

☐ Yes ☐ No

Q12. Are chart notes attached documenting a diagnosis of uveitis?

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☐ Yes ☐ No

Q13. Has the patient had an inadequate response, intolerance, or contraindication to one or more of the following: A) oral or topical glucocorticoids (prednisone, methylprednisolone, prednisolone), B) immunosuppressive agents, or C) periocular or intraocular injection (triamcinolone)?

☐ Yes ☐ No

Q14. Are chart notes attached documenting a diagnosis of active psoriatic arthritis (PsA)?

☐ Yes ☐ No

Q15. Is there documentation of one of the following:
• Documentation of inadequate response, intolerance, or contraindication to a conventional DMARD (e.g., methotrexate, leflunomide, or sulfasalazine)
• Has axial disease, dactylitis, and /or ethesitis
• Has severe disease as determined by prescriber
• Has concomitant moderate to severe nail disease
• Has concomitant active inflammatory bowel disease

☐ Yes ☐ No

Q16. Are chart notes attached documenting an FDA-approved diagnosis not otherwise excluded from part D?

☐ Yes ☐ No

Q17. Is the drug being prescribed by or in consultation with an appropriate specialist such as a rheumatologist, dermatologist, gastroenterologist, or ophthalmologist?

☐ Yes ☐ No

Q18. Is the request for a formulary adalimumab product?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q19. Is there documentation of inadequate response, intolerance, or contraindication to ALL formulary adalimumab agents indicated for the patient's diagnosis?

☐ Yes ☐ No

Q20. Additional Information:

_____ _____

Prescriber Signature Date

v2025