Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Xeljanz

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is the patient within the age group listed in the FDA labeling for the indication? If YES, go to 2. If NO, go to 3.

☐ Yes ☐ No

Q2. Is this a reauthorization request? If YES, go to 3. If NO, go to 4.

☐ Yes ☐ No

Q3. Is there confirmation of continued positive clinical response since starting Xeljanz/Xeljanz XR?

☐ Yes ☐ No

Q4. Is the requested drug being prescribed by or in consultation with the appropriate specialist per diagnosis: a rheumatologist or gastroenterologist?

☐ Yes ☐ No

Q5. Does the patient have a documented diagnosis of moderately to severe active rheumatoid arthritis (RA), active psoriatic arthritis (PsA), active ankylosing spondylitis (AS), moderately to

Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Xeljanz

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**

severely active colitis (UC), or active polyarticular course juvenile idiopathic arthritis (pcJIA)? If YES, go to 6. If NO, go to 7.

☐ Yes ☐ No

Q6. Is there documentation of an inadequate response, intolerance, or contraindication to at least one TNF blocker indicated for the patient's diagnosis?

☐ Yes ☐ No

Q7. Will the requested drug be used concomitantly with other biologic disease modifying anti-rheumatic drugs (DMARDs) or potent immunosuppressants (such as azathioprine or cyclosporine)?

☐ Yes ☐ No

Q8. Additional Information:

Prescriber Signature

Date

v2025