



**MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM**

Adalimumab - 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: <input type="checkbox"/> 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. 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?

☐ Yes

☐ No

Q3. Is there confirmation of continued positive clinical response since starting the drug? If yes, go to 14.

☐ 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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<p>Q5. Has the patient had an inadequate response, intolerance, or contraindication to a trial of at least 1 conventional DMARD (e.g., methotrexate, hydroxychloroquine, leflunomide, sulfasalazine)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>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?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Has the patient had an inadequate response, intolerance or contraindication to 1 of the following: methotrexate, ultraviolet-B (UVB) therapy, or acitretin?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q8. Are chart notes attached documenting a diagnosis of Crohn's disease?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q9. Are chart notes attached documenting a diagnosis of hidradenitis suppurativa?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q10. 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)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q11. Are chart notes attached documenting a diagnosis of uveitis?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q12. 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)?</p>



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<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q13. Are chart notes attached documenting an FDA-approved diagnosis not otherwise excluded from part D?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q14. Is the drug being prescribed by or in consultation with an appropriate specialist such as a rheumatologist, dermatologist, gastroenterologist, or ophthalmologist?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q15. Requested Duration:	
<input type="checkbox"/> 12 Months	<input type="checkbox"/> Other:
Q16. Additional Information:	

Prescriber Signature

Date

v2026