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: _____

Prior authorization criteria

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.

For this drug to be covered, the patient must meet the following criteria:

1. Must be used for a medically accepted indication*
2. For a diagnosis of psoriatic arthritis and rheumatoid arthritis:
   - Must first have a documented trial and failure (defined as an inability to improve symptoms) or intolerance to one non-biologic immunomodulator (e.g. azathioprine, 6-mercaptopurine, methotrexate, leflunomide)
3. For a diagnosis of ulcerative colitis:
   - Must first have a documented trial and failure (defined as an inability to improve symptoms) or intolerance to one non-biologic immunomodulator (e.g. azathioprine, 6-mercaptopurine, methotrexate, leflunomide)
   - Induction dosing is limited to 16 weeks. Induction and maintenance dosing must be applied consistent with the FDA-approved label
4. Prescriber is a specialist or has consulted with a specialist for the condition being treated
5. Must not use Xeljanz or Xeljanz XR in combination with other biological drugs (e.g., Enbrel, Humira)

All fields must be complete and legible for review. Your office will receive a response via fax.
Updated 08/2020
Last reviewed 08/2020

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, the DRUGDEX Information System, and Lexi-Drugs.)

Additional information

Note: When criteria are met, coverage duration is 1 year.

Priority Health Precertification Documentation

A. Is the prescriber a specialist or has consulted with a specialist for the condition being treated?

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

B. Will Xeljanz or Xeljanz XR be used in combination with other biological drugs (e.g., Humira, Enbrel)?

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

C. Answer the applicable questions in the table below.

Condition	Additional requirements for specific indications
(Please check the appropriate boxes to indicate the patient has met the required criteria	
☐ Rheumatoid arthritis ☐ Psoriatic arthritis	**1. Has the patient had a documented trial and failure (defined as an inability to improve symptoms) or intolerance to 1 non-biologic immunomodulator?** ☐ Yes. ☐ No. **Are you requesting an exception to the criteria?** ☐ Yes. ***Rationale for exception***: _____ ☐ No
☐ Ulcerative colitis	1. **Has the patient had a documented trial and failure (defined as an inability to improve symptoms) or intolerance to 1 non-biologic immunomodulator?** ☐ Yes. ☐ No. **Are you requesting an exception to the criteria?** ☐ Yes. ***Rationale for exception***: _____ ☐ No 2. **Is the induction and maintenance dosing of Xeljanz/Xeljanz XR consistent with the FDA-approved label?** ☐ Yes. ☐ No. **Are you requesting an exception to the criteria?** ☐ Yes. ***Rationale for exception***: _____ ☐ No

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☐ Other condition	**1. The patient's condition is:** _____ **2. Rationale for use is:** _____

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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