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:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

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

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

Weight (if applicable): _____ **Date weight obtained:** _____

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 • Pediatrics: Xeljanz 5 mg BID (60 tabs/30 days) or Xeljanz Oral Solution 5 mg BID or weight-based equivalent twice daily (300 mL/30 days)

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Indication:	Dosage:
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
Ulcerative Colitis	• Induction: Xeljanz 10 mg twice daily (60 tabs/30 days) or Xeljanz XR 22 (30 tabs/30 days) 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 (60 tabs/30 days) or Xeljanz XR 22 mg (30 tabs/30 days) once daily for a maximum of 16 weeks. Discontinue Xeljanz 10 mg twice daily or Xeljanz XR 22 mg once daily (30 tabs/30 days) after 16 weeks if adequate therapeutic response is not achieved. • Maintenance: Xeljanz 5 mg twice daily (60 tabs/30 days) or Xeljanz XR 11 mg once daily (30 tabs/30 days). For patients with loss of response during maintenance treatment, Xeljanz 10 mg twice daily or Xeljanz XR 22 mg once daily (30 tabs/30 days) 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
Active Ankylosing Spondylitis	• Xeljanz 5mg twice daily (60 tabs/30 days) or Xeljanz XR 11mg once daily (30 tabs/30 days) • Patients with moderate and severe renal impairment or moderate hepatic impairment Xeljanz 5mg once daily (30 tabs/30 days)

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**

- ❑ Member is 18 years of age or older
- ❑ Trial and failure of, contraindication, or adverse reaction to methotrexate

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

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

- ❑ Patient has tried and failed **BOTH** of the preferred drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Enbrel®

❑ Psoriatic Arthritis

- ❑ Member is 2 years of age or older
- ❑ Trial and failure of, contraindication, or adverse reaction to methotrexate
- ❑ Trial and failure of at least **ONE (1) other DMARD** therapy **(check each tried)**:

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

- ❑ Patient has tried and failed **TWO (2)** of the preferred drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Enbrel®	❑ Pyzchiva® syringe/vial (Requires trial and failure of a preferred TNF-alpha inhibitor)

❑ Polyarticular Course Juvenile Idiopathic Arthritis

- ❑ Member is 2 years of age or older
- ❑ Member has a diagnosis of Polyarticular Course Juvenile Idiopathic Arthritis (pcJIA)
- ❑ Trial and failure of, contraindication, or adverse reaction to methotrexate
- ❑ Trial and failure of at least **ONE (1) other DMARD** therapy **(check each tried)**:

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

- ❑ Patient has tried and failed **BOTH** of the preferred drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Enbrel®

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❑ Moderate-to-Severe Active Ulcerative Colitis

- ❑ Member is 18 years of age or older
- ❑ Member has a diagnosis of active ulcerative colitis
- ❑ Member has trial and failure of **BOTH** of the preferred drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Pyzchiva® syringe/vial (Requires trial and failure of a preferred TNF-alpha inhibitor)

❑ Ankylosing Spondylitis

- ❑ Member is 18 years of age or older
- ❑ Member has a diagnosis of active ankylosing spondylitis
- ❑ Trial and failure of **BOTH** of the preferred drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Enbrel®

Medication being provided by 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.

***REVISED/UPDATED/REFORMATTED:** ~~6/30/2017; 9/1/2017; 9/1/2018; 12/9/2018; 3/13/2019; 4/16/2019; 9/7/2019; 6/18/2020; 7/19/2021; 8/10/2021; 1/5/2022; 1/12/2022; 7/11/2022; 6/26/2023 11/10/2023; 3/25/2025, 10/17/2025;~~ **12/16/2025**