USFHP 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

https://www.usfamilyhealth.org/for-providers/pharmacy-information/

Prior authorization does not expire. Clinical documentation may be required.

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. 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 **6** ☐ 18 years of age and OLDER – proceed to question **7**	
6. What is the indication or diagnosis for pediatric patients (2 to 17 years of age)?	☐ Active polyarticular course juvenile idiopathic arthritis (pcJIA) – proceed to question **10** ☐ Active psoriatic arthritis (PsA) - proceed to question **8** ☐ Other indication or diagnosis – **STOP: Coverage not approved.**	

7. What is the indication or diagnosis for adult patients (18 years of age or older)?	☐ Moderately to severely active **rheumatoid arthritis** – proceed to question **10** ☐ Active psoriatic arthritis (PsA) – proceed to question **8** ☐ Active ankylosing spondylitis (AS, ax-SpA) – proceed to question **9** ☐ Moderately to severely active **ulcerative colitis** – proceed to question **10** ☐ Other indication or diagnosis – **STOP: Coverage not approved.**	
8. Has the patient had an inadequate response, intolerance, or contraindication to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [such as, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [such as, azathioprine], etc.)?	☐ Yes proceed to question **10**	☐ No **STOP** **Coverage not approved**
9. Has the patient experienced an inadequate response to at least two nonsteroidal anti-inflammatory drugs (NSAIDs) (for example: ibuprofen, naproxen, diclofenac) over a period of AT LEAST two months?	☐ Yes proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Will the patient be receiving any other targeted immunomodulatory biologics concurrently, including but not limited to the following: TNF inhibitors, IL-1, IL-6, IL-17, IL-23, IL-36, JAK inhibitors?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **11**
11. Provider is aware of the FDA safety alerts and boxed warnings.	☐ Acknowledged **Sign and date below**	

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date