BlueCross BlueShield Federal Employee Program

XELJANZ / XELJANZ XR PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Xeljanz / Xeljanz XR

(tofacitinib)

NOTE: Form must be completed in its **entirety** for processing

Please select strength and provide quantity:

❑**5mg**	**qty _____ tablet(s) per 90 days**	❑**XR 11mg**	**qty _____ tablet(s) per 90 days**
❑**10mg**	**qty _____ tablet(s) per 90 days**	❑**XR 22mg**	**qty _____ tablet(s) per 90 days**
❑**Oral solution 1mg/mL**	**qty _____ mL per 90 days**		

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 4**
   ❑**NO** - this is **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Has the prescriber considered the risks for malignancy and major adverse cardiovascular events (MACE) (such as advanced age, smoking history, cardiovascular risk factors etc.) and determined that Xeljanz therapy is appropriate? ❑Yes ❑No
4. Has the patient been tested for latent tuberculosis (TB)? ❑Yes* ❑No
   If YES, was the result of the test positive or negative for TB infection? ❑Positive* ❑Negative
   If POSITIVE, has the patient completed treatment or is the patient currently receiving treatment for latent TB? ❑Yes ❑No
5. Does the patient have any active bacterial, invasive fungal, viral, or other opportunistic infections present? ❑Yes ❑No
6. Does the patient have severe hepatic impairment (Child-Pugh Class C)? ❑Yes ❑No
7. Does the patient have a lymphocyte count less than 500 cells per cubic millimeter (cells/mm3)? ❑Yes ❑No
8. Does the patient have an absolute neutrophil count (ANC) less than 1000 cells per cubic millimeter (cells/mm3)? ❑Yes ❑No
9. Does the patient have a hemoglobin less than 9 grams per deciliter (g/dL)? ❑Yes ❑No
10. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
11. Will Xeljanz be used in combination with potent immunosuppressant such as azathioprine or cyclosporine? ❑Yes ❑No
12. Will Xeljanz be used in combination with another biologic *DMARD or targeted synthetic DMARD? ❑Yes* ❑No
    If YES, please specify medication: _____

    ****DMARDs: Actemra or an Actemra biosimilar, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.***

PLEASE PROCEED TO PAGE 2 FOR DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

13. What is the patient's diagnosis?

❑ Ankylosing spondylitis (AS)

a. **Standard/Basic Option Patient:** Humira including preferred Humira biosimilars, Enbrel, Rinvoq, and Taltz are preferred products. Patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year. Would you like to participate in this program and switch the patient to one of the preferred products? ❑Yes* ❑No

***If YES,** please select the preferred product: ❑Humira/preferred biosimilar ❑Enbrel ❑Rinvoq ❑Taltz

b. Does the patient have active ankylosing spondylitis (AS)? ❑Yes ❑No

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least two non-steroidal anti-inflammatory drugs (NSAIDs)? ❑Yes ❑No

d. Does the patient have intolerance or contraindication or have they had an inadequate treatment response to at least one TNF blocker such as Humira or a Humira biosimilar, Cimzia, Enbrel, Remicade, or Simponi/Simponi Aria? ❑Yes ❑No

❑ Polyarticular course juvenile idiopathic arthritis (pcJIA)

a. Does the patient have active polyarticular course juvenile idiopathic arthritis (pcJIA)? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have an inadequate treatment response to a 3 month trial of at least one conventional disease-modifying antirheumatic drug (DMARD)? ❑Yes ❑No

c. Does the patient have intolerance or contraindication or have they had an inadequate treatment response to at least one TNF blocker such as Humira or a Humira biosimilar, Enbrel, Remicade, or Simponi Aria? ❑Yes ❑No

d. **Standard/Basic Option Patient**: Is this medication being requested as a change from Actemra SC or an Actemra SC biosimilar, Cimzia, or Orencia SC to allow the member access to their copay benefit? ❑Yes* ❑No

***If YES**, please select medication: ❑Actemra SC/Actemra SC biosimilar ❑Cimzia ❑Orencia SC

❑ Psoriatic arthritis (PsA)

a. Will this medication be used in combination with a conventional (nonbiologic) DMARD such as methotrexate, leflunomide, sulfasalazine, etc.? ❑Yes ❑No

b. Does the patient have active psoriatic arthritis? ❑Yes ❑No

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3 month trial of at least one conventional disease-modifying antirheumatic drug (DMARD)? ❑Yes ❑No

d. Does the patient have intolerance or contraindication or have they had an inadequate treatment response to at least one TNF blocker such as Humira or a Humira biosimilar, Cimzia, Enbrel, Remicade, or Simponi/Simponi Aria? ❑Yes ❑No

e. **Standard/Basic Option Patient:** Is this medication being requested as a change from one of the following to allow the member access to their copay benefit: Bimzelx, Cimzia, Cosentyx, Orencia SC, or Simponi? ❑Yes* ❑No

***If YES**, please select medication: ❑Bimzelx ❑Cimzia ❑Cosentyx ❑Orencia SC ❑Simponi

❑ Rheumatoid arthritis (RA)

a. Does the patient have moderate to severely active rheumatoid arthritis (RA)? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3 month trial of at least one conventional disease-modifying antirheumatic drug (DMARD)? ❑Yes ❑No

c. Does the patient have intolerance or contraindication or have they had an inadequate treatment response to at least one TNF blocker such as Humira or a Humira biosimilar, Cimzia, Enbrel, Remicade, or Simponi/Simponi Aria? ❑Yes ❑No

d. **Standard/Basic Option:** Is this medication being requested as a change from one of the following to allow the member access to their copay benefit: Actemra SC or an Actemra SC biosimilar, Cimzia, Kevzara, Kineret, Olumiant, Orencia SC, or Simponi? ❑Yes* ❑No

***If YES**, select medication below:

❑Actemra SC/Actemra SC biosimilar ❑Cimzia ❑Kevzara ❑Kineret ❑Olumiant ❑Orencia SC ❑Simponi

PLEASE PROCEED TO PAGE 3 FOR ADDITIONAL DIAGNOSES

BlueCross BlueShield Federal Employee Program

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PAGE 3 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑Ulcerative colitis (UC)

a. **Standard/Basic Option Patient:** Has the patient tried and failed Humira or a Humira biosimilar? ❑Yes ❑No*

***If NO,** Humira including preferred Humira biosimilars, Rinvoq, Skyrizi, Stelara SC, and Tremfya are preferred products. Patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year. Would you like to participate in this program and switch the patient to one of the preferred products? ❑Yes* ❑No

***If YES**, please select the preferred product: ❑Humira/preferred biosimilar ❑Rinvoq ❑Skyrizi ❑Stelara SC ❑Tremfya

b. Does the patient have moderate to severely active ulcerative colitis (UC)? ❑Yes ❑No

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one conventional therapy option? ❑Yes ❑No

d. Does the patient have intolerance or contraindication or have they had an inadequate treatment response to at least one TNF blocker such as Humira or a Humira biosimilar, Remicade, or Simponi? ❑Yes ❑No

❑Other ***(please specify):*** _____

ULCERATIVE COLITIS AND ANKYLOSING SPONDYLITIS DIAGNOSES FOR STANDARD AND BASIC OPTION PATIENTS REQUIRES PAGE 6 TO BE COMPLETED

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Patient Information (required)			Provider Information (required)		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: R			Physician Signature:		
PHYSICIAN COMPLETES					

CONTINUATION OF THERAPY (PA RENEWAL)

Xeljanz / Xeljanz XR

(tofacitinib)

NOTE: Form must be completed in its **entirety** for processing

Please select strength and provide quantity:

❑**5mg**	**qty _____ tablet(s) per 90 days**	❑**XR 11mg**	**qty _____ tablet(s) per 90 days**
❑**10mg**	**qty _____ tablet(s) per 90 days**	❑**XR 22mg**	**qty _____ tablet(s) per 90 days**
❑**Oral solution 1mg/mL**	**qty _____ mL per 90 days**		

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑**NO** - this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Has the prescriber considered the risks for malignancy and major adverse cardiovascular events (MACE) (such as advanced age, smoking history, cardiovascular risk factors etc.) and determined that Xeljanz therapy is appropriate? ❑Yes ❑No
4. Has the patient's condition improved or stabilized with therapy? ❑Yes ❑No
5. Does the patient have any active bacterial, invasive fungal, viral, or opportunistic infections present? ❑Yes ❑No
6. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
7. Will Xeljanz be used in combination with potent immunosuppressant such as azathioprine or cyclosporine? ❑Yes ❑No
8. Will Xeljanz be used in combination with another biologic *DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify the medication: _____
   ****DMARDs: Actemra or an Actemra biosimilar, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.***
9. What is the patient's diagnosis?
   ❑Ankylosing spondylitis (AS)
   a. **Standard/Basic Option Patient:** Humira including preferred Humira biosimilars, Enbrel, Rinvoq, and Taltz are preferred products. Patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year. Would you like to participate in this program and switch the patient to one of the preferred products? ❑Yes* ❑No
      If YES, please select the preferred product: ❑Humira/preferred biosimilar ❑Enbrel ❑Rinvoq ❑Taltz
   ❑Polyarticular course juvenile idiopathic arthritis (pcJIA)

PLEASE PROCEED TO PAGE 5 FOR ADDITIONAL DIAGNOSES

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PAGE 5 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑Rheumatoid arthritis (RA)

❑Psoriatic arthritis (PsA)

a. Will this medication be used in combination with a conventional (nonbiologic) DMARD such as methotrexate, leflunomide, sulfasalazine, etc.? ❑Yes ❑No

❑Ulcerative colitis (UC)

a. **Standard/Basic Option Patient:** Has the patient tried and failed Humira or a Humira biosimilar? ❑Yes ❑No*****

If NO, Humira including preferred Humira biosimilars, Rinvoq, Skyrizi, Stelara SC, and Tremfya are preferred products. Patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year. Would you like to participate in this program and switch the patient to one of the preferred products? ❑Yes***** ❑No

If YES, please select the preferred product: ❑Humira/preferred biosimilar ❑Rinvoq ❑Skyrizi ❑Stelara SC ❑Tremfya

❑Other ***(please specify):*** _____

ULCERATIVE COLITIS AND ANKYLOSING SPONDYLITIS DIAGNOSES FOR STANDARD AND BASIC OPTION PATIENTS REQUIRES PAGE 6 TO BE COMPLETED

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PAGE 6 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

ULCERATIVE COLITIS AND ANKYLOSING SPONDYLITIS DIAGNOSES FOR STANDARD AND BASIC OPTION PATIENTS REQUIRES PAGE 6 TO BE COMPLETED

6. Please select diagnosis and answer the following question:

❑Ankylosing spondylitis (AS)

a. Does the patient have an intolerance or contraindication* or have they had an inadequate treatment response to TWO of the following preferred medications: Humira including preferred Humira biosimilars, Rinvoq, Enbrel, or Taltz? ❑Yes* ❑No

Contraindications include (not all inclusive): allergy, autoantibody formation/lupus-like syndrome, or a history of congestive heart failure, hepatitis B virus infection, malignancy, or demyelinating disorder such as multiple sclerosis, Guillain-Barre syndrome, or optic neuritis.

Please select answer: ❑Yes ❑No*

***If NO,** is there a clinical reason for not trying TWO of the preferred medications? ❑Yes ❑No

❑Ulcerative colitis

a. Does the patient have an intolerance or contraindication* or have they had an inadequate treatment response to Humira including preferred Humira biosimilars, Rinvoq, Skyrizi, Stelara SC, or Tremfya? ❑Yes* ❑No

Contraindications include (not all inclusive): allergy, autoantibody formation/lupus-like syndrome, or a history of congestive heart failure, hepatitis B virus infection, malignancy, or demyelinating disorder such as multiple sclerosis, Guillain-Barre syndrome, or optic neuritis.

Please select answer: ❑Yes ❑No*

***If NO,** is there a clinical reason for not trying Humira or a Humira biosimilar, Rinvoq, Skyrizi, Stelara SC, or Tremfya? ❑Yes ❑No