CVS caremark™ {{PANUMCODE}}

# Xeljanz, Xeljanz XR

## Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

**Patient's Name:** {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
**Patient's ID:** {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
**Physician's Name:** {{PHYFIRST}} {{PHYLAST}}
**Specialty:** _____, **NPI#:** _____
**Physician Office Telephone:** {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
**Request Initiated For:** {{DRUGNAME}}

1. What is the prescribed quantity and frequency?
   a) ❑ Xeljanz 5 mg Quantity and frequency: _____
   b) ❑ Xeljanz 10 mg Quantity and frequency: _____
   c) ❑ Xeljanz 1 mg/mL Quantity and frequency: _____
   d) ❑ Xeljanz XR 11 mg Quantity and frequency: _____
   e) ❑ Xeljanz XR 22 mg Quantity and frequency: _____
   f) ❑ Other _____

2. What is the diagnosis?
   ❑ Moderately to severely active rheumatoid arthritis (RA)
   ❑ Active psoriatic arthritis (PsA)
   ❑ Moderately to severely active ulcerative colitis (UC)
   ❑ Active articular juvenile idiopathic arthritis, *please specify:*
      ❑ Polyarticular juvenile idiopathic arthritis
      ❑ Oligoarticular juvenile idiopathic arthritis
   ❑ Other _____

3. What is the ICD-10 code? _____

4. What is patient's weight? _____ kg

Section A: All Requests

5. Will the requested drug be used in combination with any other biologic (e.g., Humira), targeted synthetic disease-modifying antirheumatic drug (DMARD) (e.g., Otezla, Rinvoq, Olumiant), or potent immunosuppressant such as azathioprine or cyclosporine? ❑ Yes ❑ No

6. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic DMARD (e.g., Rinvoq, Olumiant) associated with an increased risk of tuberculosis? *If Yes, skip to #8* ❑ Yes ❑ No

7. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [PPD], interferon-release assay [IGRA], chest x-ray) within 6 months of initiating therapy? *If Yes, skip to #10* ❑ Yes ❑ No

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8. Does the patient have risk factors for tuberculosis (TB) (e.g., persons with close contact to people with infectious TB disease; persons who have recently immigrated from areas of the world with high rates of TB [e.g., Africa, Asia, Eastern Europe, Latin America, Russia]; children less than 5 years of age who have a positive TB test; groups with high rates of TB transmission [e.g., homeless persons, injection drug users, persons with HIV infection], or persons who work or reside with people who are at an increased risk for active TB [e.g., hospitals, long-term care facilities, correctional facilities, homeless shelters])? ❑ Yes ❑ No *If No, skip to #13*

9. Has the patient been tested for tuberculosis (TB) within the previous 12 months? ❑ Yes ❑ No

10. What were the results of the tuberculosis (TB) test? *If Negative, skip to #13*
❑ Positive for TB ❑ Negative for TB ❑ Unknown

11. Does the patient have latent or active tuberculosis (TB)? ❑ Latent ❑ Active ❑ Unknown

12. Has treatment for latent tuberculosis (TB) infection been initiated or completed?
❑ Yes - treatment initiated ❑ Yes - treatment completed ❑ No

13. Is this request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #19*

14. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #19* ❑ Yes ❑ No ❑ Unknown

15. *If patient's diagnosis is ulcerative colitis,* has the patient achieved or maintained remission?
***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of remission.***
❑ Yes ❑ No

16. Indicate which applies:
❑ Patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug
❑ Patient achieved or maintained positive clinical response since starting treatment with the requested drug
❑ None of the above

17. What is the percent of disease activity improvement from baseline in tender joint count, swollen joint count, pain, or disability? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response. _____%***

18. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response.***

| | | |
|---|---|---|
| ❑ Number of swollen joints | ❑ Number of tender joints | ❑ Dactylitis |
| ❑ Enthesitis | ❑ Skin and/or nail involvement | ❑ Stool frequency |
| ❑ Rectal bleeding | ❑ Urgency of defecation | ❑ C-reactive protein (CRP) |
| ❑ Fecal calprotectin | ❑ Endoscopic appearance of the mucosa | ❑ Functional ability |

❑ Number of joints with limitation of movement
❑ Number of joints with active arthritis (e.g., swelling, pain, limitation of motion)
❑ Improvement on a disease activity scoring tool (e.g., Ulcerative Colitis Endoscopic Index of Severity [UCEIS], Mayo Score])
❑ None of the above

19. *If patient's diagnosis is psoriatic arthritis,* will the requested drug be used in combination with a conventional synthetic DMARD? *If Yes or No, no further questions.* ❑ Yes ❑ No
❑ Not applicable, diagnosis is NOT psoriatic arthritis, *continue to diagnosis section.*

***Complete the following section based on the patient's diagnosis, if applicable.***

Section B: Rheumatoid Arthritis

20. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic DMARD (e.g., Rinvoq, Olumiant) that is indicated for moderately to severely active rheumatoid arthritis? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.*** ❑ Yes ❑ No

21. Does the patient meet BOTH of the following: a) the patient was tested for the rheumatoid factor (RF) biomarker AND b) the RF biomarker test was positive? ***ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing and skip to #26.*** ❑ Yes ❑ No

22. Does the patient meet BOTH of the following: a) the patient was tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker AND b) the anti-CCP biomarker test was positive? ***ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing and skip to #26.*** ❑ Yes ❑ No

23. Has the patient been tested for the rheumatoid factor (RF) biomarker? ***ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing.*** ❑ Yes ❑ No

24. Has the patient been tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker? ***ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing.*** ❑ Yes ❑ No

25. Has the patient been tested for the C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR) biomarker(s)? ***ACTION REQUIRED: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing.*** ❑ Yes ❑ No
    Please specify results:
    a) CPR: ❑ Positive ❑ Negative ❑ Test for CRP was not completed
    b) ESR: ❑ Positive ❑ Negative ❑ Test for ESR was not completed

26. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate at a dose greater than or equal to 20 mg per week? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and no further questions.*** ❑ Yes ❑ No

27. Has the patient experienced intolerance to methotrexate? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and no further questions.*** ❑ Yes ❑ No

28. Does the patient have a contraindication to methotrexate? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No
    *If Yes, indicate the contraindication:* _____

Section C: Ulcerative Colitis

29. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for the treatment of moderately to severely active ulcerative colitis? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and skip to #34.*** ❑ Yes ❑ No

30. Has the patient been hospitalized for acute, severe ulcerative colitis (e.g., continuous bleeding, severe toxic symptoms, including fever and anorexia)? ***ACTION REQUIRED: If Yes, please attach supporting chart notes or medical record documentation of hospitalization and skip to #34.*** ❑ Yes ❑ No

31. Has the patient had an inadequate response with at least one tumor necrosis factor inhibitor (TNF-i)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and skip to #34.*** ❑ Yes ❑ No

32. Has the patient experienced an intolerance with at least one tumor necrosis factor inhibitor (TNF-i)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and skip to #34.*** ❑ Yes ❑ No

33. Does the patient have a contraindication to a tumor necrosis factor inhibitor (TNF-i)? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

34. Is the request for induction or maintenance of remission?
    ❑ Induction ❑ Maintenance *If Maintenance, skip to #36*

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35. Will the prescribed treatment for induction of remission exceed a duration of 16 weeks?
    ❑ Yes ❑ No *No further questions*

36. Is the patient experiencing a loss of response during treatment for maintenance of remission? ❑ Yes ❑ No

37. Will the lowest effective dose be utilized and limited to the shortest duration needed? ❑ Yes ❑ No

Section D: Articular Juvenile Idiopathic Arthritis

38. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic disease-modifying antirheumatic drug indicated for active articular juvenile idiopathic arthritis? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and further questions.*** ❑ Yes ❑ No

39. Has the patient had an inadequate response to methotrexate or another non-biologic DMARD administered at an adequate dose and duration? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and further questions.*** ❑ Yes ❑ No

40. Does the patient have any of the following risk factors? ❑ Yes ❑ No
    a) positive rheumatoid factor
    b) positive anti-cyclic citrullinated peptide antibodies
    c) pre-existing joint damage

41. Does the patient meet any of the following? ❑ Yes ❑ No
    a) high-risk joints are involved (e.g., cervical spine, wrist, or hip)
    b) high disease activity
    c) high risk for disabling joint disease

***I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.***

**X**_____

**Prescriber or Authorized Signature** **Date (mm/dd/yy)**

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