Updated: 08/2018
PARP Approved: 08/2018

Prior Authorization Criteria

Xeljanz™/ Xeljanz™XR (Generic)

All requests for Brand Name (generic medication) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Drug Name Prior Authorization Criteria:
For all requests for Brand Name (generic medication) all of the following criteria must be met:

For all requests for Xeljanz™/Xeljanz™ (tofacitinib) all of the following criteria must be met:

1) Member is an adult age of 18 years or older
2) Medication must be prescribed by or in association with a rheumatologist, gastroenterologist, or dermatologist.
3) Member must have lymphocyte count greater than or equal to 500 cells per cubic mm, ANC greater than or equal to 1000 cells per cubic mm, and hemoglobin level greater than or equal to 9g/dL.
4) The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines

Coverage may be provided with a diagnosis of **Moderately to Severely Active Rheumatoid Arthritis** and the following criteria is met:

- Member must have a history of trial and failure, contraindication, or intolerance to ALL of the following:
    - Three-month of trial with methotrexate.
- **Initial Duration of Approval:** 3 months
- **Reauthorization criteria**
    - Reauthorization benefit will be approved if there is documented, significant improvement with prior courses of treatment.
    - Member must have lymphocyte count greater than or equal to 500 cells per cubic mm, ANC greater than or equal to 500 cells per cubic mm, and hemoglobin level greater than or equal to 9g/dL.
- **Reauthorization Duration of approval:** 12 months

Coverage may be provided with a diagnosis of **Active Psoriatic Arthritis** and the following criteria is met:

- Member has moderately to severely active psoriatic arthritis which must include documentation of either active psoriatic lesions or documented history of psoriasis.
- Member must have a history of trial and failure, contraindication, or intolerance to ALL of the following:
    - Member without axial disease:
        - Four- week trial each of at least 2 NSAIDs.
        - Eight-week trial of methotrexate or other DMARD

    - Member with axial disease:
        - Four- week trial each of at least 2 NSAIDs
    - Member with psoriatic arthritis with enthesitis:
        - Four-week trial each of at least 2 NSAIDs
- **Initial Duration of Approval:** 3 months
- **Reauthorization criteria**
    - Reauthorization benefit will be approved if there is documented, significant improvement with prior courses of treatment.
    - Member must have lymphocyte count greater than or equal to 500 cells per cubic mm, ANC greater than or equal to 500 cells per cubic mm, and hemoglobin level greater than or equal to 9g/dL.
    - **Reauthorization Duration of approval:** 12 months

Coverage may be provided with a diagnosis of **Ulcerative Colitis** and the following criteria is met:

- Member must have a history of trial and failure, contraindication, or intolerance to conventional treatments including ALL of the following for at least 3 months:
    - Aminosalicylates, 5-ASAs (*i.e.*, Sulfasalazine, Pentasa®, Asacol®, Colazal®)
    - Steroids (*i.e.*, prednisone, Entocort®)
    - Immunomodulators (*i.e.*, Azathioprine, 6-Mercaptopurine, Methotrexate)
- **Initial Duration of Approval:** 3 months
- **Reauthorization criteria**
    - Reauthorization benefit will be approved if there is documented, significant improvement with prior courses of treatment.
    - Member must have lymphocyte count greater than or equal to 500 cells per cubic mm, ANC greater than or equal to 500 cells per cubic mm, and hemoglobin level greater than or equal to 9g/dL.
    - **Reauthorization Duration of approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Updated: 08/2018
PARP Approved: 08/2018

Xeljanz™/Xeljanz™ XR (tofacitinib)
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway Health℠ Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Gateway ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

1. Will the medication be prescribed by or in association with a rheumatologist, gastroenterologist, or dermatologist?
   ☐ Yes ☐ No

2. Does the member have a lymphocyte count greater than or equal to 500 cells per cubic mm, ANC greater than or equal to 1000 cells per cubic mm, and hemoglobin level greater than or equal to 9g/dL?
   ☐ Yes ☐ No

3. Which of the following diagnoses will the medication be used for:
   a. Moderately to Severely Active Rheumatoid Arthritis, if yes please answer the following questions:
      ☐ Yes ☐ No

      i. Does the member have a history of trial and failure, contraindication, or intolerance to a three month trial with methotrexate?
         ☐ Yes ☐ No

   b. Active Psoriatic Arthritis, if yes please answer the following questions, if yes please answer the following questions:
      ☐ Yes ☐ No

      i. Does the member have moderately to severely active psoriatic arthritis which must include either active psoriatic lesions or documented history of psoriasis? Please provide documentation.
         ☐ Yes ☐ No

ii. Does the member have a history of trial and failure, contraindication, or intolerance to ANY of the following:

1. Member without axial disease:
   a. Four- week trial each of at least 2 NSAIDs.
      ☐ Yes ☐ No

   b. Eight-week trial of methotrexate or other DMARD
      ☐ Yes ☐ No

2. Member with axial disease:
   a. Four- week trial each of at least 2 NSAIDs
      ☐ Yes ☐ No

3. Member with psoriatic arthritis with enthesitis:
   a. Four-week trial each of at least 2 NSAIDs
      ☐ Yes ☐ No

b. Ulcerative Colitis
   a. Does the member have a history of trial and failure, contraindication, or intolerance to conventional treatments including ALL of the following for at least 3 months?
      ☐ Yes ☐ No

      i. Aminosalicylates, 5-ASAs (*i.e.,* Sulfasalazine, Pentasa®, Asacol®, Colazal®)
      ii. Steroids (*i.e.,* prednisone, Entocort®)
      iii. Immunomodulators (*i.e.,* Azathioprine, 6-Mercaptopurine, Methotrexate)

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member experienced a significant improvement with treatment? ☐ Yes ☐ No
Please describe:

Please provide the following lab values

Lymphocyte Count:

Hemoglobin:

ANC:

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date