



# Xeljanz & Xeljanz XR (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](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:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

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MEMBER'S LAST NAME: \_\_\_\_\_ MEMBER'S FIRST NAME: \_\_\_\_\_

<b>1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?</b> <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
<b>MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):</b>  	<b>DURATION OF THERAPY (SPECIFY DATES):</b>  	<b>RESPONSE/REASON FOR FAILURE/ALLERGY:</b>  
<b>2. LIST DIAGNOSES:</b> <input type="checkbox"/> Moderately to severely active rheumatoid arthritis <input type="checkbox"/> Psoriatic arthritis <input type="checkbox"/> Polyarticular juvenile idiopathic arthritis (pJIA) <input type="checkbox"/> Ulcerative colitis <input type="checkbox"/> Other diagnosis: _____ ICD-10 _____		<b>ICD-10:</b>  
<b>3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.</b>		
<b>Prescriber specialty:</b> Select if the requested medication is prescribed by one of the following specialists: <input type="checkbox"/> Dermatologist <input type="checkbox"/> Rheumatologist <input type="checkbox"/> Gastroenterologist  Has the patient tried and had an inadequate response to at least a three month trial with Enbrel? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Must submit prior dates of use.</i> Has the patient tried and had an inadequate response to at least a three month trial with Humira? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Must submit prior dates of use.</i>		
For <u>moderately to severely active rheumatoid arthritis</u> , also answer the following: Is the patient concurrently taking another TNF antagonists or biologic, such as Kineret, Remicade, Rituxan, Orenia, Cimzia, Enbrel, Humira, Actemra or Simponi? <input type="checkbox"/> Yes <input type="checkbox"/> 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?* <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Must submit documentation.</i>  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)?* <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Must submit documentation.</i>		
For <u>psoriatic arthritis</u> , 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Must submit prior dates of use</i>		
For <u>polyarticular juvenile arthritis</u> , 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)]? <input type="checkbox"/> Yes <input type="checkbox"/> No		





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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: \_\_\_\_\_

**For Ulcerative Colitis, please also answer the following:**

Is disease in the colon and limited to the distal 15 cm of colon?  Yes  No

Does patient have a history of treatment failure with oral glucocorticoids, intravenous glucocorticoids, azathioprine and/or mercaptopurine?  Yes  No *Please provide documentation.*

**Reauthorization:**

If this is a reauthorization request, answer the following:

Select if the requested medication is prescribed by one of the following specialists:

- Dermatologist
- Rheumatologist
- Gastroenterologist

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.

**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:** \_\_\_\_\_

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**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

