Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Xeljanz - Medicare

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

Health Partners 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: □ Medicare	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. Is the requested drug being prescribed by or in consultation with a rheumatologist, dermatologist, or gastroenterologist?

☐ Yes ☐ No

Q2. Does the patient have the diagnosis of rheumatoid arthritis (RA), psoriatic arthritis (PsA), ankylosing spondylitis (AS) or active polyarticular course juvenile idiopathic arthritis (PJIA)?

☐ Yes ☐ No

Q3. Is there documentation of an inadequate response, intolerance, or contraindication to at least one TNF blocker for RA, PsA and AS, or to at least one first-line therapy (including full-dose NSAIDs) for PJIA?

☐ Yes ☐ No

Q4. Does the patient have the diagnosis of ulcerative colitis (UC)?

☐ Yes ☐ No

Q5. Is there documentation of an inadequate response, intolerance, or contraindication to at least one treatments (such as one of the following: tumor necrosis factor antagonist, oral or intravenous corticosteroid, azathioprine or 6-MP)?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older for RA, PsA, AS or UC, or 2 years of age or older for PJIA?

☐ Yes ☐ No

Q7. Has the patient been evaluated for current infections including active or latent tuberculosis (TB) infection with a tuberculin skin test prior to the initiation of therapy?

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Patient Name:	**Prescriber Name:**

☐ Yes ☐ No

Q8. Was the tuberculin skin test negative?

☐ Yes ☐ No

Q9. Is there a treatment plan for the active or latent infection?

☐ Yes ☐ No

Q10. 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

Q11. Additional Information:

Q12. Requested Duration:

☐ 12 months ☐ Other

Prescriber Signature

Date

2023 Medicare Prior Authorization Request