



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 when the following conditions are met:

- 1. Patient meets the FDA approved age; and
2. Patient is not using or planning to use tofacitinib in combination with biologic DMARDs or potent immunosuppressants...
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...
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...
ii. Documented trial and therapy failure with two preferred biological agents used for psoriatic arthritis.

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

Strength Dosage Instructions Quantity Days Supply

Diagnosis:

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

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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)

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

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: _____

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.