PRIOR AUTHORIZATION FORM
XELJANZ™

Anthem HealthKeepers
Offered by HealthKeepers, Inc.

Requests for prior authorization (PA) must include patient name, Medicaid ID #, drug name and appropriate clinical information to support the request on the basis of medical necessity.
Please include all requested information; incomplete forms will delay the PA process.

The completed form may be faxed to **1-844-512-7020 for Retail Pharmacy or 1-844-512-7022 for Medical Injectables**.

All questions must be answered.

Today's Date: ___ ___/___ ___/___ ___ ___ ___ Requested Start Date: ___ ___/___ ___/___ ___ ___ ___

PATIENT INFORMATION

Name: (Last, First) _____ **Medicaid ID#:** ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Date of Birth: ___ ___/___ ___/___ ___ ___ ___ **Gender:** □ **Male** □ **Female**

DRUG INFORMATION

Drug Name, Dosage Form & Strength:	Quantity Per Day:

Is Xeljanz™ being used for the treatment of moderately to severely active rheumatoid arthritis? □ Yes □ No

Has the patient had an inadequate response to or intolerance to methotrexate? □ Yes □ No
Provide details: _____
_____

Has the patient had a therapeutic trial and treatment failure with at least ONE preferred drug (i.e. Enbrel® or Humira®)? □ Yes □ No
Provide details: _____
_____

Is the patient currently using any biologic DMARDs or potent immunosuppressants (i.e. azathioprine, cyclosporin)? □ Yes □ No
If yes, please explain: _____
_____
_____

PRESCRIBER INFORMATION

Name (print):_____ **NPI Number:** ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Phone Number: (___ ___ ___) ___ ___ ___-___ ___ ___ ___ **Fax Number:** (___ ___ ___) ___ ___ ___-___ ___ ___ ___

Signature of Prescribing Provider: _____

PLEASE INCLUDE ALL REQUESTED INFORMATION.
INCOMPLETE FORMS WILL DELAY THE PRIOR AUTHORIZATION PROCESS.

FAX TO 1-844-512-7020 for Retail Pharmacy or 1-844-512-7022 for Medical Injectables.
PRIOR AUTHORIZATION CRITERIA IS SUBJECT TO CHANGE AND THUS DRUG COVERAGE.