



Request for Prior Authorization
JANUS KINASE (JAK) INHIBITORS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for Janus kinase (JAK) inhibitors. Payment will be considered for a FDA approved or compendia indicated diagnosis when the following conditions are met:

- 1. Patient meets the FDA approved age; and
2. Patient is not using or planning to use a JAK inhibitor in combination with other JAK inhibitors, biologic DMARDs or potent immunosuppressants (azathioprine or cyclosporine); and
3. Has been tested for latent tuberculosis prior to initiating therapy and will be monitored for active tuberculosis during treatment; and
4. Recommended laboratory monitoring of lymphocytes, neutrophils, hemoglobin, liver enzymes and lipids are being conducted according to the manufacturer labeling; and
5. Patient does not have a history of malignancy, except for those successfully treated for non-melanoma skin cancer (NMSC); and
6. Patient is not at an increased risk of gastrointestinal perforation.
7. Patient does not have an active, serious infection, including localized infections; and
8. Medication will not be given concurrently with live vaccines; and
9. Follows FDA approved dosing based on indication; and
10. Patient has a diagnosis of:
a. Moderate to severe rheumatoid arthritis with
i. A documented trial and inadequate response to two preferred oral disease modifying antirheumatic drugs (DMARD) used concurrently. The combination must include methotrexate plus another preferred oral DMARD (hydroxychloroquine, sulfasalazine, or leflunomide); and
ii. A documented trial and inadequate response to two preferred biological DMARDs; or
b. Psoriatic arthritis with
i. A documented trial and inadequate response to therapy with the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and
ii. Documented trial and therapy failure with two preferred biological agents used for psoriatic arthritis.
c. Moderately to severely active ulcerative colitis with
i. A documented trial and inadequate response to two preferred conventional therapies including amino salicylates and azathioprine/6-mercaptopurine; and
ii. A documented trial and inadequate response with a preferred biological DMARD; and
iii. If requested dose for tofacitinib is 10mg twice daily, an initial 16 weeks of therapy will be allowed. Continued requests as this dose will need to document an adequate therapeutic benefit.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Non-Preferred

Olumiant, Xeljanz, Xeljanz XR

Strength, Dosage Instructions, Quantity, Days Supply

Diagnosis:

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Will the JAK inhibitor be used in combination with other JAK inhibitors, biologic DMARDs or potent immunosuppressants?

Yes No

Screening for Latent TB infection: Date: _____ Results: _____

Will patient be monitored for active tuberculosis during treatment? Yes No

Does patient have a history of malignancy, except successfully treated non-melanoma skin cancer (NMSC)? Yes No

Does patient have an increased risk of gastrointestinal perforation? Yes No

Recommended laboratory monitoring will be conducted according to manufacturer labeling (lymphocytes, neutrophils, hemoglobin, liver enzymes and lipids)?

Yes No Date of most recent labs: _____

Does patient have an active, serious infection, including localized infections? Yes No

Will requested medication be given concurrently with live vaccines? Yes No

Moderate to Severe Rheumatoid Arthritis (RA) (Olumiant, Xeljanz or Xeljanz XR)

Methotrexate trial: Dose: _____ Trial dates: _____

Failure reason: _____

Plus preferred oral DMARD trial: Drug Name & Dose: _____ Trial dates: _____

Failure reason: _____

Preferred Biological DMARD Trial #1: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

Preferred Biological DMARD Trial #2: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

Psoriatic Arthritis (Xeljanz or Xeljanz XR)

Methotrexate trial (leflunomide or sulfasalazine if methotrexate is contraindicated):

Dose: _____ Trial dates: _____

Failure reason: _____

Preferred Biological DMARD Trial #1: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

Preferred Biological DMARD Trial #2: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

Ulcerative Colitis (Xeljanz)

Document two preferred conventional therapies including amino salicylates and azathioprine/6-mercaptopurine

Trial #1 : Dose: _____ Trial dates: _____

Failure reason: _____

Trial #2: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

Preferred Biological DMARD Trial #1: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

If requesting continuation of tofacitinib 10mg twice daily dose, document adequate therapeutic benefit:

Other medical conditions to consider: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
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IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*