Prior Authorization Request Form for
tofacitinib **(Xeljanz, Xeljanz XR)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1

Please complete patient and physician information (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2

Please complete clinical assessment:

1. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	☐ Yes proceed to question **2**	☐ No proceed to question **4**
2. Has the patient had an inadequate response to Humira?	☐ Yes proceed to question **5**	☐ No proceed to question **3**
3. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
4. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Is the patient 18 years of age or older?	☐ Yes proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Does the patient have a hemoglobin level LESS THAN 9 g/dL?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **7**
7. Does the patient have an absolute neutrophil count (ANC) LESS THAN 1,000/mm3?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **8**
8. Does the patient have an absolute lymphocyte count (ALC) LESS THAN 500/mm3?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **9**

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9. **What is the indication or diagnosis?**	☐ Moderately to severely active **rheumatoid arthritis** – proceed to question **10** ☐ Active **psoriatic arthritis** – proceed to question **11** ☐ Moderately to severely active **ulcerative colitis** – proceed to question **11** ☐ Other indication or diagnosis – STOP: **Coverage not approved.**		
10. **Has the patient had an inadequate response or an intolerance to methotrexate?**		☐ Yes proceed to question **12**	☐ No **STOP** **Coverage not approved**
11. **Has the patient had an inadequate response or an intolerance to methotrexate or other disease-modifying antirheumatic drugs (DMARDs)?**		☐ Yes proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. **Will the patient be receiving other biologic DMARDs or potent immunosuppressants (for example, azathioprine and cyclosporine) at the same time (concomitantly)?**		☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **13**
13. **Does the patient have a history of thromboembolic disease?**		☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **14**
14. **Does the patient have evidence of a negative TB test result in the past 12 months (or TB is adequately managed)?**		☐ Yes proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. **Will the patient be receiving other targeted immunomodulatory biologics with Xeljanz or Xeljanz XR, including but not limited to the following: Actemra, Cimzia, Cosentyx, Enbrel, Humira, Ilumya, Kevzara, Kineret, Olumiant, Orencia, Remicade, Rituxan, Siliq, Simponi, Stelara, Taltz, Skyrizi, Rinvoq or Tremfya? (Note: Does not apply to Otezla)**		☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **16**
16. **Is the provider aware of the FDA-approved dosing requirements by indications, and is aware of the FDA safety alert AND BOXED WARNING from July 2019? The FDA approved dosing is as follows:** **• Moderately to severely active rheumatoid arthritis (RA): 5 mg twice a day or 11 mg once a day** **• Active psoriatic arthritis (PsA): 5 mg twice a day or 11 mg once a day** **• Moderately to severely active ulcerative colitis (UC): doses allowed up to 10 mg twice a day**		☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[08 April 2020]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: