Fax Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

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 (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. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug, excluding requests for the FDA approved indication of alopecia areata, vitiligo, or other excluded medical use(s), as defined in Section 1927(d)(2) of the Social Security Act, State Plan, and Rules when the following conditions are met:

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

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

Preferred
☐ Xeljanz

Non-Preferred
☐ Cibinqo ☐ Olumiant ☐ Opzelura ☐ Rinvoq ☐ 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 amino salicylates 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:
_____
_____

iowa total care ia health link Hawki

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☐ **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:_____

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:_____

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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

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.*