Please complete ALL information below and fax your request to 1-888-671-5285

# Xeljanz® & Xeljanz XR® Prior Authorization Request (Page 1 of 2)

**DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED**

| Member Information (required) | | | Provider Information (required) | | |
|---|---|---|---|---|---|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NPI#: | Specialty: | |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |

## Medication Information (required)

| Medication Name: | Strength: | Dosage Form: |
|---|---|---|
| ❑ Check if **generic substitution** is acceptable<br>❑ Check if request is for **continuation of therapy** | Directions for Use: | |

## Clinical Information (required)

**Select the diagnosis below:**

- ❑ Psoriatic arthritis (for example: arthropathic psoriasis; L40.5, L40.59)
- ❑ Rheumatoid arthritis (for example: M05.79, M06.9)
- ❑ Ulcerative colitis (for example: K51.00, K51.90, K51.919)
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

**Prescriber's Specialty:**

Select if Xeljanz/Xeljanz XR is prescribed by or in consultation with one of the following specialists:

❑ Dermatologist ❑ Gastroenterologist ❑ Rheumatologist

**Clinical Information:**

Does the patient have a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 40.2 for specific phobia diagnostic criteria)? ❑ **Yes** ❑ **No**

Is this request for continuation of prior Xeljanz/Xeljanz XR therapy? ❑ **Yes** ❑ **No**

Will the patient receive Xeljanz/Xeljanz XR in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine)? ❑ **Yes** ❑ **No**

Will the patient receive Xeljanz/Xeljanz XR in combination with other janus kinase (JAK) inhibitors (e.g., Olumiant)? ❑ **Yes** ❑ **No**

**Psoriatic Arthritis:**

Does the patient have active disease? ❑ **Yes** ❑ **No**

Has the patient had trial and failure, contraindication, or intolerance to ONE non-biologic disease modifying anti-rheumatic drug (DMARD) (e.g., methotrexate [Rheumatrex/Trexall], Arava [leflunomide], Azulfidine [sulfasalazine])? ❑ **Yes** ❑ **No**

Select if the patient has had trial and failure, contraindication, or intolerance to the following:

- ❑ Cimzia (certolizumab pegol)
- ❑ Humira (adalimumab)
- ❑ Simponi (golimumab) or Simponi Aria (golimumab IV)
- ❑ Stelara (ustekinumab)

**Rheumatoid Arthritis:**

Does the patient have moderately to severely active disease? ❑ **Yes** ❑ **No**

Has the patient had trial and failure, contraindication, or intolerance to ONE non-biologic disease modifying anti-rheumatic drug (DMARD) (e.g., methotrexate [Rheumatrex/Trexall], Arava [leflunomide], Azulfidine [sulfasalazine])? ❑ **Yes** ❑ **No**

Select if the patient has had trial and failure, contraindication, or intolerance to the following, or attestation demonstrating a trial may be inappropriate:

- ❑ Cimzia (certolizumab pegol)
- ❑ Humira (adalimumab)
- ❑ Simponi (golimumab) or Simponi Aria (golimumab IV)

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**Ulcerative Colitis:**

Does the patient have moderately to severely active disease? ❑ **Yes** ❑ **No**

Select if the patient has had trial and failure, contraindication or intolerance to the following conventional therapies:

- ❑ 6-mercaptopurine (Purinethol)
- ❑ Aminosalicylate (e.g., mesalamine [Asacol, Pentasa, Rowasa], olsalazine [Dipentum], sulfasalazine [Azulfidine, Sulfazine])
- ❑ Azathioprine (Imuran)
- ❑ Corticosteroids (e.g., prednisone, methylprednisolone)

Select if the patient has had trial and failure, contraindication, or intolerance to the following, or attestation demonstrating a trial may be inappropriate:

- ❑ Humira (adalimumab)
- ❑ Simponi (golimumab)

**Reauthorization:**

Is there documentation the patient has had a positive clinical response to Xeljanz/Xeljanz XR therapy? ❑ **Yes** ❑ **No**

Will the patient receive Xeljanz/Xeljanz XR in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine)? ❑ **Yes** ❑ **No**

Will the patient receive Xeljanz/Xeljanz XR in combination with other janus kinase (JAK) inhibitors (e.g., Olumiant)? ❑ **Yes** ❑ **No**

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

_____

_____

Please note: This request may be denied unless all required information is received.