

## PRIOR AUTHORIZATION REQUEST FORM

### Xeljanz, Xeljanz XR, Xeljanz solution

For authorization, please answer each question and fax this form PLUS chart notes back to RealRx Medicaid Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call Pharmacy Customer Service for assistance.

- Healthy U: 855-856-5694
- Healthy U CHIP: 855-203-3633
- Health Choice Utah: 855-864-1404

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		
Product Requested: <input type="checkbox"/> Xeljanz (tofacitinib), <input type="checkbox"/> Xeljanz (tofacitinib) XR, <input type="checkbox"/> Xeljanz (tofacitinib) solution		
Directions for Use: _____		

<b>PART I: Criteria for Approval: (All of the following criteria must be met) - Then move to PART II</b>	Yes	No
1. Does the patient have any of the following diagnoses:? (check the applicable) <input type="checkbox"/> Ankylosing Spondylitis (AS) <input type="checkbox"/> Polyarticular Course Juvenile Idiopathic Arthritis (pJIA) <input type="checkbox"/> Psoriatic Arthritis (PsA) <input type="checkbox"/> Rheumatoid Arthritis (RA) <input type="checkbox"/> Ulcerative Colitis (UC) <input type="checkbox"/> Other - Off Label or Compendia Use (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the medication being prescribed by or in consultation with a provider specializing in the disease treatment?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the provider attest that the patient is not taking concurrent treatment or that the medication will not be used in combination with other TNF-inhibitor, biologic response modifier or other biologic DMARDs, Janus kinase Inhibitors, or Phosphodiesterase 4 inhibitor (i.e., apremilast, tofacitinib, baricitinib) as verified by prescriber attestation, patient medication fill history, or submitted documentation?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the requested medication and diagnosis follow FDA-approved age, dosing, monitoring and contraindications? <b>If answer is No, go to Part II, section 6</b>	<input type="checkbox"/>	<input type="checkbox"/>
5. Has the patient tried and failed for at least 3 months (2 months for Ulcerative Colitis), demonstrated an intolerance to, or has a contraindication to the preferred TNF, if applicable?	<input type="checkbox"/>	<input type="checkbox"/>
<b>PART II: Select and fill out applicable sections:</b>		
<b>Section 1: Additional criteria for Ankylosing Spondylitis (AS) (All of the following criteria must be met)</b>		
1. Is the patient at least 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the patient have a diagnosis of Ankylosing Spondylitis demonstrated by description of baseline symptoms present in the chart notes?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the patient tried and failed, demonstrated an intolerance to, or has a contraindication to at least <b>TWO</b> different prescription strength nonsteroidal anti-inflammatory drugs (NSAID) at the maximally tolerated dose for at least 1 month each?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Section 2: Additional criteria for Polyarticular Juvenile Idiopathic Arthritis (JIA) (All of the following criteria must be met)</b>		
1. Is the patient at least 2 years of age or older and weighs 10 kg or more?	<input type="checkbox"/>	<input type="checkbox"/>

2. Does the patient have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis demonstrated by description of baseline symptoms present in the chart notes?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the patient tried and failed, demonstrated an intolerance to, or has a contraindication to <b>ONE</b> NSAID or glucocorticoid for 3 months?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the patient tried and failed, demonstrated an intolerance to, or has a contraindication to methotrexate or leflunomide for 3 months, if clinically appropriate?	<input type="checkbox"/>	<input type="checkbox"/>
5. If the request is for Xeljanz solution, does the patient weigh less than 40kg or has other clinical rationale requiring liquid formulation? <b>If answer is Yes, go to Part III</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Section 3: Additional criteria for Psoriatic Arthritis (PsA) (All of the following criteria must be met)</b>		
1. Is the patient at least 2 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the patient have a diagnosis of active psoriatic arthritis demonstrated by description of baseline symptoms present in the chart notes?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the patient had an adequate trial and failure of at least <b>ONE</b> of the following disease-modifying antirheumatic drugs (DMARDs) for at least 3 months, unless all are contraindicated: methotrexate, leflunomide, sulfasalazine, azathioprine, if clinically appropriate?	<input type="checkbox"/>	<input type="checkbox"/>
4. If the request is for Xeljanz solution, does the patient weigh less than 40kg or has other clinical rationale requiring liquid formulation? <b>If answer is Yes, go to Part III</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Section 4: Additional criteria for Rheumatoid Arthritis (RA) (All of the following criteria must be met)</b>		
1. Is the patient at least 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the patient have a diagnosis of moderately to severely active rheumatoid arthritis demonstrated by description of baseline symptoms present in the chart notes?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the patient had an adequate trial and failure of at least <b>ONE</b> disease modifying antirheumatic drug (DMARD) for at least 3 months (e.g. hydroxychloroquine, leflunomide, methotrexate, sulfasalazine) or contraindication to all, if clinically appropriate?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Section 5: Additional criteria for Ulcerative Colitis (UC) (All of the following criteria must be met)</b>		
1. Is the patient at least 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the patient have a diagnosis of moderate to severe Ulcerative Colitis as confirmed by applicable testing such as diagnostic imaging, inflammatory biomarker, or disease activity scale and supported by description of baseline symptoms/labs present in the chart notes?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the member had an adequate trial and failure of at least <b>ONE</b> of the following for at least 2 months, or has a contraindication to all? <input type="checkbox"/> High dose oral 5-aminosalicylic acid drug <input type="checkbox"/> Topical 5-aminosalicylic acid drug	<input type="checkbox"/>	<input type="checkbox"/>
<b>Section 6: Other - Off Label or Compendia Use of FDA-Approved Drugs Additional Criterion:</b>		
1. Does the clinical documentation show an adequate trial and failure with at least <b>ONE</b> FDA-labeled and Medicaid preferred medication, if applicable?	<input type="checkbox"/>	<input type="checkbox"/>
2. Provider attest the requested drug is being used for a medically accepted indication that is supported by information from the appropriate compendia* of current literature. Including at least (1) major multi-site study or three (3) smaller studies published in JAMA, NEJM, Lancet, or other peer review specialty medical journals in the most recent years? * Compendia use must be recommended by generally accepted compendia such as American Hospital Formulary Service Drug Information (AHFS), United States Pharmacopeia-Drug Information (USP-DI), the Micromedex Information System, Pediatric and Neonatal Lexi-Drugs, or clinical guidelines.	<input type="checkbox"/>	<input type="checkbox"/>
<b>PART III: For Xeljanz Solution (PART 1 &amp; PART II MUST also need to be met)</b>		
1. For requests of Xeljanz solution, has the patient tried and failed an oral tablet or is there clinical rationale for using the solution?  Rationale: _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Reauthorization</b>		
1. Has the provider submitted updated chart notes demonstrating positive clinical response?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Prescriber Certification</b>		
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.		
Physician's Signature:	Date:	

**Initial Authorization:** Up to six (6) months

**Reauthorization:** Up to one (1) year

**\*\* Failure to submit clinical documentation to support this request will result in a dismissal of the request.\*\***

Note:

- **WARNING: SERIOUS INFECTIONS AND MALIGNANCY**
  - **SERIOUS INFECTIONS**
    - Patients treated with XELJANZ/XELJANZ XR/XELJANZ Oral Solution are at increased risk for developing serious infections that may lead to hospitalization or death. Most patients who developed these infections were taking concomitant immunosuppressants such as methotrexate or corticosteroids.
    - If a serious infection develops, interrupt XELJANZ/XELJANZ XR/XELJANZ Oral Solution until the infection is controlled.
  - **MORTALITY**
    - In a large, randomized, postmarketing safety study in rheumatoid arthritis (RA) patients 50 years of age and older with at least one cardiovascular risk factor comparing XELJANZ 5 mg twice a day or XELJANZ 10 mg twice a day to tumor necrosis factor (TNF) blockers, a higher rate of all-cause mortality, including sudden cardiovascular death, was observed with XELJANZ 5 mg twice a day or XELJANZ 10 mg twice a day. A XELJANZ/XELJANZ Oral Solution 10 mg twice daily (or a XELJANZ XR 22 mg once daily) dosage is not recommended for the treatment of RA or PsA.
  - **MALIGNANCY**
    - Malignancies, including lymphomas and solid tumors, have occurred in patients treated with XELJANZ and other Janus kinase inhibitors used to treat inflammatory conditions. In RA patients, a higher rate of malignancies (excluding NMSC) was observed in patients treated with XELJANZ 5 mg twice a day or XELJANZ 10 mg twice a day compared with TNF blockers.
    - Lymphomas and lung cancers were observed at a higher rate in patients treated with XELJANZ 5 mg twice a day or XELJANZ 10 mg twice a day in RA patients compared to those treated with TNF blockers. Patients who are current or past smokers are at additional increased risk.
    - Epstein Barr Virus-associated post-transplant lymphoproliferative disorder has been observed at an increased rate in renal transplant patients treated with XELJANZ and concomitant immunosuppressive medications
  - **MAJOR ADVERSE CARDIOVASCULAR EVENTS**
    - RA patients 50 years of age and older with at least one cardiovascular risk factor, treated with XELJANZ 5 mg twice daily or XELJANZ 10 mg twice daily, had a higher rate of major adverse cardiovascular events (MACE) (defined as cardiovascular death, myocardial infarction, and stroke), compared to those treated with TNF blockers. Patients who are current or past smokers are at additional increased risk. Discontinue XELJANZ/XELJANZ XR/XELJANZ Oral Solution in patients that have experienced a myocardial infarction or stroke
  - **THROMBOSIS**
    - Thrombosis, including pulmonary embolism, deep venous thrombosis, and arterial thrombosis have occurred in patients treated with XELJANZ and other Janus kinase inhibitors used to treat inflammatory conditions. Many of these events were serious and some resulted in death. RA patients 50 years of age and older with at least one cardiovascular risk factor treated with XELJANZ 5 mg twice daily or XELJANZ 10 mg twice daily compared to TNF blockers had an observed increase in incidence of these events. Avoid XELJANZ/XELJANZ XR/XELJANZ Oral Solution in patients at risk. Discontinue XELJANZ/XELJANZ XR/XELJANZ Oral Solution and promptly evaluate patients with symptoms of thrombosis

Policy: PHARM-HYB-192

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Reviewed/Revised Date:

Next Review Date:

Current Effective Date: 01/01/2026

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