Iowa Department of Human Services

Request for Prior Authorization
JANUS KINASE (JAK) INHIBITORS

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for Janus kinase (JAK) inhibitors. Payment will be considered when the following conditions are met:

1) **The patient is 18 years of age or older; and**
2) **Has a diagnosis of moderate to severe rheumatoid arthritis; and**
3) **Has 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, leflunomide, or minocycline); and**
4) **Has a documented trial and inadequate response to two preferred biological DMARDs; and**
5) **The patient is not using or planning to use tofacitinib in combination with biologic DMARDs or potent immunosuppressants (azathioprine or cyclosporine); and**
6) **Has been tested for latent tuberculosis prior to initiating therapy and will be monitored for active tuberculosis during treatment; and**
7) **Recommended laboratory monitoring of lymphocytes, neutrophils, hemoglobin, liver enzymes and lipids are being conducted according to the manufacturer labeling; and**
8) **Patient does not have a history of malignancy, except those successfully treated for non-melanoma skin cancer (NMSC); and**
9) **Patient is not at an increased risk of gastrointestinal perforation.**

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

Non-Preferred

☐ Xeljanz ☐ Xeljanz XR

Diagnosis:_____

Strength_____ **Dosage Instructions**_____ **Quantity**_____ **Days Supply**_____

Trial Information:

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:_____

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Will tofacitinib be used in combination with 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:_____

Other medical conditions to consider:_____

_____

_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

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.*