Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Humira - 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 Humira?

☐ Yes ☐ No

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

☐ Yes ☐ No

Q4. Is documentation provided that the patient had an inadequate response, intolerance, or contraindication to a trial of at least one conventional disease modifying anti-rheumatic drugs (cDMARD) (e.g., methotrexate, hydroxychloroquine, sulfasalazine, azathioprine?

☐ Yes ☐ No

Q5. Does the patient have a documented diagnosis of plaque psoriasis?

☐ Yes ☐ No

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Q6. Is the disease moderate to severe?

☐ Yes ☐ No

Q7. Is documentation provided that 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)?

☐ Yes ☐ No

Q8. 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?

☐ Yes ☐ No

Q9. Does the patient have a documented diagnosis of polyarticular juvenile idiopathic arthritis (JIA)?

☐ Yes ☐ No

Q10. Is documentation provided that the patient had an inadequate response, intolerance or contraindication to at least one conventional disease modifying anti-rheumatic drug (cDMARD) (e.g., methotrexate)?

☐ Yes ☐ No

Q11. Does the patient have the diagnosis of Crohn's disease?

☐ Yes ☐ No

Q12. Is the patient 6 years of age or older?

☐ Yes ☐ No

Q13. Is documentation provided that the patient had an inadequate response, intolerance, or contraindication to one of the following therapies: corticosteroids, conventional DMARDs (such as, azathioprine, 6-mercaptopurine, methotrexate), or the patient has lost response to or is intolerant to infliximab?

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☐ Yes ☐ No

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

☐ Yes ☐ No

Q15. Is the patient 5 years of age or older?

☐ Yes ☐ No

Q16. Is documentation provided that the patient had an inadequate response, intolerance, or contraindication to one of the following: corticosteroids or a conventional DMARD (e.g., azathioprine, 6-mercaptopurine (6-MP))?

☐ Yes ☐ No

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

☐ Yes ☐ No

Q18. Is the patient 12 years of age or older?

☐ Yes ☐ No

Q19. Is documentation provided that 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), or C) intralesional triamcinolone injections?

☐ Yes ☐ No

Q20. Does the patient have a documented diagnosis of uveitis?

☐ Yes ☐ No

Q21. Is documentation provided that the patient had an inadequate response, intolerance, or contraindication to at least one of the following: A) oral or topical glucocorticoids (e.g. prednisone), B) an immunosuppressant agent, or C) periocular or intraocular injection (triamcinolone)?

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☐ Yes ☐ No

Q22. Does the patient have a documented diagnosis of ankylosing spondylitis (AS) or active non-radiographic axial spondyloarthritis (nr-axSpA), adult?

☐ Yes ☐ No

Q23. Does the patient have a documented history of inadequate response, intolerance, or contraindication to at least 2 nonsteroidal anti-inflammatory drugs (NSAIDs)?

☐ Yes ☐ No

Q24. Is the patient 2 years of age or older?

☐ Yes ☐ No

Q25. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q26. Is the drug being prescribed by or in consultation with an appropriate specialist such as a rheumatologist, dermatologist, gastroenterologist, or ophthalmologist?

☐ Yes ☐ No

Q27. 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

Q28. Was the tuberculin skin test negative?

☐ Yes ☐ No

Q29. Is there documentation of a treatment plan to address active or latent infection?

☐ Yes ☐ No

Q30. Requested Duration:

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Member Name:	**Prescriber Name:**

☐ 12 Months ☐ Other:

Q31. Additional Information:

_____ _____

Prescriber Signature Date

v2025