Health Partners Plans

HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

Xeljanz - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: ☐ Medicare	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:
Strength:
Directions / SIG:

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the requested drug being prescribed by or in consultation with a rheumatologist or gastroenterologist?

☐ Yes ☐ No

Q2. Does the patient have the diagnosis of rheumatoid arthritis or psoriatic arthritis?

☐ Yes ☐ No

Q3. Is there documentation of an inadequate response, intolerance, or contraindication to at least one disease modifying anti-rheumatic drug (DMARD) AND one tumor necrosis factor antagonist (such as Enbrel or Humira)?

☐ Yes ☐ No

Q4. Does the patient have the diagnosis of ulcerative colitis?

☐ Yes ☐ No

Q5. Is the requested product Xeljanz (not the XR formulation)?

☐ Yes ☐ No

Q6. Is there documentation of an inadequate response, intolerance, or contraindication to one tumor necrosis factor antagonist (such as Humira)?

☐ Yes ☐ No

Q7. Is the patient 18 years of age or older?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q8. Has the patient been evaluated for current infections including active or latent tuberculosis (TB) infection with a tuberculin skin test prior to the initiation of therapy?

☐ Yes ☐ No

Q9. Was the tuberculin skin test negative?

☐ Yes ☐ No

Q10. Has the patient received appropriate treatment for the active or latent infection?

☐ Yes ☐ No

Q11. Will the requested drug be used concomitantly with other biologic disease modifying anti-rheumatic drugs (DMARDs) or potent immunosuppressants (such as azathioprine or cyclosporine)?

☐ Yes ☐ No

Q12. Additional Information:

Q13. Duration:

☐ 12 months

Prescriber Signature

Date

2020 Medicare Prior Authorization Request

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