aetna®

Xeljanz/Xeljanz XR® (tofacitinib) Medication Precertification Request

(All fields must be completed and legible for Precertification Review)

Aetna Precertification Notification
Phone: 1-855-240-0535
FAX: 1-877-269-9916

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:
Patient Current Weight: _____ lbs or _____ kgs	Patient Height: _____ inches or _____ cms	Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Rheumatologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: ☐ Xeljanz (tofacitinib) 5 mg ☐ Xeljanz (tofacitinib) 10 mg ☐ Xeljanz XR (tofacitinib) 11mg
Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other any other where applicable (*).

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION - Required clinical information must be completed for ALL precertification requests.

For Initiation Requests: (clinical documentation required):

☐ Yes ☐ No Will Xeljanz, Xeljanz XR (tofacitinib) be used concomitantly with apremilast, biologic DMARDs (e.g., adalimumab, infliximab,) or potent immunosuppressants (i.e., azathioprine, cyclosporine)?

☐ Yes ☐ No Has the patient been tested for TB with a PPD test, interferon-release assay (IGRA) or chest x-ray within 6 months of initiating a biologic therapy?
→ (check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray
Please enter the results: ☐ Positive ☐ Negative ☐ Unknown
If positive, Does the patient have latent or active TB? ☐ Latent ☐ Active
If latent TB, ☐ Yes ☐ No Will TB treatment be started before initiation of therapy with Xeljanz, Xeljanz XR (tofacitinib)?

Psoriatic Arthritis

☐ Yes ☐ No Is there evidence that the disease is active?
☐ Yes ☐ No Will Xeljanz, Xeljanz XR (tofacitinib) be used concomitantly with a conventional DMARD (e.g., leflunomide, methotrexate, sulfasazine)?
☐ Yes ☐ No Does the patient have **axial** psoriatic arthritis?
→ ☐ Yes ☐ No Was the treatment with 2 or more non-steroidal anti-inflammatory drugs (NSAIDs) ineffective?
→ Please provide the names and length of treatment:
NSAID #1: _____
Please indicate length of treatment: ☐ Less than 30 days ☐ 30-60 days ☐ 60-90 days ☐ 90 days or more
NSAID #2: _____
Please indicate length of treatment: ☐ Less than 30 days ☐ 30-60 days ☐ 60-90 days ☐ 90 days or more

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G. CLINICAL INFORMATION (*continued*) - Required clinical information must be completed for ALL precertification requests.

☐ Yes ☐ No Does the patient have **non-axial** psoriatic arthritis?
→ ☐ Yes ☐ No Does the patient have severe disease at presentation, defined as severe disability at onset with erosive disease involving multiple joints?
→ ☐ Yes ☐ No Was the treatment with methotrexate ineffective?
→ ☐ Yes ☐ No Was treatment with methotrexate not tolerated or contraindicated?
→ Please select: ☐ not tolerated ☐ contraindicated
☐ Yes ☐ No Was treatment with another conventional DMARD ineffective?
→ Please select: ☐ cyclophosphamide ☐ cyclosporine ☐ hydroxychloroquine ☐ Leflunomide ☐ sulfasalazine ☐ Other: Please explain: _____
Please indicate length of treatment: ☐ Less than 30 days ☐ 30-60 days ☐ 60-90 days ☐ 90 days or more
→ Please indicate length of methotrexate therapy: ☐ Less than 30 days ☐ 30-60 days ☐ 60-90 days ☐ 90 days or more

Rheumatoid Arthritis

Please indicate the severity of the patient's rheumatoid arthritis: ☐ Mild ☐ Moderate ☐ Severe
☐ Yes ☐ No Is there evidence that the disease is active?
☐ Yes ☐ No Was treatment with methotrexate ineffective?
→ ☐ Yes ☐ No Was treatment with methotrexate not tolerated or contraindicated?
→ Please select: ☐ not tolerated ☐ contraindicated
☐ Yes ☐ No Was treatment with another conventional DMARD (other than methotrexate) ineffective?
→ Please select: ☐ azathioprine ☐ hydroxychloroquine ☐ leflunomide ☐ sulfasalazine
Please indicate length of treatment: ☐ Less than 30 days ☐ 30-60 days ☐ 60-90 days ☐ 90 days or more
→ Please indicate length of the methotrexate therapy: ☐ Less than 30 days ☐ 30-60 days ☐ 60-90 days ☐ 90 days or more

Ulcerative Colitis

☐ Yes ☐ No Is the patient hospitalized with active fulminant ulcerative colitis?
→ Please indicate the severity of the patient's ulcerative colitis: ☐ Mild ☐ Moderate ☐ Severe
☐ Yes ☐ No Is there evidence that the disease is active?
→ ☐ Yes ☐ No Is the patient refractory to immunosuppression with corticosteroids (e.g., methylprednisolone, prednisone)?
→ ☐ Yes ☐ No Does the patient require continuous immunosuppression with corticosteroids (e.g., methylprednisolone, prednisone)?
→ Name and dose: Name: _____ Dose: _____
Please indicate the route: ☐ Oral ☐ IV
Length of time on therapy: ☐ 1- 9 days ☐ 10 to 29 days ☐ 30 days or greater
☐ Yes ☐ No Was treatment with immunosuppressant agent (e.g., azathioprine, 6-mercaptopurine) ineffective, not tolerated, or contraindicated?
→ Please select: ☐ ineffective ☐ not tolerated ☐ contraindicated
Provide the name of the drug(s): _____
Please indicate length of treatment: ☐ Less than 30 days ☐ 30-60 days ☐ 60-90 days ☐ 90 days or more
☐ Yes ☐ No Was treatment with 5-aminosalicylic acid agents (e.g., balsalazide, mesalamine, sulfasalazine) ineffective, not tolerated, or contraindicated?
→ Please select: ☐ ineffective ☐ not tolerated ☐ contraindicated
Provide the name of the drug(s): _____
Please indicate length of treatment: ☐ Less than 30 days ☐ 30-60 days ☐ 60-90 days ☐ 90 days or more
→ Please select the symptoms the patient exhibit: ☐ more than 10 stools per day ☐ continuous bleeding ☐ abdominal pain ☐ distension ☐ acute, severe toxic symptoms, including fever and anorexia

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G. CLINICAL INFORMATION (*continued*) - Required clinical information must be completed for ALL precertification requests.

For Continuation requests:

Please indicate the length of time on Xeljanz, Xeljanz XR (tofacitinib) therapy: _____

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of Xeljanz, Xeljanz XR (tofacitinib)? (Sampling of Xeljanz, Xeljanz XR (tofacitinib) does not guarantee coverage under the provisions of the pharmacy benefit)

☐ Yes ☐ No Will Xeljanz, Xeljanz XR (tofacitinib) be used concomitantly with apremilast, biologic DMARDs (e.g., adalimumab, infliximab) or potent immunosuppressants (i.e., azathioprine, cyclosporine)?

☐ Yes ☐ No Is there clinical documentation supporting disease stability?

☐ Yes ☐ No Is there clinical documentation supporting disease improvement?

☐ Yes ☐ No Does the patient have any risk factors for TB?

→ ☐ Yes ☐ No Has the patient had a TB test within the past year?

→ (check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray

Results: ☐ Positive ☐ Negative ☐ Unknown

For Rheumatoid arthritis, Ulcerative colitis Only:

Please indicate the severity of the patient's disease at baseline (pretreatment with Xeljanz, Xeljanz XR (tofacitinib): ☐ Mild ☐ Moderate ☐ Severe

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.