SENTARA HEALTH PLANS

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: select one drug below

❑ **Xeljanz®** (tofacitinib) **Tablets**	❑ **Xeljanz®** (tofacitinib) **Solution**	❑ **Xeljanz® XR®** (tofacitinib extended release) **Tablets**

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:** _____

NOTE: The Health Plan considers the use of concomitant therapy with more than one biologic immunomodulator (e.g., Dupixent, Entyvio, Humira, Rinvoq, Stelara) prescribed for the same or different indications to be experimental and investigational. Safety and efficacy of these combinations has **NOT** been established and will **NOT** be permitted.

❑ Will the member be discontinuing a previously prescribed biologic if approved for requested medication?

❑ Yes **OR** ❑ No

❑ If yes, please list the medication that will be discontinued and the medication that will be initiated upon approval along with the corresponding effective date.

Medication to be discontinued: _____ **Effective date:** _____

Medication to be initiated: _____ **Effective date:** _____

(Continued on next page)

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. **Check the diagnosis below that applies**.

❑ Diagnosis: Moderate-to-Severe Rheumatoid Arthritis

- ❑ Member has a diagnosis of moderate-to-severe **rheumatoid arthritis**
- ❑ Prescribed by or in consultation with a **Rheumatologist**
- ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**:
  - ❑ hydroxychloroquine
  - ❑ leflunomide
  - ❑ methotrexate
  - ❑ sulfasalazine
- ❑ Member meets **ONE** of the following:
  - ❑ Member tried and failed, has a contraindication, or intolerance to **ONE** of the following:
    - ❑ **ONE** preferred adalimumab product
    - ❑ Enbrel®
    - ❑ Other Tumor Necrosis Factor (TNF) blocker medication approved for treatment of Moderate-to-Severe Rheumatoid Arthritis: _____
  - ❑ Member has been established on Xeljanz/XR® for at least 90 days **AND** prescription claims history indicates **at least a 90-day supply of Xeljanz/XR was dispensed within the past 130 days (verified by chart notes or pharmacy paid claims)**
- ❑ Member is **NOT** receiving Xeljanz® in combination with other JAK inhibitors, biologic immunomodulators, or with other immunosuppressants

❑ Diagnosis: Active Psoriatic Arthritis

- ❑ Member has a diagnosis of active **psoriatic arthritis**
- ❑ Prescribed by or in consultation with a **Rheumatologist or Dermatologist**
- ❑ Member is ≥ 2 years of age
- ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**:
  - ❑ cyclosporine
  - ❑ leflunomide
  - ❑ methotrexate
  - ❑ sulfasalazine

(Continued on next page)

- ❑ Member meets **ONE** of the following:
  - ❑ Member tried and failed, has a contraindication, or intolerance to **ONE** of the following:
    - ❑ **ONE** preferred adalimumab product
    - ❑ Enbrel®
    - ❑ Other Tumor Necrosis Factor (TNF) blocker medication approved for treatment of Active Psoriatic Arthritis: _____
  - ❑ Member has been established on Xeljanz/XR®/solution for at least 90 days **AND** prescription claims history indicates **at least a 90-day supply of Xeljanz/XR was dispensed within the past 130 days (verified by chart notes or pharmacy paid claims)**
- ❑ Member is **NOT** receiving Xeljanz® in combination with other JAK inhibitors, biologic immunomodulators, or with other immunosuppressants

❑ Diagnosis: Moderate-to-Severe Ulcerative Colitis (UC)

- ❑ Member has a diagnosis of moderate-to-severe **Ulcerative Colitis**
- ❑ Prescribed by or in consultation with a Gastroenterologist
- ❑ Member meets **ONE** of the following unless member has a contraindication or intolerance:
  - ❑ Member has tried and failed corticosteroids
  - ❑ Member has tried and failed at least **ONE** of the following **DMARD**:
    - ❑ 5-aminosalicylates (balsalazide, olsalazine, sulfasalazine)
    - ❑ oral mesalamine (Apriso, Asacol/HD, Delzicol, Lialda, Pentasa)
    - ❑ Other immunosuppressant drug: _____
  - ❑ Member has previously tried and failed another biologic medication other than the requested medication (e.g., adalimumab, Tremfya, ustekinumab)
- ❑ Member meets **ONE** of the following:
  - ❑ Member tried and failed, has a contraindication, or intolerance to **ONE** of the following:
    - ❑ **ONE** preferred adalimumab product
    - ❑ Other Tumor Necrosis Factor (TNF) blocker medication approved for treatment of Moderate-to-Severe Ulcerative Colitis (UC): _____
  - ❑ Member has been established on Xeljanz/XR® for at least 90 days **AND** prescription claims history indicates **at least a 90-day supply of Xeljanz/XR was dispensed within the past 130 days (verified by chart notes or pharmacy paid claims)**
- ❑ Member is **NOT** receiving Xeljanz® in combination with other JAK inhibitors, biologic immunomodulators, or with other immunosuppressants

(Continued on next page)

❑ Diagnosis: Active Polyarticular Course Juvenile Idiopathic Arthritis

Dosing: Children ≥ 2 years weighing ≥10 kg and Adolescents:
- 10 to < 20 kg: Oral solution (1 mg/mL): 3.2 mg twice daily
- 20 to < 40 kg: Oral solution (1 mg/mL): 4 mg twice daily
- ≥ 40 kg: Oral solution (1 mg/mL) or immediate-release tablet: 5 mg twice daily

- ❑ Member has a diagnosis of active polyarticular course **juvenile idiopathic arthritis**
- ❑ Prescribed by or in consultation with a **Rheumatologist**
- ❑ Member is ≥ 2 years of age
- ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**:
  - ❑ cyclosporine
  - ❑ hydroxychloroquine
  - ❑ leflunomide
  - ❑ methotrexate
  - ❑ sulfasalazine
- ❑ Member meets **ONE** of the following:
  - ❑ Member tried and failed, has a contraindication, or intolerance to **ONE** of the following:
    - ❑ **ONE** preferred adalimumab product
    - ❑ Enbrel®
    - ❑ Other Tumor Necrosis Factor (TNF) blocker medication approved for treatment of Active Polyarticular Course Juvenile Idiopathic Arthritis: _____
  - ❑ Member has been established on Xeljanz® IR/solution for at least 90 days **AND** prescription claims history indicates **at least a 90-day supply of Xeljanz IR/solution was dispensed within the past 130 days (verified by chart notes or pharmacy paid claims)**
- ❑ Member is **NOT** receiving Xeljanz® in combination with other JAK inhibitors, biologic immunomodulators, or with other immunosuppressants

❑ Diagnosis: Active Ankylosing Spondylitis

- ❑ Member has a diagnosis of active **ankylosing spondylitis**
- ❑ Prescribed by or in consultation with a **Rheumatologist**
- ❑ Member tried and failed, has a contraindication, or intolerance to **ONE** NSAIDs

(Continued on next page)

- ❑ Member meets **ONE** of the following:
  - ❑ Member tried and failed, has a contraindication, or intolerance to **ONE** of the following:
    - ❑ **ONE** preferred adalimumab product
    - ❑ Enbrel®
    - ❑ Other Tumor Necrosis Factor (TNF) blocker medication approved for treatment of Active Ankylosing Spondylitis: _____
  - ❑ Member has been established on Xeljanz/XR® for at least 90 days **AND** prescription claims history indicates **at least a 90-day supply of Xeljanz/XR was dispensed within the past 130 days (verified by chart notes or pharmacy paid claims)**
- ❑ Member is **NOT** receiving Xeljanz® in combination with other JAK inhibitors, biologic immunomodulators, or with other immunosuppressants

Medication being provided by a Specialty Pharmacy – Proprium Rx

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.*

***Approved by Pharmacy and Therapeutics Committee**: ~~4/17/2013; 7/19/2018; 8/17/2023; 7/26/2024; 11/21/2024; 11/20/2025;~~ **1/22/2026**
REVISED/UPDATED/REFORMATTED: ~~3/30/2016; 8/11/2016; 9/22/2016; 12/21/2016; 8/5/2017; 12/28/2017; 2/19/2018; 11/23/2018; 9/7/2019; 11/14/2019; 6/30/2020; 8/31/2020; 12/7/2020; 3/3/2022; 4/25/2022; 6/16/2022; 12/23/2022;5/26/2023; 8/13/2023; 3/27/2024; 8/23/2024; 12/23/2024; 7/7/2025, 12/08/2025;~~ **3/5/2026**