BlueCross BlueShield of North Carolina

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

Incomplete Form May Delay Processing

Prescriber 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:

Diagnosis and Medication Information	
Medication Requested:	Diagnosis Code:
Strength and Route of Administration:	

Please answer questions below

Initial Evaluation (**Renewal evaluation on page 3**)

1. Is this request for an expedited review? ☐ Yes ☐ No
   Check the "Yes" box to request an expedited review if the enrollee or his/her physician or other prescriber believes that waiting for a decision under the standard time frame may place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. *A standard review will have a decision made within 72 hours for a coverage determination.*

2. Please select the requested medication:
   ☐ Xeljanz immediate release tablet ☐ Xeljanz XR tablet ☐ Xeljanz oral solution

3. Please select the diagnosis for the requested medication and answer any associated questions:
   ☐ **Polyarticular juvenile idiopathic arthritis (pcJIA)**
   ☐ **Psoriatic arthritis**
   ☐ **Rheumatoid arthritis (RA)**
      A. Does the patient have moderately to severely active rheumatoid arthritis? ☐ Yes ☐ No
   ☐ **Ulcerative colitis**
      A. Does the patient have moderately to severely active ulcerative colitis? ☐ Yes ☐ No
   ☐ **Ankylosing spondylitis**
   ☐ **Other (please specify):** _____

4. Is the patient currently (within the past 90 days) being treated with the requested medication? ☐ Yes ☐ No
   A. **If YES to 4.**, is the patient at risk if therapy is changed? ☐ Yes ☐ No
      i. **If YES to 4A.,** please **provide clinical justification** to support that the patient is at risk if therapy is changed. Medical records may be sent in for review.
      _____
      _____
      _____

PLEASE CONTINUE 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?..... ☐ Yes ☐ No

i. **If YES,** please specify which medication: _____
_____

ii. **If NO,** does the patient have an intolerance, FDA labeled contraindication, or hypersensitivity to a preferred TNF medication?..... ☐ Yes ☐ No

a. **If YES,** please specify which medication: _____
_____

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 on this request. I further certify that the patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information.

Physician Signature: _____ Date: _____

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Office Phone #:	Office Fax #:	Home Phone #:
Address:		Sex: ☐ Female ☐ Male
City: State: Zip:		DOB:

Diagnosis and Medication Information	
Medication Requested:	Diagnosis Code:
Strength and Route of Administration:	

Please answer questions below

Renewal Evaluation (Initial evaluation on page 1)

1. Is this request for an expedited review? ☐ Yes ☐ No
   Check the "Yes" box to request an expedited review if the enrollee or his/her physician or other prescriber believes that waiting for a decision under the standard time frame may place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. *A standard review will have a decision made within 72 hours for a coverage determination.*

2. Has the patient been previously approved for the requested medication through the plan's Prior Authorization criteria? ☐ Yes ☐ No

3. Please select the requested medication:
   ☐ Xeljanz immediate release tablet ☐ Xeljanz XR tablet ☐ Xeljanz oral solution

4. Please select the diagnosis for the requested medication and answer any associated questions:
   - ☐ **Polyarticular juvenile idiopathic arthritis (pcJIA)**
   - ☐ **Psoriatic arthritis**
   - ☐ **Rheumatoid arthritis**
   - ☐ **Ulcerative colitis**
   - ☐ **Ankylosing spondylitis**
   - ☐ **Other (please specify):**_____

5. Has the patient had clinical improvement (slowing of disease progression or decrease in symptom severity and/or frequency)? ☐ Yes ☐ No

6. 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 on this request. I further certify that the patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information.

Physician Signature:_____ Date: _____

Updated: 01/01/2024