SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Xeljanz® (tofacitinib)**/Xeljanz® XR®** (tofacitinib xr) **(Non-Preferred)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

Recommended Dose:

Indication:	Dosage:
Moderate to Severe Active Rheumatoid Arthritis	• Xeljanz 5 mg twice daily (60 tabs/30 days) or • Xeljanz XR 11 mg once daily (30 tabs/30 days) • Patients with moderate and severe renal impairment or moderate hepatic impairment is XELJANZ 5 mg once daily (30 tabs/30 days)
Psoriatic Arthritis (in combination with nonbiologic DMARDs)	• Xeljanz 5 mg twice daily (60 tabs/30 days) or Xeljanz XR 11 mg once daily (30 tabs/30 days) • Patients with moderate and severe renal impairment or moderate hepatic impairment is Xeljanz 5 mg once daily
Polyarticular Course Juvenile Idiopathic Arthritis (pcJIA) (≥ 2 years)	• Xeljanz 5 mg twice daily (60 tabs/30 days) or weight-based equivalent twice daily • Xeljanz Oral Solution 5 mg twice daily (300ml/30 days) or weight-based equivalent twice daily

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Indication:	**Dosage:**
Ulcerative Colitis	• Induction: Xeljanz 10 mg twice daily (qty 60/30days) or Xeljanz XR 22 (qty 30/30days) mg once daily for 8 weeks; evaluate patients and transition to maintenance therapy depending on therapeutic response. If needed, continue Xeljanz 10 mg twice daily (qty 60/30days) or Xeljanz XR 22 mg (qty 30/30days) once daily for a maximum of 16 weeks. Discontinue Xeljanz 10 mg twice daily or Xeljanz XR 22 mg once daily (qty 30/30days) after 16 weeks if adequate therapeutic response is not achieved. • Maintenance: Xeljanz 5 mg twice daily (qty 60/30days) or Xeljanz XR 11 mg once daily (qty 30/30days). For patients with loss of response during maintenance treatment, Xeljanz 10 mg twice daily or Xeljanz XR 22 mg once daily (qty 30/30days) may be considered and limited to the shortest duration, with careful consideration of the benefits and risks for the individual patient. Use the lowest effective dose needed to maintain response.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

DIAGNOSIS: (Check one of the diagnoses below to ensure authorization will not be delayed.)

❑ Rheumatoid Arthritis – Moderate to Severe

❑ Trial and failure of, contraindication, or adverse reaction to methotrexate

AND

❑ Trial and failure of at least **ONE (1) other DMARD** therapy **(check each tried)**:

❑ auranofin	❑ azathioprine
❑ hydroxychloroquine	❑ leflunomide
❑ sulfasalazine	❑ Other: _____

AND

❑ Patient has tried and failed **TWO (2)** of the following biologics:

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ Psoriatic Arthritis

❑ Trial and failure of methotrexate

OR

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- ❑ Requested medication will be used in conjunction with methotrexate

OR

- ❑ Member has a contraindication to methotrexate (e.g., alcohol abuse, cirrhosis, chronic liver disease, or other contraindication)

AND

- ❑ Trial and failure of at least **ONE (1) other DMARD** therapy **(check each tried)**:

❑ auranofin	❑ azathioprine
❑ hydroxychloroquine	❑ leflunomide
❑ sulfasalazine	❑ Other: _____

AND

- ❑ Patient has tried and failed **TWO (2)** of the following biologics:

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ Polyarticular Course Juvenile Idiopathic Arthritis

- ❑ Member is 2 years of age or older

AND

- ❑ Member has a diagnosis of Juvenile Idiopathic Arthritis

AND

- ❑ Patient has tried and failed **TWO (2)** of the following biologics

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ Moderate-to-Severe Active Ulcerative Colitis

- ❑ Trial and failure of a complaint regimen of oral or rectal aminosalicylates (i.e., sulfasalazine or mesalamine) for **TWO (2)** consecutive months

AND

- ❑ Trial and failure of a compliant regimen of oral corticosteroids (budesonide 9mg daily for 8 weeks) or high dose steroids (40-60mg prednisone) unless contraindicated, or intravenous corticosteroids (for severe and fulminant UC or failure to respond to oral corticosteroids)

AND

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- ❑ Trial and failure of a compliant regimen of azathioprine or mercaptopurine for **three (3)** consecutive months

AND

- ❑ Member has trial and failure of Humira® **AND** Infliximab

❑ Ankylosing Spondylitis

- ❑ Member has a diagnosis of active ankylosing spondylitis

AND

- ❑ Prescribed by or in consultation with a Rheumatologist

AND

- ❑ Trial and failure of, contraindication, or adverse reaction to methotrexate

AND

- ❑ Patient has tried and failed **TWO (2)** of the following biologics

❑ Humira®	❑ Enbrel®	❑ Infliximab

Medication being provided by a Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*