pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

XELJANZ (tofacitinib) (non-preferred) PRIOR AUTHORIZATION FORM

Cytokine and CAM Antagonists and **Quantity Limits/Daily Dose Limits** prior authorization guidelines are accessible on the Department's Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Additional info ☐Renewal request (PA#:_____)	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Product requested: ☐Xeljanz 5 mg tablet ☐other: _____			
Directions:	Quantity:	Refills:	Recipient's weight: _____ lbs/kg
Diagnosis (*submit documentation*):			Diagnosis code (*required*):

ALL requests	
1. **Specialty Pharmacy Drug Program:** What Specialty Pharmacy will be used? ☐Diplomat Specialty ☐Walgreens Specialty	
2. Check all that apply to the Recipient and *submit documentation for each*. ☐screened for hepatitis B (antibody and/or surface antigen) ☐screened for tuberculosis ☐up-to-date with all age-appropriate immunizations (if < 21 years of age, in accordance with EPSDT guidelines)	
INITIAL requests	
3. Does the Recipient have a history of trial and failure, contraindication, or intolerance of at least 3 months of treatment with methotrexate or another DMARD?	☐Yes ☐No *Submit documentation of all medications tried and outcomes.*
4. Does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred agents? *Check all that apply.* ☐Enbrel ☐Humira	☐Yes ☐No *Submit documentation of all medications tried and outcomes.*
5. Does the Recipient have recent results of the following lab tests? *Check all that apply.* ☐CBC with differential ☐serum creatinine ☐liver function tests (LFTs)	☐Yes ☐No *Submit documentation of results.*
6. Is the Recipient prescribed a medication that is a potent CYP3A4 inducer (eg, carbamazepine, dexamethasone, oxcarbazepine, phenobarbital, phenytoin, primidone, St. John's Wort?	☐Yes ☐No *Submit Recipient's complete medication list.*
RENEWAL requests	
1. Since starting Xeljanz, has the Recipient experienced a positive clinical response and/or improved level of functioning?	☐Yes ☐No *Submit documentation of clinical response.*
2. Does the Recipient have recent results of the following lab tests? *Check all that apply.* ☐CBC with differential ☐serum creatinine ☐liver function tests (LFTs)	☐Yes ☐No *Submit documentation of results.*
3. Is the Recipient prescribed a medication that is a potent CYP3A4 inducer (eg, carbamazepine, dexamethasone, oxcarbazepine, phenobarbital, phenytoin, primidone, St. John's Wort?	☐Yes ☐No *Submit Recipient's complete medication list.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**:

Confidentiality Notice: The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.