PriorityHealth

Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**
This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Xeljanz® or Xeljanz® XR (tofacitinib)

Member

Last Name: ____________________ First Name: ____________________
ID #: ____________________ DOB: __________ Gender: __________
Primary Care Physician: ____________________

Requesting Provider: ____________________ Prov. Phone: __________ Prov. Fax: __________
Provider Address: ____
Provider NPI: ____________________ Contact Name: ____________________

Provider Signature: ____________________ Date: __________

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Xeljanz oral tablet
☐ Xeljanz XR oral tablet

Start date (or date of next dose): ____________________
Date of last dose (if applicable): ____________________
Dosing frequency: ____________________

Precertification Requirements

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

Before this drug is covered, the patient must meet all of the following requirements:

1. Must be used for a medically-accepted indication*
2. Must have tried and failed one oral DMARD (e.g. methotrexate) OR one injectable biologic DMARD (e.g., Humira)
3. For initial approval, must have a negative TB test in the past 12 months

Medically-accepted indication*

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 01/2019
Last reviewed 01/2019

Priority Health Precertification Documentation

A. What is the date and result of the patient's most recent TB test?

- ☐ Negative **Date:** ____________________
- ☐ Positive
- ☐ Not completed. **Are you requesting an exception to the criteria?**
  - ☐ Yes. ***Rationale for exception***: ____
  - ☐ No

B. What is the patient's diagnosis?

- ☐ Rheumatoid arthritis (moderate to severe)
  1. **Has the patient had an inadequate response or intolerance to methotrexate?**
     - ☐ Yes
     - ☐ No. **Are you requesting an exception to the criteria?**
       - ☐ Yes. ***Rationale for exception***: ____
       - ☐ No
- ☐ Psoriatic arthritis (active)
- ☐ Ulcerative colitis (moderate to severe)
- ☐ *Other – the patient's condition is:* ____
  - ***Rationale for Other use***: ____

C. Has the patient tried and failed one oral DMARD?

☐ Yes.

	Dose	Dates	Outcome
☐ azathioprine	____________	__________________	__________________
☐ cyclosporine	____________	__________________	__________________
☐ hydroxychloroquine	____________	__________________	__________________
☐ leflunomide	____________	__________________	__________________
☐ methotrexate	____________	__________________	__________________
☐ sulfasalazine	____________	__________________	__________________
☐ Other:	____________	__________________	__________________

☐ No. **Are you requesting an exception to the criteria?**
- ☐ Yes. ***Rationale for exception***: ____
- ☐ No

D. Has the patient tried and failed one injectable biologic DMARD?

☐ Yes.

	Dose	Dates	Outcome
☐ Enbrel	____________	__________________	__________________
☐ Humira	____________	__________________	__________________
☐ Cimzia	____________	__________________	__________________
☐ Remicade	____________	__________________	__________________
☐ Simponi	____________	__________________	__________________
☐ Actemra	____________	__________________	__________________
☐ Orencia	____________	__________________	__________________
☐ Rituxan	____________	__________________	__________________
☐ *Other:*	____________	__________________	__________________

☐ No. **Are you requesting an exception to the criteria?**
- ☐ Yes. ***Rationale for exception***: ____
- ☐ No

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Priority Health Medicare Exception Request *(exceptions to the above criteria)*

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Xeljanz or Xeljanz XR likely be the most effective option for this patient?
☐ No
☐ Yes, because:____

If the patient is currently using Xeljanz or Xeljanz XR, would changing the patient's current regimen likely result in adverse effects for the patient?
☐ No
☐ Yes, because:____

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