IOWA Health and Human Services

Request for Prior Authorization
JANUS KINASE (JAK) INHIBITORS

FAX Completed Form To
1 (800) 574-2515
Provider Help Desk
1 (877) 776-1567

(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; or**
      ii. **If TNF inhibitors are clinically inadvisable, documentation of at least one approved systemic therapy; or**
   d. **Moderately to severely active Crohn's disease (upadacitinib); with**
      i. **A documented trial and inadequate response with a preferred TNF inhibitor; or**
      ii. **If TNF inhibitors are clinically inadvisable, documentation of at least one approved systemic therapy; 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 (topical treatments):**
         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 chronic hand eczema (topical treatments):**
         a. **Chronic hand eczema has persisted for more than 3 months or recurred two or more times within a 12-month time frame after the initial occurrence with complete clearances between relapses; and**

b. Patient has been instructed to use no more than 30 grams per 2 weeks or 60 grams per month of topical delgocitinib; or

vi. For moderate to severe atopic dermatitis (oral treatments):

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; or

i. Giant Cell Arteritis; with

i. Documentation patient is currently taking a glucocorticoid, with a tapering dose, or has discontinued use of glucocorticoids.

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

Preferred

☐ Opzelura ☐ Xeljanz

☐ Rinvoq

Non-Preferred

☐ Anzupgo ☐ Olumiant ☐ Xeljanz XR

☐ Cibinqo ☐ Xeljanz Oral Solution

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: ____

Approved Systemic Therapy if TNF Inhibitor is clinically inadvisable:

Drug Name/Dose: ________________________ Trial Dates: ____________________

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

____

____

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

Preferred TNF Inhibitor: Name/Dose: ______________________ Trial Dates: ____________
Failure reason: ____

Approved Systemic Therapy if TNF Inhibitor is clinically inadvisable:

Drug 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: ____

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 (Topical Treatments)

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 Chronic Hand Eczema (Topical Treatments)

Has hand eczema persisted for more than 3 months or recurred two or more times within a 12-month timeframe after the initial occurrence with complete clearance between relapses? ☐ Yes ☐ No

Has patient been instructed to use no more than 30gms per 2 weeks or 60gms per month of topical delgocitinib?
☐ Yes ☐ No

Moderate to Severe Atopic Dermatitis (Oral Treatments)

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): ______________________

☐ **Giant Cell Arteritis**

Is patient currently taking a glucocorticoid?

☐ Yes; Is dose being tapered? ☐ Yes ☐ No

☐ No

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.*