Jefferson Health Plans

# *MEDICARE ADVANTAGE*
## *PRIOR AUTHORIZATION REQUEST FORM*

Adalimumab- Bwwd (Hadlima) - 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?

☐ Yes ☐ No

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

☐ Yes ☐ No

Q3. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q4. Does the patient have a diagnosis of Rheumatoid Arthritis?

☐ Yes ☐ No

Q5. Has the patient had an inadequate response, intolerance, or contraindication to the trial of at least one disease modifying anti-rheumatic drugs (DMARD) (e.g., methotrexate, hydroxychloroquine, sulfasalazine)? If yes, go to question 21.

☐ Yes ☐ No

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Q6. Does the patient have a diagnosis of Plaque Psoriasis?

☐ 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 (requires prior authorization)? If YES, go to 21.

☐ Yes ☐ No

Q9. Does the patient have limited disease and 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 21.

☐ Yes ☐ No

Q10. Does the patient have the diagnosis of Polyarticular Juvenile Idiopathic Arthritis (JIA)?

☐ Yes ☐ No

Q11. Is the patient 2 years of age or older?

☐ Yes ☐ No

Q12. Has the patient had an inadequate response, intolerance, or contraindication to one or more DMARD (e.g., methotrexate)? If YES, go to 21.

☐ Yes ☐ No

Q13. Does the patient have a diagnosis of Crohn's disease?

☐ Yes ☐ No

Q14. Is the patient 6 years of age or older?

☐ Yes ☐ No

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Q15. Has the patient had an inadequate response, intolerance, or contraindication to one of the following therapies: corticosteroids, methotrexate, azathioprine, OR lost response to or intolerant to infliximab? If YES, go to 21.

☐ Yes ☐ No

Q16. Does the patient have the diagnosis of Ulcerative Colitis? If YES, go to 21.

☐ Yes ☐ No

Q17. Does the patient have the diagnosis of hidradenitis suppurativa?

☐ Yes ☐ No

Q18. Has the patient had an inadequate response, intolerance or contraindication to a topical antibiotic (e.g., clindamycin) and an oral antibiotic (e.g., doxycycline, minocycline, amoxicillin-clavulanic acid, clindamycin, rifampin, dapsone)?

☐ Yes ☐ No

Q19. Does the patient have a diagnosis of Uveitis?

☐ Yes ☐ No

Q20. 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

Q21. Is the drug being prescribed by or in consultation with an appropriate specialist such as a rheumatologist, dermatologist, gastroenterologist, or ophthalmologist?

☐ Yes ☐ No

Q22. 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

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Q23. Was the tuberculin skin test negative?

☐ Yes ☐ No

Q24. Has the patient received appropriate prophylaxis in accordance with Centers for Disease Control and Prevention (CDC) guidelines?

☐ Yes ☐ No

Q25. Requested Duration:

☐ 12 months ☐ Other

Q26. Additional Information:

Prescriber Signature Date

v2025