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. Is this an initial request or re-authorization request?

☐ Initial request ☐ Re-authorization request

Q2. What is the diagnosis?

☐ Rheumatoid Arthritis (RA)
☐ Juvenile Idiopathic Arthritis (JIA)
☐ Ankylosing Spondylitis (AS)
☐ Non-radiographic Axial Spondyloarthritis (nr-axSpA)
☐ Moderate to Severe Plaque Psoriasis (PsO)
☐ Crohn's Disease (CD)
☐ Ulcerative Colitis (UC)
☐ Hidradenitis Suppurativa (HS)
☐ Psoriatic Arthritis (PsA)
☐ Uveitis (UV)
☐ Behcet Disease
☐ Sarcoidosis
☐ Other

Q3. If other, please specify:

Q4. Is the patient within the age group listed in the FDA labeling for the indication?

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document

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:** |
|---|---|

☐ Yes ☐ No

Q5. For the diagnosis Rheumatoid Arthritis (RA), is the medication prescribed by or in consultation with a rheumatologist?

☐ Yes ☐ No

Q6. For the diagnosis Rheumatoid Arthritis (RA), does the patient have a documented inadequate response, intolerance, or contraindication to at least one conventional DMARD (e.g., methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) OR had a 3-month trial of a bDMARD or tsDMARD for the requested indication?

☐ Yes ☐ No

Q7. For the diagnosis Juvenile Idiopathic Arthritis (JIA), is the medication prescribed by or in consultation with a rheumatologist?

☐ Yes ☐ No

Q8. For the diagnosis Juvenile Idiopathic Arthritis (JIA), does the patient have a documented inadequate response, intolerance, or contraindication to at least one conventional DMARD (e.g., methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) OR had a 3-month trial of a bDMARD or tsDMARD for the requested indication?

☐ Yes ☐ No

Q9. For the diagnosis Ankylosing Spondylitis (AS), is the medication prescribed by or in consultation with a rheumatologist?

☐ Yes ☐ No

Q10. Does the patient have a documented inadequate response, intolerance, or contraindication to at least two nonsteroidal anti-inflammatory drugs (NSAIDs)?

☐ Yes ☐ No

Q11. For the diagnosis Non-radiographic Axial Spondyloarthritis (nr-axSpA), is the medication prescribed by or in consultation with a rheumatologist?

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document

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:** |
|---|---|

☐ Yes ☐ No

Q12. Does the patient have a documented inadequate response, intolerance, or contraindication to at least two nonsteroidal anti-inflammatory drugs (NSAIDs)?

☐ Yes ☐ No

Q13. For the diagnosis Moderate to Severe Plaque Psoriasis (PsO), is the medication prescribed by or in consultation with a dermatologist?

☐ Yes ☐ No

Q14. Is there documentation that the patient is a candidate for systemic therapy or phototherapy?

☐ Yes ☐ No

Q15. Does the patient have a documented inadequate response, intolerance, or contraindication to at least one of the following: methotrexate, UVB therapy, or acitretin OR had a 3-month trial of a bDMARD or tsDMARD for the requested indication?

☐ Yes ☐ No

Q16. For the diagnosis Crohn's Disease (CD), is the medication prescribed by or in consultation with a gastroenterologist?

☐ Yes ☐ No

Q17. Is the disease moderate to severe?

☐ Yes ☐ No

Q18. For the diagnosis Ulcerative Colitis (UC), is the medication prescribed by or in consultation with a gastroenterologist?

☐ Yes ☐ No

Q19. Is the disease moderate to severe?

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document

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:** |
|---|---|

☐ Yes ☐ No

Q20. For the diagnosis Hidradenitis Suppurativa (HS), is the medication prescribed by or in consultation with a dermatologist?

☐ Yes ☐ No

Q21. Does the patient have a documented inadequate response, intolerance, or contraindication to at least one oral antibiotic (e.g., doxycycline, minocycline, amoxicillin-clavulanic acid, clindamycin, rifampin, dapsone), or intralesional triamcinolone injections OR had a 3-month trial of a bDMARD or tsDMARD for the requested indication?

☐ Yes ☐ No

Q22. For the diagnosis Psoriatic Arthritis (PsA), is the medication prescribed by or in consultation with a rheumatologist?

☐ Yes ☐ No

Q23. Does the patient have a documented inadequate response, intolerance, or contraindication to a cDMARD (e.g., methotrexate, leflunomide, or sulfasalazine) OR had a 3-month trial of a bDMARD or tsDMARD for the requested indication?

☐ Yes ☐ No

Q24. Does the patient have one of the following conditions?

☐ Has axial disease, dactylitis, and/or enthesitis
☐ Has severe disease as determined by prescriber
☐ Has concomitant moderate to severe nail disease
☐ Has concomitant active inflammatory bowel disease
☐ None of the above

Q25. For the diagnosis Uveitis (UV), is the medication prescribed by or in consultation with an ophthalmologist?

☐ Yes ☐ No

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document

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:** |
|---|---|

Q26. Does the patient have a documented inadequate response, intolerance, or contraindication to at least one of the following: oral or topical glucocorticoids (e.g., prednisone), an immunosuppressant agent, or periocular or intraocular injection (e.g., triamcinolone) OR had a 3-month trial of a bDMARD or tsDMARD for the requested indication?

☐ Yes ☐ No

Q27. For the diagnosis Behcet Disease, is the medication prescribed by or in consultation with a rheumatologist or dermatologist?

☐ Yes ☐ No

Q28. Does the patient have a documented inadequate response, intolerance, or contraindication to one conventional agent (e.g., colchicine, azathioprine, methotrexate, mycophenolate, dapsone) OR had a 3-month trial of a bDMARD or tsDMARD for the requested indication?

☐ Yes ☐ No

Q29. For the diagnosis Sarcoidosis, is the medication prescribed by or in consultation with a rheumatologist or pulmonologist?

☐ Yes ☐ No

Q30. Does the patient have a documented inadequate response, intolerance, or contraindication to both of the following: at least one corticosteroid, AND at least one immunosuppressant (e.g., methotrexate, mycophenolate mofetil, chloroquine) OR had a 3-month trial of a bDMARD or tsDMARD for the requested indication?

☐ Yes ☐ No

Q31. For patients new to plan with a current history of taking an adalimumab containing product in the last 90 days and for reauthorization of prior approval, is there confirmation of positive clinical response?

☐ Yes ☐ No

Q32. Additional Information:

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document

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:** |
|---|---|
| | |

_____ _____

Prescriber Signature Date

*v2026*

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document