



Request for Prior Authorization

FAX Completed Form To

I (800) 574-2515

JANUS KINASE (JAK) INHIBITORS

Provider Help Desk

I (877) 776-1567

(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, Prescriber must complete all information above, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization (PA) is required for Janus kinase (JAK) inhibitors. Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated.

- 1. Patient is not using or planning to use a JAK inhibitor in combination with other JAK inhibitors, biological therapies, or potent immunosuppressants (azathioprine or cyclosporine); and
2. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
3. Patient has a diagnosis of:
a. Moderate to severe rheumatoid arthritis; with
i. A documented trial and inadequate response, at a maximally tolerated dose, with methotrexate; and
ii. A documented trial and inadequate response to one preferred TNF inhibitor; or
b. Psoriatic arthritis; with
i. A documented trial and inadequate response, at a maximally tolerated dose, with methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and
ii. Documented trial and therapy failure with one preferred TNF inhibitor used for psoriatic arthritis; or
c. Moderately to severely active ulcerative colitis; with
i. A documented trial and inadequate response to two preferred conventional therapies including aminosaliclates and azathioprine/6-mercaptopurine; and
ii. A documented trial and inadequate response with a preferred TNF inhibitor; 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; or
d. Moderately to severely active Crohn's disease; with
i. A documented trial and inadequate response to two preferred conventional therapies including aminosaliclates (sulfasalazine), azathioprine/6-mercaptopurine, and/or methotrexate; and
ii. A documented trial and inadequate response with a preferred TNF inhibitor; or
e. Polyarticular Course Juvenile Idiopathic Arthritis; with
i. A documented trial and inadequate response to intraarticular glucocorticoid injections; and
ii. A documented trial and inadequate response to the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and
iii. A documented trial and inadequate response with a preferred TNF inhibitor; or
f. Axial spondyloarthritis conditions (e.g., ankylosing spondylitis or nonradiographic axial spondyloarthritis); with
i. A documented trial and inadequate response to at least two preferred non-steroidal anti-inflammatories (NSAIDS) at a maximally tolerated dose for a minimum of at least one month; and
ii. A documented trial and inadequate response with at least one preferred TNF inhibitor; or
g. Atopic dermatitis; with
i. Documentation patient has failed to respond to good skin care and regular use of emollients; and
ii. A documented adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and
iii. A documented trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and
iv. For mild to moderate atopic dermatitis:
a. A documented trial and therapy failure with crisaborole; and
b. Affected area is less than 20% of body surface area (BSA); and
c. Patient has been instructed to use no more than 60 grams of topical ruxolitinib per week; or
v. For moderate to severe atopic dermatitis:
a. A documented trial and therapy failure with cyclosporine or azathioprine; and

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- b. Requests for upadacitinib for pediatric patients 12 to less than 18 years if age must include the patient's weight in kg.

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

**Preferred**

**Non-Preferred**

Xeljanz       Cibinco    Olumiant    Opzelura    Rinvoq    Xeljanz Oral Solution    Xeljanz XR

**Strength** \_\_\_\_\_ **Dosage Instructions** \_\_\_\_\_ **Quantity** \_\_\_\_\_ **Days Supply** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

**Will the JAK inhibitor be used in combination with other JAK inhibitors, biological therapies or potent immunosuppressants?**

Yes     No

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

**Methotrexate trial:** Dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Failure reason: \_\_\_\_\_

**Preferred TNF Inhibitor:** Name/Dose: \_\_\_\_\_ Trial Dates: \_\_\_\_\_

Failure reason: \_\_\_\_\_

**Psoriatic Arthritis (Rinvoq, Xeljanz or Xeljanz XR)**

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

Name/Dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Failure reason: \_\_\_\_\_

**Preferred TNF Inhibitor:** Name/Dose: \_\_\_\_\_ Trial Dates: \_\_\_\_\_

Failure reason: \_\_\_\_\_

**Ulcerative Colitis (Rinvoq, Xeljanz or Xeljanz XR)**

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

**Trial #1 :** Dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Failure reason: \_\_\_\_\_

**Trial #2:** Name/Dose: \_\_\_\_\_ Trial Dates: \_\_\_\_\_

Failure reason: \_\_\_\_\_

**Preferred TNF Inhibitor:** Name/Dose: \_\_\_\_\_ Trial Dates: \_\_\_\_\_

Failure reason: \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

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**Moderately to severely active Crohn’s disease (Rinvoq)**

Document two preferred conventional therapies including aminosalicylates, azathioprine/6-mercaptopurine, and/or methotrexate

**Trial #1 :** Dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_  
Failure reason: \_\_\_\_\_

**Trial #2:** Name/Dose: \_\_\_\_\_ Trial Dates: \_\_\_\_\_  
Failure reason: \_\_\_\_\_

**Preferred TNF Inhibitor:** Name/Dose: \_\_\_\_\_ Trial Dates: \_\_\_\_\_  
Failure reason: \_\_\_\_\_

**Polyarticular Course Juvenile Idiopathic Arthritis (Xeljanz)**

**Intraarticular Glucocorticoid Injection trial:** Name/Dose: \_\_\_\_\_ Trial Dates: \_\_\_\_\_  
Failure reason: \_\_\_\_\_

**Methotrexate trial (leflunomide or sulfasalazine if methotrexate is contraindicated):**  
Name/Dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_  
Failure reason: \_\_\_\_\_

**Preferred TNF Inhibitor:** Name/Dose: \_\_\_\_\_ Trial Dates: \_\_\_\_\_  
Failure reason: \_\_\_\_\_

**Axial spondyloarthritis conditions (e.g., ankylosing spondylitis or nonradiographic axial spondyloarthritis) (Rinvoq, Xeljanz or Xeljanz XR)**

**Preferred NSAID trial 1:** Name/Dose: \_\_\_\_\_ Trial Dates: \_\_\_\_\_  
Failure reason: \_\_\_\_\_

**Preferred NSAID trial 2:** Name/Dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_  
Failure reason: \_\_\_\_\_

**Preferred TNF Inhibitor:** Name/Dose: \_\_\_\_\_ Trial Dates: \_\_\_\_\_  
Failure reason: \_\_\_\_\_

**Atopic Dermatitis**

**Has patient failed to respond to good skin care and regular use of emollients?**  Yes  No

Document emollient use: Product name, dosing instructions & duration of use: \_\_\_\_\_  
\_\_\_\_\_

**Preferred Medium to High Potency Topical Corticosteroid Trial:**  
Drug name & dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_  
Failure reason: \_\_\_\_\_

**Preferred Topical Immunomodulator Trial:**  
Drug name & dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_  
Failure reason: \_\_\_\_\_

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**Mild to Moderate Atopic Dermatitis (Opzelura)**

**Crisaborole Trial:**

Drug name & dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Failure reason: \_\_\_\_\_

Is affected area less than 20% of body surface area?  Yes  No

Has patient been instructed to use no more than 60gms of topical ruxolitinib per week?  Yes  No

**Moderate to Severe Atopic Dermatitis (Cibinqo or Rinvoq)**

**Cyclosporine or Azathioprine Trial:**

Drug name & dose: \_\_\_\_\_ Trial dates: \_\_\_\_\_

Failure reason: \_\_\_\_\_

**Requests for upadacitinib for pediatric patients 12 to less than 18 years of age include weight in kg: \_\_\_\_\_**

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 Health and Human Services, that the member continues to be eligible for Medicaid.