Prescriber Criteria Form **i** Xeljanz 2025 PA Fax 914-A v4 020125.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, Enbrel [etanercept], 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, Enbrel [etanercept], 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, Enbrel [etanercept], 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, Enbrel [etanercept], Humira [adalimumab], Idacio [adalimumab-aacf])?	Yes ◯	No ◯

Comments:	_____

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.

Prescriber (or Authorized) Signature: _____ **Date:**_____