

Prescriber Criteria Form

Xeljanz 2025 PA Fax 914-A v3 010125.docx  
 Xeljanz (tofacitinib), Xeljanz XR (tofacitinib extended-release)  
 Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.  
 Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact  
 CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are  
 met, we will authorize the coverage of Xeljanz.

Drug Name (select from list of drugs shown):

**Patient Name:**

**Patient ID:**

**Patient DOB:**

**Patient Phone:**

**Prescriber Name:**

**Prescriber Address:**

**City:**

**State:**

**Zip:**

**Prescriber Phone:**

**Prescriber Fax:**

**Diagnosis:**

**ICD Code(s):**

**Please circle the appropriate answer for each question.**

1	Has the patient previously received the requested drug for one of the following conditions: A) rheumatoid arthritis, B) psoriatic arthritis, C) ulcerative colitis, D) polyarticular course juvenile idiopathic arthritis, E) ankylosing spondylitis? [If yes, then no further questions.]	Yes	No
2	Does the patient have a diagnosis of moderately to severely active rheumatoid arthritis (RA)? [If no, then skip to question 4.]	Yes	No
3	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab-aacf, Humira [adalimumab], Idacio [adalimumab-aacf])? [No further questions.]	Yes	No
4	Does the patient have a diagnosis of active psoriatic arthritis (PsA)? [If no, then skip to question 7.]	Yes	No
5	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab-aacf, Humira [adalimumab], Idacio [adalimumab-aacf])? [If no, then no further questions.]	Yes	No

6	Will the requested drug be used in combination with a nonbiologic disease-modifying antirheumatic drug (DMARD)? [No further questions.]	Yes	No
7	Does the patient have a diagnosis of moderately to severely active ulcerative colitis? [If no, then skip to question 9.]	Yes	No
8	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab-aacf, Humira [adalimumab], Idacio [adalimumab-aacf])? [No further questions.]	Yes	No
9	Does the patient have a diagnosis of active polyarticular course juvenile idiopathic arthritis (pcJIA)? [If no, then skip to question 11.]	Yes	No
10	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab-aacf, Humira [adalimumab], Idacio [adalimumab-aacf])? [No further questions.]	Yes	No
11	Does the patient have a diagnosis of active ankylosing spondylitis? [If no, then no further questions.]	Yes	No
12	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab-aacf, Humira [adalimumab], Idacio [adalimumab-aacf])?	Yes	No

Comments:	
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By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

<b>Prescriber (or Authorized) Signature:</b> _____	<b>Date:</b> _____
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