



PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Humira

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: <input type="checkbox"/> 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 a reauthorization request?

Yes - Go to 2

No - Go 3

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

Yes

No

Q3. Does the patient have the diagnosis of rheumatoid arthritis or psoriatic arthritis?

If No, go to 6.

Yes

No

Q4. Is the patient 18 years of age or older?

Yes

No

Q5. Has the patient had an inadequate response, intolerance, or contraindication to the trial of at least one disease modifying anti-rheumatic drug (DMARD) (e.g., methotrexate, hydroxychloroquine, sulfasalazine, azathioprine)? If YES, go to 29.



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Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q6. Does the patient have the diagnosis of plaque psoriasis? If YES, go to 7. If NO, go to 11. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. Is the patient 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. Is the disease moderate to severe? If YES, go to 9. If NO, go to 10. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. 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? If YES, go to 30. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q10. 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 30. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q11. Does the patient have the diagnosis of polyarticular juvenile idiopathic arthritis (pJIA)? If YES, go to 12. If NO, go to 14. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q12. Is the patient 2 years of age or older? If YES, go to 13. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q13. Has the patient had an inadequate response, intolerance or contraindication to at least one disease modifying anti-rheumatic drug (DMARD) (e.g., methotrexate)? If YES, go to 29.	



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<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q14. Does the patient have the diagnosis of Crohn's disease? If YES, go to 15. If NO, go to 17. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q15. Is the patient 6 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q16. Has the patient had an inadequate response, intolerance, or contraindication to one of the following therapies: corticosteroids, azathioprine, 6-mercaptopurine, methotrexate) or lost response to or intolerant to infliximab? If YES, go to 31. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q17. Does the patient have the diagnosis of ulcerative colitis? If YES, go to 18. If NO, go to 20. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q18. Is the patient 5 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q19. Has the patient had an inadequate response, intolerance, or contraindication to one of the following: corticosteroids or a DMARD (e.g., azathioprine, 6-mercaptopurine (6-MP))? If YES, go to 31. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q20. Does the patient have the diagnosis of hidradenitis suppurativa? If YES, go to 21. If NO, go to 23. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q21. Is the patient 12 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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Q22. Has 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), and C) intralesional triamcinolone injections? If YES, go to 30.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q23. Does the patient have the diagnosis of uveitis? If YES, go to 24. If NO, go to 26.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q24. Is the patient 2 years of age or older?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q25. Has the patient had an inadequate response, intolerance, or contraindication to at least one of the following: A) oral or topical glucocorticoids (prednisone, methylprednisolone, prednisolone), B) immunosuppressive agents (e.g., azathioprine, methotrexate, cyclosporine), or C) periocular or intraocular injection (triamcinolone)? If YES, go to 32.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q26. Does the patient have the diagnosis of ankylosing spondylitis (AS) or active non-radiographic axial spondyloarthritis (nr-axSpA), adult? If YES, go to 27.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q27. Is the patient 18 years of age or older? If YES, go to 28	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q28. Does the patient have a documented history of an inadequate response, intolerance, or contraindication to at least 2 nonsteroidal anti-inflammatory drugs (NSAIDs)? If YES, go to 29.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q29. Is Humira being prescribed by or in consultation with a rheumatologist? If YES, go to 33.	



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<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q30. Is Humira being prescribed by or in consultation with a dermatologist? If YES, go to 33.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q31. Is Humira being prescribed by or in consultation with a gastroenterologist? If YES, go to 33.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q32. Is Humira being prescribed by or in consultation with an ophthalmologist? If YES, go to 33.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q33. Has the patient been evaluated for active or latent tuberculosis (TB) infection with a tuberculin skin test prior to the initiation of therapy? If YES, go to 34.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q34. Was the tuberculin skin test negative?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q35. 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
Q36. Additional Information:	

Prescriber Signature

Date

v2025

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