



If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

**PATIENT INFORMATION**

Last Name:

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First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Medicaid ID Number:

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Date of Birth:

				-					-										
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Gender:  Male  Female

Weight in Kilograms: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Last Name:

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First Name:

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NPI Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Phone Number:

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Fax Number:

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**DRUG INFORMATION**

Drug Name/Form: \_\_\_\_\_

Strength: \_\_\_\_\_

Dosing Frequency: \_\_\_\_\_

Length of Therapy: \_\_\_\_\_

Quantity per Day: \_\_\_\_\_

*(Form continued on next page.)*

Patient's Last Name:

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Patient's First Name:

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**DIAGNOSIS AND MEDICAL INFORMATION**

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1. Is Xeljanz™ being used for the treatment of moderately to severely active rheumatoid arthritis?

Yes     No

2. Has the patient had an inadequate response to or intolerance to methotrexate?

Yes     No

Provide details:

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3. 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:

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4. Is the patient currently using any biologic DMARDs or potent immunosuppressants (i.e., azathioprine, cyclosporin)?

Yes     No

If yes, please explain:

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**Prescriber Signature (Required)**

**Date**

By signature, the Physician confirms the above information is accurate and verifiable by patient records.

**Please include ALL requested information; Incomplete forms will delay the SA process.**

Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

The completed form may be: **FAXED TO 800-932-6651**, phoned to 800-932-6648, or mailed to:

Magellan Medicaid Administration / ATTN: MAP

11013 W. Broad Street, Glen Allen, VA 23060

**Virginia Medicaid Pharmacy Services Portal:** <http://www.virginiamedicaidpharmacyservices.com>