PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Xeljanz (tofacitinib)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. What diagnosis is this drug being prescribed for (pick one)? *

- ☐ Rheumatoid arthritis (RA)
- ☐ Psoriatic arthritis (PSA)
- ☐ Other

Q2. Please provide ICD code(s) for diagnosis.

Q3. Is the patient a NEW START to the requested medication?

☐ Yes ☐ No (please provide start date)

Q4. Is the prescribing physician a Rheumatologist?

☐ Yes ☐ No

Q5. Is the prescribing physician a Dermatologist?

☐ Yes ☐ No

Q6. If request is for psoriatic arthritis, does patient have documented spinal involvement?

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☐ Yes ☐ No

Q7. Does the patient have adequate trial of or clinical significant intolerance to methotrexate?

☐ Yes ☐ No

Q8. Does the patient have a contraindication to methotrexate?

☐ Yes ☐ No

Q9. If the patient has a contraindication to methotrexate, does the patient have failure of an adequate trial to the following? Please select all that apply

☐ hydroxychloroquine ☐ sulfasalazine ☐ leflunomide

Q10. If the patient has a contraindication to methotrexate, does the patient have contraindication to the following? Please select all that apply

☐ hydroxychloroquine ☐ sulfasalazine ☐ leflunomide

Q11. Select the agents the patient has failed an adequate trial of at least 8 weeks of, clinically significant intolerance, or contraindication to

☐ Enbrel
☐ Humira
☐ Cimzia
☐ Cosentyx
☐ Orencia
☐ Remicade or Renflexis
☐ Simponi
☐ Stelara
☐ Other (please specify)
☐ None

Q12. Is Xeljanz going to be used concomitantly with a biologic?

☐ Yes ☐ No

Q13. Additional Comments

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Prescriber Signature _____ Date _____

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.