

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:
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Directions for use:

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

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