

Biologic Immunomodulators Xeljanz Tablet, Xeljanz XR, Xeljanz Solution Prior Authorization (PA) Request Form

To submit request electronically, please go to providerportal.surescripts.net/ProviderPortal/login **OR** covermymeds.com using Plan/PBM Name "BCBS NC"

Fax: 888-446-8535

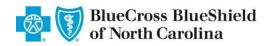
Mail: Blue Cross NC, ATTN: Part D Coverage Determination

P.O. Box 2251, Durham, NC 27702-2251

Call: 888-298-7552 Blue Medicare Rx

888-296-9790 Blue Medicare HMO/PPO

	Inco	mplete Form May	/ Delay Processing		
Prescribe	er Information		Patient Information		
Physician Name:	NPI#	±:	Patient Name:		
Office Contact Person:			Patient ID #:		
Office Phone #:	Office Fax #:		Home Phone #:		
Address:			Sex: □ Female □ Male		
City:	State: Zip:	:	DOB:		
	Diag	nosis and Medi	cation Information		
Medication Requested:	<u> </u>		Diagnosis Code:		
Strength and Route of Admi	nistration:				
	Pl	lease answer q	uestions below		
			al evaluation on page 3)		
Check the "Yes" box to r believes that waiting for	equest an exped a decision under n function in seri	ited review if the e	nrollee or his/her physician or other prescribe frame may place the enrollee's life, health, or andard review will have a decision made within 72		⊔ No
2. Please select the request ☐ Xeljanz immediate re		□ Xeljanz XF	R tablet □ Xeljanz oral solution		
3. Please select the diagnos ☐ Polyarticular juven			nd answer any associated questions:		
☐ Psoriatic arthritis	•	. ,			
☐ Rheumatoid arthrit A Does the patien		ely to severely acti	ve rheumatoid arthritis?	ПYes	П №
☐ Ulcerative colitis					
		ely to severely acti	ve ulcerative colitis?	□ Yes	□ No
☐ Ankylosing spondy					
☐ Other (please spec	ify):				
A. If YES to 4. , is t i. If YES to 4 .	he patient at risk A., please provi e	κ if therapy is char	ed with the requested medication? nged? cation to support that the patient is at risk if sent in for review.		
	PL	LEASE CONTINU	E TO NEXT PAGE		



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B. If NO to 4. or 4.A., does the patient's medication history include the use of a preferred tumor necrosis factor (TNF) medication? i. If YES, please specify which medication:		□ No
ii. If NO , does the patient have an intolerance, FDA labeled contraindication, or hypersensitivity to a preferred TNF medication? a. If YES , please specify which medication:	□ Yes 	□ No
5. Will the patient be using the requested medication in combination with another biologic immunomodulator?	□ Yes	□ No
I certify that I have appropriate authority to request a coverage determination for the medication indicated I further certify that the patient's medical records accurately reflect the information provided. I understand NC may request medical records for this patient at any time in order to verify this information.		
Physician Signature: Date:		



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		Incomplete Form May			
Prescribe	r Inform	The state of the s	Patient Information		
Physician Name:		NPI #:	Patient Name:		
Office Contact Person:			Patient ID #:		
Office Phone #: Office Fax #:		ax #:	Home Phone #:		
Address:			Sex: □ Female □ Male		
City: S	State:	Zip:	DOB:		
		Diagnosis and Medic	cation Information		
Medication Requested:			Diagnosis Code:		
Strength and Route of Admir	nistration:				
		Please answer qu	uestions below		
	Re		al evaluation on page 1)		
Check the "Yes" box to re believes that waiting for a	equest an a decision n function	expedited review if the en under the standard time	nrollee or his/her physician or other prescriber frame may place the enrollee's life, health, or andard review will have a decision made within 72	s □ No	
Has the patient been previously approved for the requested medication through the plan's Prior Authorization criteria?					
3. Please select the requeste ☐ Xeljanz immediate re			R tablet □ Xeljanz oral solution		
4. Please select the diagnosi ☐ Polyarticular juveni ☐ Psoriatic arthritis ☐ Rheumatoid arthriti ☐ Ulcerative colitis ☐ Ankylosing spondy ☐ Other (please speci	le idiopa s litis		nd answer any associated questions:		
			e progression or decrease in symptom □ Yes	s □ No	
6. Will the patient be using the immunomodulator?			nation with another biologic □ Yes	s □ No	
I further certify that the patier	nt's medic	cal records accurately ref	e determination for the medication indicated on this reflect the information provided. I understand that Blue order to verify this information.		
Physician Signature:			Date:		