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 (preferred) / XELJANZ XR (non-preferred) (tofacitinib) 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 ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Product requested: ☐Xeljanz tablet (preferred) ☐Xeljanz XR tablet (non-preferred) ☐_____

Strength:	Directions:	Quantity:	Refills:
Diagnosis (*submit documentation*):		Diagnosis code (*required*):	

Specialty Pharmacy Drug Program: Which specialty pharmacy will be used? ☐Diplomat Specialty ☐Walgreen's Specialty

INITIAL requests		
1. Check all that apply to the beneficiary and *submit documentation for each*. ☐up-to-date with all age-appropriate immunizations ☐screened for tuberculosis ☐has been using the requested medication in the past 90 days ☐screened for hepatitis B (surface antigen & core antibody) ☐vaccinated for hepatitis B		
2. Does the beneficiary have recent results of the following lab tests? *Check all that apply.* ☐CBC with differential ☐liver function tests (LFTs) ☐serum creatinine	☐Yes ☐No	*Submit documentation of results.*
3. Is the beneficiary prescribed a medication that is a potent CYP3A4 inducer (e.g., carbamazepine, dexamethasone, oxcarbazepine, phenobarbital, phenytoin, primidone, St. John's Wort)?	☐Yes ☐No	*Submit beneficiary's complete medication list.*
4. ***Rheumatoid arthritis:*** Does the beneficiary 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.*
5. ***Psoriatic arthritis*:** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the following? ☐four-week trial each of at least 2 different NSAIDs ☐eight-week trial of methotrexate or other DMARD *(does not apply to axial disease)*	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
6. ***Ulcerative colitis:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the following? ☐aminosalicylates ☐corticosteroids ☐conventional immunomodulators	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
7. ***Xeljanz XR requests*:** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agents approved for the diagnosis? *Check all that apply.* ☐Cosentyx ☐Humira ☐Xeljanz	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
8. ***For a diagnosis other than the approved indication(s),*** submit documentation supporting the use of the requested medication for the beneficiary's diagnosis & other treatments tried.		
RENEWAL requests		
1. Since starting Xeljanz, did the beneficiary experience a positive clinical response and/or improved level of functioning?	☐Yes ☐No	*Submit documentation of clinical response.*
2. Does the beneficiary have recent results of the following lab tests? *Check all that apply.* ☐CBC with differential ☐liver function tests (LFTs) ☐serum creatinine	☐Yes ☐No	*Submit documentation of results.*
3. Is the beneficiary prescribed a medication that is a potent CYP3A4 inducer (eg, carbamazepine, dexamethasone, oxcarbazepine, phenobarbital, phenytoin, primidone, St. John's Wort)?	☐Yes ☐No	*Submit beneficiary's complete medication list.*

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

Prescriber Signature:	**Date**: