Premier Health Plan

Premier Health Plan
Pharmacy Services
Phone: 866-822-2714
Fax: 855-862-6518

XELJANZ
Prior Authorization Form

☐ Standard Request (72 hours) ☐ 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 ☐ 11mg tablet (Xeljanz XR)			
☐ 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 both preferred TNF products*

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

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☐ 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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