

**Xeljanz, Xeljanz XR
Prior Authorization Request**

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506**. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

- Which drug is being prescribed? Xeljanz Xeljanz XR Other _____
- What is the diagnosis?
 Moderately to severely active rheumatoid arthritis (RA) Active psoriatic arthritis (PsA)
 Other _____
- What is the ICD-10 code? _____

Section A: Preferred Product

- These are the preferred products for which coverage is provided for treatment of the following conditions:
a) Rheumatoid arthritis: **Enbrel, Humira, Kevzara, Orencia (subcutaneous)/Orencia ClickJect**
b) Psoriatic arthritis: **Cosentyx, Enbrel, Humira, Otezla**

Can the patient's treatment be switched to a preferred product?

Yes - Please specify: _____ *If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.*

No

Not applicable - Requested for condition not listed above, skip to Section B: All Requests

- Is this request for continuation of therapy with the requested product? Yes No *If No, skip to #7*
- Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes. Yes No *If No, skip to Section B: All Requests*
- Has the patient had a documented inadequate response or intolerable adverse event with any of the following preferred products? Please indicate ALL that apply. **ACTION REQUIRED: If Yes, attach supporting chart note(s).**

<input type="checkbox"/> Cosentyx:	<input type="checkbox"/> Inadequate response	<input type="checkbox"/> Intolerable adverse event
<input type="checkbox"/> Enbrel:	<input type="checkbox"/> Inadequate response	<input type="checkbox"/> Intolerable adverse event
<input type="checkbox"/> Humira:	<input type="checkbox"/> Inadequate response	<input type="checkbox"/> Intolerable adverse event
<input type="checkbox"/> Kevzara:	<input type="checkbox"/> Inadequate response	<input type="checkbox"/> Intolerable adverse event
<input type="checkbox"/> Orencia (SC/ClickJect):	<input type="checkbox"/> Inadequate response	<input type="checkbox"/> Intolerable adverse event

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