Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Xeljanz - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

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.

Member Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare Advantage	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 applying the 72 hour 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. Will the patient be taking this drug concomitantly with another biologic Disease Modifying Anti-Rheumatic Drug (DMARD), a targeted synthetic DMARD, or with potent immunosuppressants such as azathioprine and cyclosporine?

☐ Yes ☐ No

Q2. Is the requested drug being prescribed by or in consultation with an appropriate specialist such as a rheumatologist or gastroenterologist?

☐ Yes ☐ No

Q3. Is this a reauthorization request? If YES, go to 4. If NO, go to 5.

☐ Yes ☐ No

Q4. Is there confirmation of continued positive clinical response since starting Xeljanz/Xeljanz XR?

☐ Yes ☐ No

Q5. Are chart notes attached documenting an FDA-approved diagnosis not otherwise excluded from part D?

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☐ 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. Requested Duration:

☐ 12 Months ☐ Other:

Q8. Additional Information:

_____ _____

Prescriber Signature Date

v2026