Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Xeljanz (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-844-242-0908**.
When conditions are met, we will authorize the coverage of Xeljanz (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Xeljanz (tofacitinib) Xeljanz XR (tofacitinib)

Other, please specify_____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

1. Has this plan authorized Xeljanz in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 3.]

2. Has the patient had at least a 20% improvement in symptoms? Y N

   [No further questions.]

3. Does the patient have a diagnosis of rheumatoid arthritis (RA) with moderate to high disease activity? Y N

   [If no, no further questions.]

4. Has the patient had failure to an adequate trial (3 months) of two disease modifying anti-rheumatic drugs (DMARDs) regimens (one must be methotrexate)? Y N

   If yes, list medications tried: _____

   Note: Monotherapy regimen: methotrexate (MTX), hydroxychloroquine (HCQ), leflunomide (LEF), sulfasalazine (SSZ).

   Combination regimen: MTX+SSZ+HCQ; MTX+HCQ, MTX+LEF, MTX+SSZ, SSZ+HCQ

   [If yes, skip to question 6.]

5. Does the patient have a contraindication to methotrexate? Y N

   Note: Contraindications such as Pregnancy, alcoholism, Chronic liver disease, Leukopenia, thrombocytopenia, or anemia.

   If yes, please document contraindication:_____

   [If no, then no further questions]

6. Has the patient had a trial and failure of at least ONE formulary anti-TNF? Y N

   [If no, then no further question.]

7. Is the patient 18 years of age or older? Y N

   [If no, no further questions.]

8. Is therapy being prescribed by, or in consultation with a rheumatologist? Y N

   [If no, then no further questions.]

9. Is the patient taking any biologic medications for RA? Y N

   [If yes, then no further questions.]

10. Has the patient been screened for latent tuberculosis (TB) and hepatitis B? Y N

    [If no, then no further questions.]

11. Does the patient have an active infection (including Hepatitis B Y N

and/or tuberculosis (TB)?

[If no, then no further questions.]

12. Is the patient currently receiving or has completed treatment for latent TB infection or Hepatitis B? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date