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Janus Kinase Inhibitors Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004

Provider Help Desk: 1-800-454-3730

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
_____	_____	_____	Specify: _____

7. Diagnosis: _____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization is required for janus kinase (JAK) inhibitors. Payment will be considered for an FDA approved or compendia indicated diagnosis when the following conditions are met:

1. Patient meets the FDA approved age
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)
3. Has been tested for latent tuberculosis prior to initiating therapy and will be monitored for active tuberculosis during treatment
4. Recommended laboratory monitoring of lymphocytes, neutrophils, hemoglobin, liver enzymes and lipids are being conducted according to the manufacturer labeling
5. Patient does not have a history of malignancy, except for those successfully treated for non-melanoma skin cancer (NMSC)
6. Patient is not at an increased risk of gastrointestinal perforation
7. Patient does not have an active, serious infection, including localized infections
8. Medication will not be given concurrently with live vaccines
9. Follows FDA approved dosing based on indication

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)
        ii. A documented trial and inadequate response to two preferred biological DMARDS
    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)
        ii. Documented trial and therapy failure with two preferred biological agents used for psoriatic arthritis
    c. Patient has a diagnosis of 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
        ii. A documented trial and inadequate response with a preferred biological DMARD
        iii. If requested dose is for tofacitinib is 10mg twice daily, an initial 16 weeks of therapy will be allowed; continued requests at 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.

Nonpreferred
☐ Olumiant ☐ Rinvoq ☐ Xeljanz ☐ Xeljanz XR

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 nonmelanoma 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 and dose:_____Trial dates:_____

Failure Rrason:_____

Preferred biological DMARD trial #1: Name/dose:_____ Trial dates:_____

Failure reason:_____

Preferred biological DMARD trial #2: Name/dose:_____ Trial dates:_____

☐ **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

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.

9. Physician signature

_____ _____

Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.