MedStar Medicare Choice
Pharmacy Services
Phone: 855-266-0712
Fax: 855-862-6517

# XELJANZ
## Prior Authorization Form

| | |
|---|---|
| □ Standard Request (72 hours)<br>□ Expedited Request (24 hours) | If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received. |

## Demographics

| Patient Information | | Prescriber Information | |
|---|---|---|---|
| Patient Name: | | Prescriber Name: | |
| DOB: | Age: | NPI#: | Specialty: |
| Health Plan ID#: | | Phone: | Fax: |
| Pharmacy Name: | Pharmacy Phone: | Office Contact: | Direct Phone # or Ext: |

## Medication Information

| Drug Requested: | Strength: | Directions: | Quantity Dispensed: | Day Supply: |
|---|---|---|---|---|
| Xeljanz (Tofacitinib) | □ 5mg tablet<br>□ 11mg tablet (Xeljanz XR) | | | |
| □ New medication<br>□ Continuation of therapy | Start Date: | If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy. | | |

## Clinical Information

| Diagnosis: | Date of Diagnosis: |
|---|---|
| | |

Disease Severity:
□ Mild
□ Moderate
□ Severe

PPD (tuberculin) test:
□ Positive
□ Negative
Date:_____

Is the member currently using another biologic Disease Modifying Antirheumatic Drug or potent immunosuppressant in combination with Xeljanz? □ Yes □ No

Medication:_____

Does the member currently have evidence of infection? □ Yes □ No

**Please indicate past medication(s) tried and failed:**
***Xeljanz requires prior drug therapy with both preferred TNF products*

| Medication | Start Date | End Date | Strength | Frequency | Reason for Discontinuing |
|---|---|---|---|---|---|
| □ Methotrexate | | | | | |
| □ Hydroxychloroquine | | | | | |
| □ Leflunomide | | | | | |
| □ Minocycline | | | | | |
| □ Sulfasalazine | | | | | |
| □ Cimzia | | | | | |
| □ ENBREL** | | | | | |
| □ HUMIRA** | | | | | |
| □ Remicade | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| □ Simponi | | | | | |
| □ Other (provide names): | | | | | |

| Please provide the following laboratory values: | | |
|---|---|---|
| Test | Date of test | Result (include units) |
| Absolute Neutrophil Count (ANC) | | |
| Lymphocyte Count | | |
| Hemoglobin | | |
| ALT | | |
| AST | | |
| Total Cholesterol | | |
| LDL Cholesterol | | |
| HDL Cholesterol | | |
| Triglycerides | | |

| Please provide any additional information which should be considered in the space below: |
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