

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

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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:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below: <input type="checkbox"/> Active psoriatic arthritis <input type="checkbox"/> Moderate to severely active rheumatoid arthritis <input type="checkbox"/> Moderately to severely active ulcerative colitis <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
For active psoriatic arthritis or moderate to severely active rheumatoid arthritis, answer the following: Is the prescriber a rheumatologist? <input type="checkbox"/> Yes <input type="checkbox"/> No Select if the patient has tried and failed the following disease modifying antirheumatic drugs (DMARDs) for at least three (3) months: <input type="checkbox"/> Auranofin <input type="checkbox"/> Leflunomide <input type="checkbox"/> Azathioprine <input type="checkbox"/> Methotrexate <input type="checkbox"/> Hydroxychloroquine <input type="checkbox"/> Sulfasalazine Has the patient tried and failed minocycline for at least three (3) months? <input type="checkbox"/> Yes <input type="checkbox"/> No Select if the patient has tried and failed the following: <input type="checkbox"/> Cimzia <input type="checkbox"/> Humira <input type="checkbox"/> Simponi					
For moderately to severely active ulcerative colitis, answer the following: Select if the patient has had an inadequate response to the following: <input type="checkbox"/> Aminosalicylate (for at least 3 months) <input type="checkbox"/> Budesonide or high dose steroids (40 to 60 mg prednisolone) Was the requested medication prescribed by a gastroenterologist? <input type="checkbox"/> Yes <input type="checkbox"/> No Select if the patient has tried and failed the following: <input type="checkbox"/> Humira <input type="checkbox"/> Simponi					
Medication being provided by: (Please check applicable box below) <input type="checkbox"/> Physician's office <input type="checkbox"/> PropriumRx <input type="checkbox"/> Specialty Pharmacy (specify name): _____					
Use of samples to initiate therapy does not meet step edit/ preauthorization criteria. *Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*					
Prescriber Signature: _____			Date: _____		

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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.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.