Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Xeljanz - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Member Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare Advantage	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is this a reauthorization request?

☐ Yes ☐ No

Q2. Is there confirmation of continued positive clinical response since starting Dose Xeljanz/Xeljanz XR?

☐ Yes ☐ No

Q3. Is the requested drug being prescribed by or in consultation with the appropriate specialist per diagnosis: a rheumatologist, or gastroenterologist?

☐ Yes ☐ No

Q4. Does the patient have a documented diagnosis of moderately to severely active rheumatoid arthritis (RA), active psoriatic arthritis (PsA), active ankylosing spondylitis (AS), moderately to severely active ulcerative colitits (UC), active polyarticular course juvenile idiopathic arthritis (pcJIA)?

☐ Yes ☐ No

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Q5. Is there documentation of an inadequate response, intolerance, or contraindication to at least one TNF blocker indicated for the patient's diagnosis?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older for RA, PsA, AS or UC, or 2 years of age or older for pcJIA?

☐ Yes ☐ No

Q7. Has the patient been evaluated for current infections including active or latent tuberculosis (TB) infection with a tuberculin skin test prior to the initiation of therapy?

☐ Yes ☐ No

Q8. Was the tuberculin skin test negative?

☐ Yes ☐ No

Q9. Is there a treatment plan for the active or latent infection?

☐ Yes ☐ No

Q10. Will the requested drug be used concomitantly with other biologic disease modifying anti-rheumatic drugs (DMARDs) or potent immunosuppressants (such as azathioprine or cyclosporine)?

☐ Yes ☐ No

Q11. Requested Duration:

☐ 12 months ☐ Other

Q12. Additional Information:

Prescriber Signature

Date

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