US Family Health Plan
Prior Authorization Request Form for
tofacitinib **(Xeljanz tablets/solution, Xeljanz XR)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

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. Does the patient have a hemoglobin level LESS THAN 9 g/dL?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **6**
6. Does the patient have an absolute neutrophil count (ANC) LESS THAN 1,000/mm3?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **7**
7. Does the patient have an absolute lymphocyte count (ALC) LESS THAN 500/mm3?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **8**

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8. What is the patient's age?	☐ LESS than 2 years of age - **STOP Coverage not approved** ☐ 2 years of age to LESS than 18 years of age- proceed to question **9** ☐ 18 years of age and OLDER – proceed to question **10**		
9. What is the indication or diagnosis?	☐ Active polyarticular course juvenile idiopathic arthritis (pcJIA) – proceed to question **14** ☐ Other indication or diagnosis – STOP: **Coverage not approved.**		
10. What is the indication or diagnosis?	☐ Moderately to severely active **rheumatoid arthritis** – proceed to question **11** ☐ Active **psoriatic arthritis** – proceed to question **12** ☐ Moderately to severely active **ulcerative colitis** – proceed to question **12** ☐ Other indication or diagnosis – STOP: **Coverage not approved.**		
11. Has the patient had an inadequate response or an intolerance to methotrexate?		☐ Yes proceed to question **13**	☐ No **STOP** **Coverage not approved**
12. Has the patient had an inadequate response or an intolerance to methotrexate or other disease-modifying antirheumatic drugs (DMARDs)?		☐ Yes proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. 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 **14**
14. Does the patient have a history of thromboembolic disease?		☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **15**
15. 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 **16**	☐ No **STOP** **Coverage not approved**
16. 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, Rinvoq, Rituxan, Siliq, Simponi, Skyrizi, Stelara, Taltz, Skyrizi, Rinvoq or Tremfya? (Note: Does not apply to Otezla)		☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **17**

17. Is the provider aware of the FDA-approved dosing requirements by indications, and also aware of the FDA safety alerts AND Boxed Warnings? 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 OR up to 22mg once a day** • **Active Polyarticular course Juvenile Idiopathic Arthritis (pcJIA):** **5 mg twice a day or weight-based equivalent twice a day (oral solution and immediate-release tablet may be converted on a mg to mg equivalent; for example, 5 mg oral solution may be switched to 5 mg immediate-release tablet)**	☐ 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 _____