



**MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM**

Adalimumab-aacf - 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. 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 or more disease modifying anti-rheumatic drugs (DMARDs) (e.g., methotrexate, hydroxychloroquine, sulfasalazine, azathioprine)?

☐ Yes

☐ No



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Member Name:	Prescriber Name:
<p>Q6. Does the patient have a diagnosis of Plaque Psoriasis?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q7. Is the disease moderate to severe?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>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)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>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?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q10. Does the patient have the diagnosis of Polyarticular Juvenile Idiopathic Arthritis (JIA)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q11. Is the patient 2 years of age or older?</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 conventional disease modifying anti-rheumatic drugs (DMARDs) (e.g., methotrexate)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q13. Does the patient have a diagnosis of Crohn's disease?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q14. Is the patient 6 years of age or older?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	



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Member Name:	Prescriber Name:
<p>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?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q16. Does the patient have the diagnosis of Ulcerative Colitis?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q17. Does the patient have the diagnosis of hidradenitis suppurativa?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q18. Has the patient had an inadequate response, intolerance or contraindication to: a topical antibiotics (e.g., clindamycin), oral antibiotics (e.g., doxycycline, minocycline, amoxicillin-clavulanic acid, clindamycin, rifampin, dapsone)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q19. Does the patient have a diagnosis of Uveitis?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>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 (azathioprine, methotrexate, cyclosporine), or C) periocular or intraocular injection (triamcinolone)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q21. Is the drug being prescribed by or in consultation with an appropriate specialist such as a rheumatologist, dermatologist, gastroenterologist, or ophthalmologist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q22. Has the patient been evaluated for active or latent tuberculosis (TB) infection with a tuberculin skin test prior to the initiation of therapy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	



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Member Name:	Prescriber Name:
Q23. Was the tuberculin skin test negative? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q24. Has the patient received appropriate prophylaxis in accordance with Centers for Disease Control and Prevention (CDC) guidelines? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q25. Requested Duration: <input type="checkbox"/> 12 months	
Q26. Additional Information:	

Prescriber Signature

Date

v2025