Jefferson Health Plans

2024 MEDICARE 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.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare	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 or Psoriatic 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

Q6. Does the patient have a diagnosis of Plaque Psoriasis?

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Patient Name:	**Prescriber Name:**

☐ Yes ☐ No

Q7. Is the disease moderate to severe?

☐ Yes ☐ No

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)?

☐ Yes ☐ No

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?

☐ Yes ☐ No

Q10. Does the patient have the diagnosis of Polyarticular Juvenile Idiopathic Arthritis (JIA)?

☐ Yes ☐ No

Q11. Is the patient 2 years of age or older?

☐ Yes ☐ No

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)?

☐ Yes ☐ No

Q13. Does the patient have a diagnosis of Crohn's disease?

☐ Yes ☐ No

Q14. Is the patient 6 years of age or older?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q15. Has the patient had an inadequate response, intolerance or contraindication to corticosteroids and methotrexate or azathioprine, or infliximab?

☐ Yes ☐ No

Q16. Does the patient have the diagnosis of Ulcerative Colitis?

☐ Yes ☐ No

Q17. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q18. Has the patient had an inadequate response, intolerance, or contraindication to one of the following: corticosteroids, azathioprine, 6-mercaptopurine (6-MP)?

☐ Yes ☐ No

Q19. Does the patient have the diagnosis of hidradenitis suppurativa?

☐ Yes ☐ No

Q20. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q21. Has the patient had an inadequate response, intolerance or contraindication to at least 2 of the following: A) topical antibiotics (e.g., clindamycin), B) oral antibiotics (e.g., doxycycline, minocycline, amoxicillin-clavulanic acid, clindamycin, rifampin, dapsone), and C) intralesional triamcinolone injections?

☐ Yes ☐ No

Q22. Does the patient have a diagnosis of Uveitis?

☐ Yes ☐ No

Q23. Is the patient 18 years of age or older?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q24. 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)?

☐ Yes ☐ No

Q25. Is the drug being prescribed by or in consultation with an appropriate specialist such as a rheumatologist, dermatologist, gastroenterologist, or ophthalmologist?

☐ Yes ☐ No

Q26. 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

Q27. Was the tuberculin skin test negative?

☐ Yes ☐ No

Q28. Has the patient received appropriate prophylaxis in accordance with Centers for Disease Control and Prevention (CDC) guidelines?

☐ Yes ☐ No

Q29. Requested Duration:

☐ 12 months

Q30. Additional Information:

Prescriber Signature

Date

2024 Medicare Prior Authorization Request