Prescriber Criteria Form

Xeljanz 2026 PA Fax 914-A v3 010126.docx
Xeljanz (tofacitinib), Xeljanz XR (tofacitinib extended-release)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Xeljanz.

Drug Name (select from list of drugs shown):

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Has the patient previously received the requested drug for one of the following conditions: A) rheumatoid arthritis, B) psoriatic arthritis, C) ankylosing spondylitis, D) ulcerative colitis, E) polyarticular course juvenile idiopathic arthritis? [If yes, then no further questions.]	Yes	No
2	Does the patient have a diagnosis of moderately to severely active rheumatoid arthritis (RA)? [If no, then skip to question 4.]	Yes	No
3	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab, etanercept)? [No further questions.]	Yes	No
4	Does the patient have a diagnosis of active psoriatic arthritis (PsA)? [If no, then skip to question 7.]	Yes	No
5	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab, etanercept)? [If no, then no further questions.]	Yes	No

6	Will the requested drug be used in combination with a nonbiologic disease-modifying antirheumatic drug (DMARD)? [No further questions.]	Yes	No
7	Does the patient have a diagnosis of moderately to severely active ulcerative colitis? [If no, then skip to question 9.]	Yes	No
8	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab)? [No further questions.]	Yes	No
9	Does the patient have a diagnosis of active polyarticular course juvenile idiopathic arthritis (pcJIA)? [If no, then skip to question 11.]	Yes	No
10	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab, etanercept)? [No further questions.]	Yes	No
11	Does the patient have a diagnosis of active ankylosing spondylitis? [If no, then no further questions.]	Yes	No
12	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab, etanercept)?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____