Xeljanz Oral Solution (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.

URGEN
FIRST NAME:
DATE OF BIRTH:
·
STATE: ZIP CODE:
•

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

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

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		IF RENEWAL: DATE THERAPY	INITIATED:		
DURATION OF THERAPY (SPECIFIC DATES):					

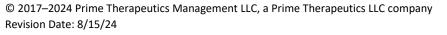
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MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:				
1. HAS THE PATIENT TRIED ANY OTHER	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO			
MEDICATION/THERAPY (SPECIFY	DURATION OF THERAPY (SPECIFY	RESPONSE/REASON FOR			
DRUG NAME AND DOSAGE):	DATES):	FAILURE/ALLERGY:			
,					
2. LIST DIAGNOSES:		ICD-10:			
Moderately to severely active rheumatoi	d arthritis				
Psoriatic arthritis Solvertieven invenile idianethic orthritic	~ !! ()				
 Polyarticular juvenile idiopathic arthritis(Other diagnosis:ICD- 					
3. REQUIRED CLINICAL INFORMATION	PLEASE PROVIDE ALL RELEVANT CLINIC	AL INFORMATION TO SUPPORT A			
PRIOR AUTHORIZATION.					
Is patient using drug as part of a clinic	al trial? 🗆 Yes 🗆 No				
Initial Request:					
Does patient have an enteral feeding	tube? 🗆 Yes 🗆 No				
Does patient have difficulty swallowin	g? 🗆 Yes 🗆 No Please submit documen	ntation.			
	other tablets or capsules (Exception: or	ally dissolving tablets and sprinkle			
capsules)? 🗆 Yes 🗆 No					
Prescriber specialty:					
	rescribed by one of the following specia	alists			
 Dermatologist 	rescribed by one of the following specia	ansts.			
□ Rheumatologist					
Has the patient tried and had an inadequate response to at least a three month trial with the biosimilar for					
Humira- adalimumab-aacf? Ves No *Must submit prior dates of use.					
Will the patient avoid concomitant therapy with another biologic or immunomodulatory agent such as Kineret,					
Remicade , Rituxan, Orencia, Cimzia, Enbrel, Humira, Actemra or Simponi, etc.) or non-biologic agents (apremilast					
etc.) or JAK-inhibitors (upadacitinib, baricitinib, fedratinib, ruxolitinib)? 🛛 Yes 🖓 No					
For moderately to severely active rheumatoid arthritis, also answer the following:					
Use the notions had a trial and inclassion are seen to mathematic an another and your high-is discuss.					
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.					
Is the natient unable to take the prece	quisite non-biologic DMARD due to the	ir chronic liver disease (such as			
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)?*					
*Must submit documentation.					



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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)]?
Que 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)?

Ves
No

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

Reauthorization:

Is the patient currently taking any other tablets or capsules (Exception: orally dissolving tablets and sprinkle

If yes, please provide rationale (if applicable), explaining why the patient is unable to take regular oral tablets or capsules:

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

- Dermatologist
- □ Rheumatologist

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

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/diagnosis are covered on all plans. This request may be denied unless all required information is received.



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MEMBER'S FIRST NAME:

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:

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

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 Phone: 877-228-7909

