together with CCHP™

Prior Authorization Form: **Xeljanz**

If this is an urgent request, please call Together with CCHP Pharmacy Services.
Otherwise, please return completed form – Phone: 844-201-4677 or Fax: 844-201-4675

Please type or print neatly. Please complete all sections of this form. Incomplete responses may delay this request.					
Office Contact:			Provider Specialty:		
Provider First Name:			Provider Last Name:		
Provider Phone:			Provider Fax:		Provider NPI #:
Patient Name:		Together with CCHP ID Number:			Patient DOB:
Drug Requested:	Strength:	Frequency:	Qty Dispensed:		Patient Age:

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

☐ **New medication** ☐ **Ongoing medication**	If ongoing, provide date started:	If medication is ongoing, Did the member show improvement while on therapy?	☐ **Yes** ☐ **No**
Diagnosis:		Date of diagnosis:	

Please indicate place of administration / infusion?	**Physician's Office** ☐ **Hospital/Facility** ☐ **Patient Home** ☐	Please indicate how medication will be billed: **Billed directly by the provider via JCODE** **Provide JCODE:**_____ ☐ **Billed by a pharmacy and delivered to the provider** ☐ **Billed by a pharmacy and delivered to the patient**
Please provide facility/provider name and address:		

Please complete the following questions for *all* diagnoses.

Please indicate disease severity:	☐ **Mild** ☐ **Moderate** ☐ **Severe**	
Date of most recent tuberculosis skin test:	Result of tuberculosis skin test: ☐ **Positive** ☐ **Negative**	
Does the member currently have evidence of infection?		☐ **Yes** ☐ **No**
Is the member currently using another biologic Disease Modifying Antirheumatic Drug or potent immunosuppressant in combination with Xeljanz? If yes, please provide name of medication:		☐ **Yes** ☐ **No**
Does the member have severe hepatic impairment?		☐ **Yes** ☐ **No**

Please indicate past medication(s) tried and failed:

(Xeljanz requires prior drug therapy with both preferred TNF products.)

Medication name	Start date	End date	Strength	Frequency	Reason for failure, discontinuation
Methotrexate					
Hydroxychloroquine					
Leflunomide					
Minocycline					

Sulfasalazine					
Cimzia					
ENBREL**					
HUMIRA**					
Remicade					
Simponi					
Other:					

****Enbrel and Humira are the preferred TNF Products for Together with CCHP**

Please provide the following laboratory values:		
Laboratory test	**Date of test**	**Result (include units)**
Absolute Neutrophil Count (ANC)		
Lymphocyte Count		
Hemoglobin		
ALT		
AST		
Total Cholesterol		
LDL Cholesterol		
HDL Cholesterol		
Triglycerides		
Please provide any additional information in the space below.		