Xeljanz and Xeljanz XR (tofacitinib)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL**		**IF RENEWAL:** DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

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Revision Date: 9/1/24

Prime THERAPEUTICS™

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Moderately to severely active rheumatoid arthritis ☐ Psoriatic arthritis ☐ Polyarticular juvenile idiopathic arthritis(pJIA) ☐ Ulcerative colitis ☐ Ankylosing Spondylitis ☐ Other diagnosis: _____ICD-10_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Prescriber specialty:

Will the patient be using this medication in conjunction with a clinical trial? ☐ Yes ☐ No

Select if the requested medication is prescribed by one of the following specialists:

- ☐ **Dermatologist**
- ☐ **Rheumatologist**
- ☐ **Gastroenterologist**

Will the patient use drug in combination with another biologic response modifier or immunomodulatory agent? ☐ Yes ☐ No

Has the patient tried and had an inadequate response to a three month trial of the biosimilar for Humira-adalimumab-aacf? ☐ Yes ☐ No Please submit documentation.

Does patient have a absolute contraindication to the biosimilar for Humira- adalimumab-aacf? ☐ Yes ☐ No Please submit documentation.

Has the patient tried and had an inadequate response to a trial of the biosimilar for Actemra, Tyenne(tocilizumab-aazg)? ☐ Yes ☐ No Please submit documentation.

Does patient have a absolute contraindication to the biosimilar for Actemra, Tyenne(tocilizumab-aazg)? ☐ Yes ☐ No Please submit documentation.

For moderately to severely active rheumatoid arthritis, also answer the following:

Has the patient had a trial and inadequate response to methotrexate or another oral non-biologic disease modifying anti-rheumatic drug (DMARD) such as Imuran, Ridaura, Plaquenil, sulfasalazine or Arava?* ☐ Yes ☐ No
Must submit documentation.

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Is the patient unable to take the prerequisite non-biologic DMARD due to their chronic liver disease (such as chronic hepatitis, fatty liver, nonalcoholic steatohepatitis (NASH) or elevated liver enzymes)?* □ Yes □ No
Must submit documentation.

For psoriatic arthritis, also answer the following:
Has the patient had a trial and inadequate response to methotrexate or another oral non-biologic disease modifying anti-rheumatic drug (DMARD) such as sulfasalazine(Azulfidine®), leflunamide(Arava®) , or cyclosporine?
□ Yes □ No ***Must submit prior dates of use***

For polyarticular juvenile arthritis, also answer the following:

Has the patient tried and had an inadequate response or intolerance to an oral disease modifying anti-rheumatic agent [e.g., methotrexate, sulfasalazine, or leflunomide (Arava)]? □ Yes □ No

Is the patient unable to take a non-biologic DMARD due to chronic liver disease (such as chronic hepatitis, fatty liver, nonalcoholic steatohepatitis/NASH, or elevated liver enzymes)? □ Yes □ No

If "no" to the above question, provide the rationale explaining why the patient cannot take the prerequisite DMARDs: _____

For Ulcerative Colitis, please also answer the following:
Is disease in the colon and limited to the distal 15 cm of colon? □ Yes □ No

Does patient have a history of treatment failure with oral glucocorticoids, intravenous glucocorticoids, azathioprine and/or mercaptopurine? □ Yes □ No *Please provide documentation*.

For Ankylosing Spondylitis, please also answer the following:
Does the patient have documentated active disease? □ Yes □ No *Please provide documentation*.

Has the patient had an adequate trial and failure of at least TWO (2) non-steroidal anti-inflammatory agents (NSAIDs) over 4 weeks (in total), unless use is contraindicated?
□ Yes □ No ***Must submit prior dates of use and medications***

Reauthorization:
If this is a reauthorization request, answer the following:
Select if the requested medication is prescribed by one of the following specialists:

- **□ Dermatologist**
- **□ Rheumatologist**
- **□ Gastroenterologist**

Does the patient continue to have a positive clinical response and is remission of disease maintained with continued use?* □ Yes □ No
Must provide supporting chart notes.

Will patient use requested medication in combination with another biologic response modifier or immunomodulatory agent? □ Yes □ No

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnoses are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP - 4201
P.O. Box 64811
St. Paul, MN 55164-0811