

# Xeljanz<sup>®</sup> (tofacitinib) Prior Authorization Form



## START HERE

### Member & Prescriber Information

Member Name:	Prescriber Name:
	Prescriber Specialty:
Member Date of Birth:	Prescriber Phone #:
Member ID #:	Prescriber Fax #:

### Criteria

Complete patient specific and condition specific criteria

Submit all pages of tofacitinib criteria for coverage document.

Diagnosis of non-FDA approved indications require condition specific specialist referral and submission of medical record documentation outlining the treatment and follow-up plan.

### Current status of patient therapy (check a box):

- New to tofacitinib therapy
- Continuing tofacitinib therapy (start date: \_\_\_\_\_)
- Primary use in condition that is non-FDA approved

### Primary indication being treated:

Drug	Status		
<input type="checkbox"/> Adalimumab (Humira)	<input type="checkbox"/> active	<input type="checkbox"/> inactive	<input type="checkbox"/> not used
<input type="checkbox"/> Certolizumab (Cimzia)	<input type="checkbox"/> active	<input type="checkbox"/> inactive	<input type="checkbox"/> not used
<input type="checkbox"/> Etanercept (Enbrel)	<input type="checkbox"/> active	<input type="checkbox"/> inactive	<input type="checkbox"/> not used
<input type="checkbox"/> Methotrexate	<input type="checkbox"/> active	<input type="checkbox"/> inactive	<input type="checkbox"/> not used
<input type="checkbox"/> Azathioprine	<input type="checkbox"/> active	<input type="checkbox"/> inactive	<input type="checkbox"/> not used
<input type="checkbox"/> Cyclosporine	<input type="checkbox"/> active	<input type="checkbox"/> inactive	<input type="checkbox"/> not used
<input type="checkbox"/> Prednisone	<input type="checkbox"/> active	<input type="checkbox"/> inactive	<input type="checkbox"/> not used
<input type="checkbox"/> Infliximab (Remicade)	<input type="checkbox"/> active	<input type="checkbox"/> inactive	<input type="checkbox"/> not used
<input type="checkbox"/> Abatacept (Orencia)	<input type="checkbox"/> active	<input type="checkbox"/> inactive	<input type="checkbox"/> not used

### Choose Regimen

- Xeljanz 5 mg tablet
- Duration of use: \_\_\_\_\_

### Sign/Date & Mail or Fax

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Prescriber NPI: \_\_\_\_\_

#### Mailing Address

Physicians Plus Insurance Corporation  
Attn: Pharmacy Services  
P.O. Box 2078  
Madison WI 53701-2078

#### Physicians Plus Pharmacy Services Fax:

(608) 327-0324

#### Prior Authorization Questions?

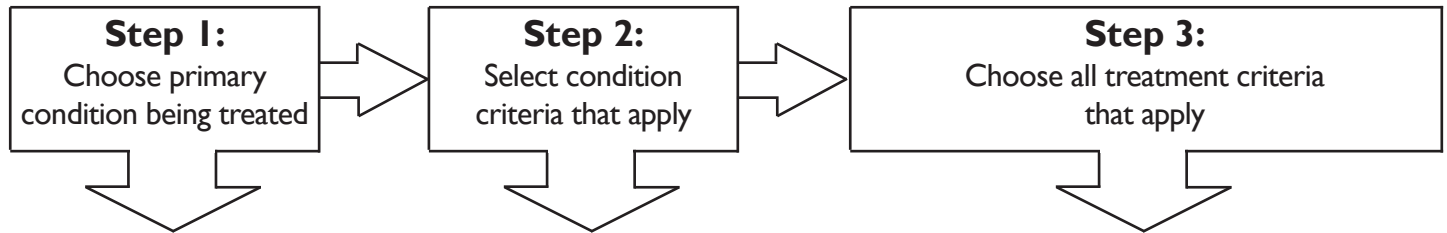
(608) 260-7803 or (800) 545-5015

[www.pplusic.com/providers](http://www.pplusic.com/providers)

**Xeljanz® (tofacitinib)**  
**Prior Authorization Form (con't)**



**Condition Specific Criteria** (Please complete and submit this page as well)



<input type="checkbox"/> <b>Rheumatoid Arthritis</b>	<input type="checkbox"/> Moderate to severe disease activity <input type="checkbox"/> Adult (>30 years old) <input type="checkbox"/> TB skin test negative <input type="checkbox"/> No active or prior history of cancer	<input type="checkbox"/> Must be prescribed by rheumatologist <input type="checkbox"/> Patient failed combination therapy with one agent being: <input type="checkbox"/> Methotrexate or <input type="checkbox"/> Leflunomide <input type="checkbox"/> Not currently using azathioprine or cyclosporine <input type="checkbox"/> Failed both formulary TNF-inhibitor based biological therapies: (refer to and complete previous page): <input type="checkbox"/> Humira (Adalimumab) <input type="checkbox"/> Cimzia (Certolizumab)
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**Remember to sign and date request on previous page before submitting.**