



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):			

Continued on next page.





**Xeljanz & Xeljanz XR (Tofacitinib)
Prior Authorization Request Form**

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



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:**

<input type="checkbox"/> Moderately to severely active rheumatoid arthritis <input type="checkbox"/> Psoriatic arthritis <input type="checkbox"/> Other diagnosis: _____ ICD-10 _____	
---	--------------

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

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

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 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, Cuprimine, 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.*

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

For psoriatic arthritis, also answer the following:
 Has the patient tried and had an inadequate response to at least a three month trial with Enbrel AND Humira?
 Yes No

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





**Xeljanz & Xeljanz XR (Tofacitinib)
Prior Authorization Request Form**



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

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:** _____

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

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

