Premier Health Plan
Pharmacy Services
Commercial Phone: 855-266-0713
Exchange Phone: 866-822-2413
Fax: 855-862-6518

XELJANZ
Prior Authorization Form

□ Standard Request □ Expedited Request	If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. ***For state exchanges only:*** The above disclaimer applies for exigent circumstances. Expedited review may also be requested when you are undergoing a current course of treatment using a non-formulary drug.

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: Xeljanz (Tofacitinib)	Strength: 5mg Tablet	Directions:	Quantity Dispensed:	Day Supply:
□ New medication □ 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 <u>both</u> preferred TNF products*

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

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Member Name:	DOB:	Health Plan ID:
Please be sure to complete and include this page with the 1st page of this form.		

☐ 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: