iowa total care | ia health link | Hawki | envolve Pharmacy Solutions

FAX Completed Form To
1.833.404.2392
Pharmacy Help Desk
1.800.460.8988
Prescriber Help Desk
1.833.587.2012

Request for Prior Authorization
JANUS KINASE (JAK) INHIBITORS

(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 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 ☐ Rinvoq ☐ 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, Rinvoq. 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

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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

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.*