iowa total care | Iowa Health Link Iowa HHS | Hawki Iowa HHS

Fax Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization
JANUS KINASE (JAK) INHIBITORS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization (PA) is required for Janus kinase (JAK) inhibitors. Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug, excluding requests for the FDA approved indication of alopecia areata or other excluded medical use(s), as defined in Section 1927(d)(2) of the Social Security Act, State Plan, and Rules when the following conditions are met:

1. **Patient is not using or planning to use a JAK inhibitor in combination with other JAK inhibitors, biological therapies, or potent immunosuppressants (azathioprine or cyclosporine); and**
2. **Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and**
3. **Patient has a diagnosis of:**
   - **a. Moderate to severe rheumatoid arthritis (baricitinib, tofacitinib, upadacitinib); with**
     - **i. A documented trial and inadequate response, at a maximally tolerated dose, with methotrexate; and**
     - **ii. A documented trial and inadequate response to one preferred TNF inhibitor; or**
   - **b. Psoriatic arthritis (tofacitinib, upadacitinib); with**
     - **i. A documented trial and inadequate response, at a maximally tolerated dose, with methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and**
     - **ii. Documented trial and therapy failure with one preferred TNF inhibitor used for psoriatic arthritis; or**
   - **c. Moderately to severely active ulcerative colitis (tofacitinib, upadacitinib); with**
     - **i. A documented trial and inadequate response with a preferred TNF inhibitor; and**
     - **ii. If requested dose for tofacitinib is 10mg twice daily, an initial 16 weeks of therapy will be allowed. Continued requests as this dose will need to document an adequate therapeutic benefit; or**
   - **d. Moderately to severely active Crohn's disease (upadacitinib); with**
     - **i. A documented trial and inadequate response with a preferred TNF inhibitor; or**
   - **e. Polyarticular Course Juvenile Idiopathic Arthritis (tofacitinib); with**
     - **i. A documented trial and inadequate response to the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and**
     - **ii. A documented trial and inadequate response with a preferred TNF inhibitor; or**
   - **f. Axial spondyloarthritis conditions (e.g., ankylosing spondylitis or nonradiographic axial spondyloarthritis) (tofacitinib, upadacitinib); with**
     - **i. A documented trial and inadequate response to at least two preferred non-steroidal anti-inflammatories (NSAIDS) at a maximally tolerated dose for a minimum of at least one month; and**
     - **ii. A documented trial and inadequate response with at least one preferred TNF inhibitor; or**
   - **g. Atopic dermatitis; with**
     - **i. Documentation patient has failed to respond to good skin care and regular use of emollients; and**
     - **ii. A documented adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; or**
     - **iii. A documented trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and**
     - **iv. For mild to moderate atopic dermatitis (ruxolitinib):**
       - **a. Affected area is less than 20% of body surface area (BSA); and**
       - **b. Patient has been instructed to use no more than 60 grams of topical ruxolitinib per week; or**
     - **v. For moderate to severe atopic dermatitis (abrocitinib, upadacitinib):**
       - **a. A documented trial and therapy failure with a systemic drug product for the treatment of moderate to severe atopic dermatitis, including biologics; and**
       - **b. Requests for upadacitinib for pediatric patients 12 to less than 18 years if age must include the patient's weight in kg; or**
   - **h. Nonsegmental vitiligo (ruxolitinib) with;**
     - **i. A documented trial and inadequate response with a potent topical corticosteroid; or**
     - **ii. A documented trial and inadequate response with a topical calcineurin inhibitor; and**
     - **iii. The patient's body surface area (BSA) is less than or equal to the affected BSA per FDA approved label, if applicable.**

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

iowa total care | Iowa Health Link Iowa HHS | Hawki Iowa HHS

Fax Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization
JANUS KINASE (JAK) INHIBITORS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Preferred **Non-Preferred**

☐ Rinvoq ☐ Opzelura ☐ Xeljanz ☐ Cibinqo ☐ Olumiant ☐ Xeljanz Oral Solution ☐ Xeljanz XR

Strength _____ **Dosage Instructions** _____ **Quantity** _____ **Days Supply** _____

Diagnosis: _____

Will the JAK inhibitor be used in combination with other JAK inhibitors, biological therapies or potent immunosuppressants? ☐ Yes ☐ No

☐ **Moderate to Severe Rheumatoid Arthritis (RA) (Olumiant, Rinvoq, Xeljanz or Xeljanz XR)**

Methotrexate trial: Dose:_____ Trial dates:_____
Failure reason:_____

Preferred TNF Inhibitor: Name/Dose:_____ Trial Dates:_____
Failure reason:_____

☐ **Psoriatic Arthritis (Rinvoq, Xeljanz or Xeljanz XR)**

Methotrexate trial (leflunomide or sulfasalazine if methotrexate is contraindicated):
Name/Dose: _____ Trial dates: _____
Failure reason: _____

Preferred TNF Inhibitor: Name/Dose: _____ Trial Dates: _____
Failure reason: _____

☐ **Ulcerative Colitis (Rinvoq, Xeljanz or Xeljanz XR)**

Preferred TNF Inhibitor: Name/Dose: _____ Trial Dates: _____
Failure reason: _____

If requesting continuation of tofacitinib 10mg twice daily dose, document adequate therapeutic benefit:
_____
_____

☐ **Moderately to severely active Crohn's disease (Rinvoq)**

Preferred TNF Inhibitor: Name/Dose: _____ Trial Dates: _____
Failure reason: _____

☐ **Polyarticular Course Juvenile Idiopathic Arthritis (Xeljanz)**

Methotrexate trial (leflunomide or sulfasalazine if methotrexate is contraindicated):
Name/Dose: _____ Trial dates: _____
Failure reason: _____

Preferred TNF Inhibitor: Name/Dose: _____ Trial Dates: _____
Failure reason: _____

☐ **Axial spondyloarthritis conditions (e.g., ankylosing spondylitis or nonradiographic axial spondyloarthritis) (Rinvoq, Xeljanz or Xeljanz XR)**

Preferred NSAID trial 1: Name/Dose: _____ Trial Dates: _____
Failure reason: _____

Fax Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization
JANUS KINASE (JAK) INHIBITORS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Preferred NSAID trial 2: Name/Dose: _____ Trial dates: _____

Failure reason: _____

Preferred TNF Inhibitor: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

☐ Atopic Dermatitis

Has patient failed to respond to good skin care and regular use of emollients? ☐ Yes ☐ No

Document emollient use: Product name, dosing instructions & duration of use: _____

_____

Document trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 weeks or topical immunomodulator for a minimum of 4 weeks:

Preferred Medium to High Potency Topical Corticosteroid Trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Preferred Topical Immunomodulator Trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Mild to Moderate Atopic Dermatitis (Opzelura)

Is affected area less than 20% of body surface area? ☐ Yes ☐ No

Has patient been instructed to use no more than 60gms of topical ruxolitinib per week? ☐ Yes ☐ No

Moderate to Severe Atopic Dermatitis (Cibinqo or Rinvoq)

Trial with systemic drug product for the treatment of moderate to severe atopic dermatitis, including biologics:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Requests for upadacitinib for pediatric patients 12 to less than 18 years of age include weight in kg:

☐ Nonsegmental vitiligo (Opzelura)

Potent Topical Corticosteroid Trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Topical Calcineurin Inhibitor Trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Provide patient's affected body surface area (BSA): _____

Other medical conditions to consider: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*