# Xeljanz Oral Solution(tofacitinib)
# Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

**Instructions:** Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

| **MEMBER INFORMATION** | |
|---|---|
| **LAST NAME:** | **FIRST NAME:** |
| **PHONE NUMBER:** | **DATE OF BIRTH:** |
| **STREET ADDRESS:** | |
| **CITY:** | **STATE:** **ZIP CODE:** |
| **PATIENT INSURANCE ID NUMBER:** | |

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

**IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK:** HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

**PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE):** _____
**AUTHORIZED REPRESENTATIVE'S PHONE NUMBER:** _____

| **PRESCRIBER INFORMATION** | |
|---|---|
| **LAST NAME:** | **FIRST NAME:** |
| **PRESCRIBER SPECIALTY:** | **EMAIL ADDRESS:** |
| **NPI NUMBER:** | **DEA NUMBER:** |
| **PHONE NUMBER:** | **FAX NUMBER:** |
| **STREET ADDRESS:** | |
| **CITY:** | **STATE:** **ZIP CODE:** |
| **REQUESTOR** (if different than prescriber)**:** | **OFFICE CONTACT PERSON:** |

| **MEDICATION OR MEDICAL DISPENSING INFORMATION** | | | |
|---|---|---|---|
| **MEDICATION NAME:** | | | |
| **DOSE/STRENGTH:** | **FREQUENCY:** | **LENGTH OF THERAPY/REFILLS:** | **QUANTITY:** |
| ☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES): | | **IF RENEWAL:** DATE THERAPY INITIATED: | |

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**MEMBER'S LAST NAME:** _____ **MEMBER'S FIRST NAME:** _____

| **1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?** ☐ YES (if yes, complete below) ☐ NO | | |
|---|---|---|
| **MEDICATION/THERAPY** (SPECIFY DRUG NAME AND DOSAGE): | **DURATION OF THERAPY** (SPECIFY DATES): | **RESPONSE/REASON FOR FAILURE/ALLERGY:** |
| | | |

| **2. LIST DIAGNOSES:** | **ICD-10:** |
|---|---|
| ☐ Moderately to severely active rheumatoid arthritis<br>☐ Psoriatic arthritis<br>☐ Polyarticular juvenile idiopathic arthritis (pJIA)<br>☐ Other diagnosis: _____ICD-10_____ | |

**3. REQUIRED CLINICAL INFORMATION:** PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

**Is patient using drug as part of a clinical trial? ☐ Yes ☐ No**

**Initial Request:**
**Does patient have an enteral feeding tube? ☐ Yes ☐ No**

**Does patient have difficulty swallowing? ☐ Yes ☐ No *Please submit documentation*.**

**Is the patient currently not taking any other tablets or capsules (Exception: orally dissolving tablets and sprinkle capsules)? ☐ Yes ☐ No**

**Prescriber specialty:**
**Select if the requested medication is prescribed by one of the following specialists:**
- ☐ **Dermatologist**
- ☐ **Rheumatologist**

**Has the patient tried and had an inadequate response to at least a three month trial with Enbrel? ☐ Yes ☐ No**
***Must submit prior dates of use.***
**Has the patient tried and had an inadequate response to at least a three month trial with Humira? ☐ Yes ☐ No**
***Must submit prior dates of use.***

**For moderately to severely active rheumatoid arthritis, also answer the following:**
**Is the patient concurrently taking another TNF antagonists or biologic, such as Kineret, Remicade , Rituxan, Orencia, Cimzia, Enbrel, Humira, Actemra, Kevzara, or Simponi? ☐ Yes ☐ No**

**Has the patient had a trial and inadequate response to methotrexate or another oral non-biologic disease modifying anti-rheumatic drug (DMARD) such as Imuran, Ridaura, Plaquenil, sulfasalazine or Arava?* ☐ Yes ☐ No**
***Must submit documentation.***

**Is the patient unable to take the prerequisite non-biologic DMARD due to their chronic liver disease (such as chronic hepatitis, fatty liver, nonalcoholic steatohepatitis (NASH) or elevated liver enzymes)?* ☐ Yes ☐ No**
***Must submit documentation.***

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**For psoriatic arthritis, also answer the following:**
**Has the patient had a trial and inadequate response to methotrexate or another oral non-biologic disease modifying anti-rheumatic drug (DMARD) such as sulfasalazine(Azulfidine®), leflunamide(Arava®), or cyclosporine?**
**□ Yes □ No *Must submit prior dates of use***

**For polyarticular juvenile arthritis, also answer the following:**
**Has the patient tried and had an inadequate response or intolerance to an oral disease modifying anti-rheumatic agent [e.g., methotrexate, sulfasalazine, or leflunomide (Arava)]? □ Yes □ No**

**Is the patient unable to take a non-biologic DMARD due to chronic liver disease (such as chronic hepatitis, fatty liver, nonalcoholic steatohepatitis/NASH, or elevated liver enzymes)? □ Yes □ No**

**If "No" to the above question, provide the rationale explaining why the patient cannot take the prerequisite DMARDs:** _____

**Reauthorization:**
**Is the patient currently taking any other tablets or capsules (Exception: orally dissolving tablets and sprinkle capsules)? □ Yes □ No**

***If yes, please provide rationale (if applicable), explaining why the patient is unable to take regular oral tablets or capsules:***

_____

**Select if the requested medication is prescribed by one of the following specialists:**
- **□ Dermatologist**
- **□ Rheumatologist**

**Does the patient continue to have a positive clinical response and is remission of disease maintained with continued use?* □ Yes □ No**
***Must provide supporting chart notes.***

**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:** Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

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**MEMBER'S LAST NAME:** _____ **MEMBER'S FIRST NAME:** _____

**ATTESTATION:** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature or Electronic I.D. Verification:** _____ **Date:** _____



**FAX THIS FORM TO: 800-424-7640**
**MAIL REQUESTS TO:** Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.
4801 E. Washington Street, Phoenix, AZ 85034
Phone: 877-228-7909