Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Xeljanz® & Xeljanz® XR Prior Authorization Request Form (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 requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Active psoriatic arthritis
- ❑ Moderate to severely active rheumatoid arthritis
- ❑ Moderately to severely active ulcerative colitis
- ❑ 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? ❑ **Yes** ❑ **No**

Select if the patient has tried and failed the following disease modifying antirheumatic drugs (DMARDs) for at least three (3) months:

- ❑ Auranofin
- ❑ Azathioprine
- ❑ Hydroxychloroquine
- ❑ Leflunomide
- ❑ Methotrexate
- ❑ Sulfasalazine

Select if the patient has tried and failed the following:

- ❑ Cimzia
- ❑ Humira
- ❑ Simponi

For moderately to severely active ulcerative colitis, answer the following:

Select if the patient has had an inadequate response to the following:

- ❑ Aminosalicylate (for at least 3 months)
- ❑ Budesonide or high dose steroids (40 to 60 mg prednisolone)

Was the requested medication prescribed by a gastroenterologist? ❑ **Yes** ❑ **No**

Select if the patient has tried and failed the following:

- ❑ Humira
- ❑ Simponi

Medication being provided by: (Please check applicable box below)

❑ Physician's office ❑ PropriumRx ❑ 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:** _____

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

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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.