PRIOR AUTHORIZATION REQUEST
Xeljanz

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. What is the indication or diagnosis?
   - ☐ Rheumatoid arthritis – **Please answer questions 4 – 7**
   - ☐ Psoriatic arthritis – **Please answer questions 8 – 13**
   - ☐ Ulcerative colitis – **Please answer questions 14 – 16**
   - ☐ COVID-19 (Coronavirus Disease 2019) Note: This includes requests for cytokine release syndrome associated with COVID-19. – **Please answer question 17**
   - ☐ Juvenile Idiopathic Arthritis (JIA) (regardless of type of onset) [Please Note: This includes patients with juvenile spondyloarthropathy/active sacroiliac arthritis] – **Please answer questions 18 – 21**
   - ☐ Renal transplantation
   - ☐ All other indications or diagnoses – Please specify _____ - **Please proceed to question 2**
2. Will the requested medication be given in combination with a BIOLOGIC or in combination with a targeted synthetic disease-modifying antirheumatic drug (DMARD) or with another potent immunosuppressant (for example, azathioprine, tacrolimus, cyclosporine, mycophenolate mofetil)?
   - ☐ Biologic DMARD
   - ☐ Potent immunosuppressant
   - ☐ Targeted synthetic DMARD
   - ☐ Conventional synthetic DMARD
   - ☐ No, the requested medication will NOT be used in combination with another BIOLOGIC or a targeted synthetic DMARD or potent immunosuppressant drug
3. ☐ Yes ☐ No Is the patient currently receiving Xeljanz or Xeljanz XR?
4. ☐ Yes ☐ No Has the patient tried ONE conventional synthetic disease-modifying antirheumatic drug (DMARD) for at least 3 months?
5. ☐ Yes ☐ No Has the patient had a 3-month trial at least one biologic for rheumatoid arthritis?
6. ☐ Yes ☐ No Is the requested medication being prescribed by or in consultation with a rheumatologist?

If you have any questions, call: 800-753-2851

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7. □ Yes □ No Has the patient had a response to therapy, as determined by the prescriber?
8. □ Yes □ No Is the requested medication being prescribed by or in consultation with a rheumatologist or a dermatologist?
9. □ Yes □ No Has the patient tried at least one conventional synthetic DMARD for at least 3 months?
10. □ Yes □ No Has the patient had a 3-month trial of a biologic for psoriatic arthritis?
11. □ Yes □ No Will the requested medication be used in combination with methotrexate or another conventional synthetic DMARD?
12. □ Yes □ No Is it contraindicated to use the requested medication in combination with methotrexate or another conventional synthetic DMARD?
13. □ Yes □ No Has the patient had a response to therapy, as determined by the prescriber?
14. □ Yes □ No Is the requested medication prescribed by or in consultation with a gastroenterologist?
15. □ Yes □ No Has the patient had a trial of at least ONE tumor necrosis factor inhibitor for ulcerative colitis?
16. □ Yes □ No Has the patient had a response to therapy, as determined by the prescriber?
17. Please provide the patient's diagnosis or indication, prescribed dose, frequency and route of administration, any other medications previously tried with duration of trial, and prescriber's or consultant's specialty. If the patient is already on this medication, when was it started?

_____

18. □ Yes □ No Is Xeljanz being prescribed by, or in consultation with, a rheumatologist?
19. □ Yes □ No Has the patient tried one other medication for this condition?
20. □ Yes □ No Does the patient have aggressive disease, as determined by the prescriber?
21. □ Yes □ No Has the patient had a response, as determined by the prescriber?

Please document the diagnoses, symptoms, and/or any other information important to this review:

_____

_____

SECTION B Physician Signature

_____

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior

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authorization as per Plan policy and procedures.

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