Prior Authorization Form

Note: Please provide as much information as possible on this form. Missing data may cause processing delays for requested authorization(s). Attach additional sheets to this form if necessary.

Please fax the completed PA form and any additional informational sheets to Nirvanahealth at the following fax number: +1(866) 871-8565

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
Health Plan Name:		Prescriber Address:	
Patient Insurance Id:			
Patient Date of Birth:		Prescriber Phone:	( )
Patient Phone:		Prescriber Fax:	( )
		Prescriber Specialty:	
		Prescriber DEA:	
		Prescriber NPI:	

Medication & Medical Information	
Requested Drug(s) & Strength(s):	[ ] Xeljanz XR 11 mg tablet,extended release [ ] Xeljanz XR 22 mg tablet,extended release
Requested Daily Quantity Limit – Amount:	
Requested Daily Quantity Limit – Days:	
Expected Length of Therapy:	
Directions:	
Diagnosis and Diagnosis Codes (ICD-10 Standard Codes):	
List drugs used previously to treat the same condition:	
Additional clinical information or history. Please include any relevant test results and/or medical record notes:	

Questionnaire

Q1: I, as the provider or designated representative of the provider, certify and attest that the information provided is complete and accurate and that, upon request, I shall provide any information to RxAdvance that RxAdvance determines is reasonably necessary to verify my responses. (Check only one that apply)

[ ] Yes

[ ] No

Q2: Is the member currently treated with this medication? (Check only one that apply)

[ ] Yes (please list start date of therapy (month/day/year)) _____ (*Required)

[ ] No

Q3: Is the request for one of the following? (Check only one that apply)

[ ] Xeljanz oral solution

[ ] Xeljanz tablets

[ ] Xeljanz XR tablets

Q4: What is the member's diagnosis? (Check only one that apply)

[ ] Moderately to severely active rheumatoid Arthritis (RA)

[ ] Active psoriatic Arthritis (PsA)

[ ] Active ankylosing spondylitis (AS)

[ ] Moderately to severely active ulcerative colitis (UC)

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request)
_____(*Required)

Q5: What is the member's diagnosis? (Check only one that apply)

[ ] Moderately to severely active rheumatoid Arthritis (RA)

[ ] Active psoriatic Arthritis (PsA)

[ ] Active ankylosing spondylitis (AS)

[ ] Moderately to severely active ulcerative colitis (UC)

[ ] Active polyarticular course juvenile idiopathic arthritis (PJIA)

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request)
_____(*Required)

Q6: What is the member's diagnosis? (Check only one that apply)

[ ] Active polyarticular course juvenile idiopathic arthritis (PJIA)

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request)
_____(*Required)

Q7: Does the member have documentation of positive clinical response to the therapy as evidenced by at least one of the following? (Check only one that apply)

[ ] Reduction in the total active (swollen and tender) joint count from baseline (please provide supporting document(s))
_____(*Required)

[ ] Improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline (please provide supporting document(s))
_____(*Required)

[ ] No (please provide medical justification for continuation of therapy)
_____(*Required)

Q8: Does the member have documentation of positive clinical response to therapy as evidenced by at least one of the following? (Check only one that apply)

[ ] Reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline (please provide supporting document(s))
_____(*Required)

[ ] Reduction in the BSA involvement from baseline (please provide supporting document(s))
_____(*Required)

[ ] No (please provide medical justification for continuation of therapy)
_____(*Required)

Q9: Dose the member have documentation of positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following? (Check only one that apply)

[ ] Disease activity (eg, pain, fatigue, inflammation, stiffness) (please provide supporting document(s))
_____(*Required)

[ ] Lab values (erythrocyte sedimentation rate, C-reactive protein level) (please provide supporting document(s))
_____(*Required)

[ ] Function, axial status (eg, lumbar spine motion, chest expansion) (please provide supporting document(s))
_____(*Required)

[ ] Total active (swollen and tender) joint count (please provide supporting document(s))
_____(*Required)

[ ] No (please provide medical justification for continuation of therapy)
_____(*Required)

Q10: Is the requested medication used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (eg, azathioprine, cyclosporine)? (Check only one that apply)

[ ] Yes (please provide medical justification for continuation of therapy)
_____(*Required)

[ ] No

Q11: Does the member have documentation of positive clinical response to therapy as evidenced by at least one of the following? (Check only one that apply)

[ ] Improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline (please provide supporting document(s))
_____(*Required)

[ ] Reversal of high fecal output state (please provide supporting document(s))
_____(*Required)

[ ] No (please provide medical justification for continuation of therapy)
_____(*Required)

Q12: Is the requested medication used in combination with other JAK inhibitors, biological therapies for UC, or potent immunosuppressants (e.g., azathioprine, cyclosporine)? (Check only one that apply)

[ ] Yes (please provide medical justification for continuation of therapy)
_____(*Required)

[ ] No

Q13: Is the request for one of the following? (Check only one that apply)

[ ] Xeljanz oral solution

[ ] Xeljanz tablets

[ ] Xeljanz XR tablets

Q14: What is the member's diagnosis? (Check only one that apply)

[ ] Moderately to severely active rheumatoid Arthritis (RA)

[ ] Active psoriatic Arthritis (PsA)

[ ] Active ankylosing spondylitis (AS)

[ ] Moderately to severely active ulcerative colitis (UC)

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request) _____(*Required)

Q15: What is the member's diagnosis? (Check only one that apply)

[ ] Moderately to severely active rheumatoid Arthritis (RA)

[ ] Active psoriatic Arthritis (PsA)

[ ] Active ankylosing spondylitis (AS)

[ ] Moderately to severely active ulcerative colitis (UC)

[ ] Active polyarticular course juvenile idiopathic arthritis (PJIA)

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request) _____(*Required)

Q16: What is the member's diagnosis? (Check only one that apply)

[ ] Active polyarticular course juvenile idiopathic arthritis (PJIA)

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request) _____(*Required)

Q17: Has the member had an inadequate response, intolerance or experienced contraindication(s) to minimum duration of a 3-month trial of one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine? (Check only one that apply)

[ ] Yes (please specify drug name, corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q18: Does the member meet any one of the following? (Check only one that apply)

[ ] Actively inflamed joints

[ ] Dactylitis

[ ] Enthesitis

[ ] Axial disease

[ ] Active skin and/or nail involvement (please specify) _____ (*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q19: Has the member had an inadequate response, intolerance or experienced contraindication(s) to minimum duration of a one-month trial to one nonsteroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen) at maximally tolerated doses? (Check only one that apply)

[ ] Yes (please specify drug name, corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q20: Has the member had an inadequate response, intolerance or experienced contraindication(s) to minimum duration of a 6-week trial to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate? (Check only one that apply)

[ ] Yes (please specify drug name, corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q21: Is the requested medication prescribed by or in consultation with a rheumatologist? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q22: Is the requested medication prescribed by or in consultation with a dermatologist or rheumatologist? (Check only one that apply)

[ ] Yes (please specify prescriber specialty) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q23: Has the member had an inadequate response, intolerance to one or more TNF inhibitors (eg, Enbrel, Humira)? (Check only one that apply)

[ ] Yes (please specify drug name, or intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q24: Is the requested medication used in combination with other JAK inhibitors, biologic disease-modifying antirheumatic drugs (DMARDs), or potent immunosuppressants (eg, azathioprine, cyclosporine)? (Check only one that apply)

[ ] Yes (please provide clinical rationale for the request) _____ (*Required)

[ ] No

Q25: Does the member meet any one of the following? (Check only one that apply)

[ ] Greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (e.g., hemoglobin, ESR, CRP) (please provide the supporting documents) _____ (*Required)

[ ] Refractory to corticosteroids (please provide the supporting documents) _____(*Required)

[ ] Dependent on corticosteroids (please provide the supporting documents)
_____(*Required)

[ ] None of above (please provide clinical rationale for the request)
_____(*Required)

Q26: Has the member had an inadequate response, intolerance or experienced contraindication(s) to one of the following conventional therapies: 6-mercaptopurine, aminosalicylate (e.g., mesalamine, olsalazine, sulfasalazine), azathioprine, or corticosteroids (eg, prednisone)? (Check only one that apply)

[ ] Yes (please specify drug name, corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Q27: Has the member had an inadequate response, intolerance to one or more TNF inhibitors (eg, Humira)? (Check only one that apply)

[ ] Yes (please specify drug name or intolerance experienced and the start and end date(s) of therapy (month/year))
_____(*Required)

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Q28: Is the requested medication used in combination with other Janus kinase (JAK) inhibitors, biological therapies for UC, or potent immunosuppressants (e.g., azathioprine, cyclosporine)? (Check only one that apply)

[ ] Yes (please provide clinical rationale for the request) _____
(*Required)

[ ] No

Q29: Is the requested medication prescribed by or in consultation with a gastroenterologist? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, Insurer, Medical Group or its designated representatives may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.	
Signature of Prescriber or Authorized Representative:	Date:
Print Authorized Representative Name:	