PRIOR AUTHORIZATION REQUEST

TOFACITINIB PRODUCTS

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is this request for initial therapy or for a continuation of therapy? [] Initial (If checked, go to 8) [] Continuation (If checked, go to 2)		
2	Will the requested medication be given in combination with a biologic or in combination with a targeted synthetic disease-modifying antirheumatic drug	Yes	No

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	(DMARD) or with another potent immunosuppressant (for example, azathioprine, tacrolimus, cyclosporine, mycophenolate mofetil)? [Note: Biologic DMARDs include Actemra (IV or SC), Kevzara, Cosentyx, Kineret, Orencia (IV or SC), a rituximab product (for example, Rituxan, Truxima), Cimzia, Enbrel, Humira, an infliximab product (for example, Remicade, Inflectra, Renflexis), Simponi (Aria or SC), Ilumya, Siliq, Stelara (IV or SC), or Taltz and targeted synthetic DMARDs include Xeljanz/XR, Olumiant, Rinvoq, or Otezla.] [If yes, no further questions.]		
3	Is the patient currently receiving the requested medication? [If no, skip to question 8.]	Yes	No
4	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 8.]	Yes	No
5	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 8.]	Yes	No
6	Has the patient been established on therapy for at least 3 months? [If no, skip to question 8.]	Yes	No
7	Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
8	Will the requested medication be given in combination with a biologic or in combination with a targeted synthetic disease-modifying antirheumatic drug (DMARD) or with another potent immunosuppressant (for example, azathioprine, tacrolimus, cyclosporine, mycophenolate mofetil)? [Note: Biologic DMARDs include Actemra (IV or SC), Kevzara, Cosentyx, Kineret, Orencia (IV or SC), a rituximab product (for example, Rituxan, Truxima), Cimzia, Enbrel, Humira, an infliximab product (for example, Remicade, Inflectra, Renflexis), Simponi (Aria or SC), Ilumya, Siliq, Stelara (IV or SC), or Taltz and targeted synthetic DMARDs include Xeljanz/XR, Olumiant, Rinvoq, or Otezla.] [If yes, no further questions.]	Yes	No
9	Is the request for generic Xeljanz? [Note: Tofacitinib product (IR/XR tablets, oral solution).] [If yes, skip to question 11.]	Yes	No
10	Does the patient have documented intolerance or failed treatment for at least 3 months with generic Xeljanz? [Note: Tofacitinib product (IR/XR tablets, oral solution).]	Yes	No

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[If no, no further questions.]

11 What is the indication or diagnosis?

[] Rheumatoid arthritis (RA) (If checked, go to 12)

[] Psoriatic arthritis (PsA) (If checked, go to 18)

[] Ulcerative colitis (UC) (If checked, go to 24)

[] Juvenile idiopathic arthritis (JIA) (regardless of type of onset) [Note: This includes patients with juvenile spondyloarthropathy/active sacroiliac arthritis.] (If checked, go to 30)

[] Ankylosing Spondylitis (AS) (If checked, go to 37)

[] Coronavirus Disease 2019 (COVID-19) [Note: This includes requests for cytokine release syndrome associated with COVID-19.] (If checked, no further questions)

[] Other (If checked, no further questions)

12	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
13	Has the patient tried at least TWO traditional systemic agents for at least 3 months? [If yes, skip to question 15.]	Yes	No
14	Has documentation been submitted to confirm that the patient has a documented intolerance to at least TWO traditional systemic agents? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
15	Has documentation been submitted to confirm that the patient has had a treatment failure with the preferred Tumor necrosis factor (TNF) inhibitor, an adalimumab product (Hadlima, Yusimry, or adalimumab-adbm), for at least 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
16	Is the requested medication being prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
17	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Dosing: IR - 5 mg twice daily, XR - 11 mg once daily.] [No further questions.]	Yes	No
18	Is the patient 2 years of age or older?	Yes	No

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	[If no, no further questions.]		
19	Has the patient tried at least TWO traditional systemic agents for at least 3 months? [If yes, skip to question 21.]	Yes	No
20	Has documentation been submitted to confirm that the patient has a documented intolerance to at least TWO traditional systemic agents? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
21	Has documentation been submitted to confirm that the patient has had a treatment failure with the preferred Tumor necrosis factor (TNF) inhibitor, an adalimumab product (Hadlima, Yusimry, or adalimumab-adbm), for at least 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
22	Is the requested medication being prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
23	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Dosing: IR - 5 mg twice daily, XR - 11 mg once daily.] [No further questions.]	Yes	No
24	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
25	Has the patient tried at least TWO traditional systemic agents for at least 3 months? [If yes, skip to question 27.]	Yes	No
26	Has documentation been submitted to confirm that the patient has a documented intolerance to at least TWO traditional systemic agents? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
27	Has documentation been submitted to confirm that the patient has had a treatment failure with a preferred Tumor necrosis factor (TNF) inhibitor, an adalimumab product (Hadlima, Yusimry, or adalimumab-adbm), for at least 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
28	Is the requested medication being prescribed by or in consultation with a rheumatologist or a gastroenterologist?	Yes	No

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	[If no, no further questions.]		
29	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Dosing: Induction - 10 mg IR twice daily or 22 mg XR once daily for 8 weeks. Maintenance - 5 mg twice daily, XR - 11 mg once daily.] [No further questions.]	Yes	No
30	Is the patient 2 years of age or older? [If no, no further questions.]	Yes	No
31	Has the patient tried at least TWO systemic agents for this condition for at least 3 months? [If yes, skip to question 33.]	Yes	No
32	Has documentation been submitted to confirm that the patient has an intolerance to at least TWO systemic agents for this condition? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
33	Does the patient have aggressive disease, as determined by the prescriber? [If no, no further questions.]	Yes	No
34	Has documentation been submitted to confirm that the patient has had a treatment failure with the preferred Tumor necrosis factor (TNF) inhibitor, an adalimumab product (Hadlima, Yusimry, or adalimumab-adbm), for at least 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
35	Is the requested medication being prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
36	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Dosing: 5 mg twice daily.] [No further questions.]	Yes	No
37	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
38	Has documentation been submitted to confirm that the patient has had a treatment failure with the preferred Tumor necrosis factor (TNF) inhibitor, an adalimumab product (Hadlima, Yusimry, or adalimumab-adbm), for at least 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No

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39	Is the requested medication being prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
40	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Dosing: IR - 5 mg twice daily, XR - 11 mg once daily.]	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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If you have any questions, call: 1-888-258-8250