UnitedHealthcare Community Plan

XELJANZ

PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

SECTION A - PATIENT INFORMATION		
Today's Date:	First Name:	Last Name:
Member ID #:	Address:	
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication NEW ☐ or a CONTINUATION of THERAPY ☐? If so, start date:_____

Is this patient currently hospitalized? ☐Yes ☐No

SECTION B - PHYSICIAN INFORMATION				
First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	Zip:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax Attention to:				

Medication: **Strength:**

Directions for use:

Diagnosis (Please be specific & provide as much information as possible)**:** **ICD-10 Code:**

SECTION C – CLINICAL INFORMATION

Initial Authorization Requests:

Does the patient have a diagnosis of moderate to severe active Rheumatoid Arthritis? ☐ **Yes** ☐ **No**

Does the patient have a history of failure, contraindication, or intolerance to methotrexate? ☐ **Yes** ☐ **No**
If yes, please explain: _____

Does the patient have a history of failure, contraindication to any of the following?

☐ Enbrel ☐ Humira ☐ Cimzia ☐ Simponi

If yes, please provide dates of therapy and details: _____

Does the patient have a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure? ☐ **Yes** ☐ **No**

Will other medications be used in combination with Xeljanz to treat this patient? ☐ **Yes** ☐ **No**
If yes, what other medications will be used? _____

Re-Authorization Requests:

Has the patient demonstrated a positive clinical response to Xeljanz therapy? ☐ **Yes** ☐ **No**
Describe benefit of therapy: _____

Physician Signature: _____ **Date:** _____