Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health
P.O. Box 5119, Helena, MT 59604
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Fax 406.513.1928 . Toll-Free 1.800.294.1350

Montana Healthcare Programs Prior Authorization Request Form
for Use of Xeljanz®/Xeljanz® XR (tofacitinib)

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	
Prescriber Name/Specialty if applicable:	Prescriber Fax:	
Dosage Requested:		

Please complete below information for applicable situation, Initiation or Continuation of therapy:

☐ **INITIATION OF THERAPY**

Please check appropriate diagnosis and complete corresponding information:

1. **Rheumatoid Arthritis, Psoriatic Arthritis, Ulcerative Colitis, and Ankylosing Spondylitis**
   a. Member has a diagnosis of:
      ☐ Moderately to severely active rheumatoid arthritis
      ☐ Active psoriatic arthritis
      ☐ Moderately to severely active ulcerative colitis
      ☐ Active ankylosing spondylitis
   b. Member is 18 years of age or older: ☐ Yes ☐ No
   c. Medication is prescribed by or in consultation with: ☐ Gastroenterologist ☐ Rheumatologist
      Action Required: If not in a specialty clinic or written by a specialist, copy of annual specialty consult with an appropriate specialist is required (please attach copy of consult):
      Name of Specialist: _____ Contact Date: _____
   d. Member has trialed and had an inadequate response, or contraindication to a preferred TNF with the same indication from the Montana Healthcare Programs Preferred Drug List: ☐ Yes ☐ No
      Drug Name: _____ Dates: _____
   e. Provider attests that they have reviewed the black box warning: ☐ Yes ☐ No
   f. Provider attests that member will not use Xeljanz®/Xeljanz® XR concomitantly with other biologics: ☐ Yes ☐ No

Limitations:

- **Rheumatoid Arthritis, Psoriatic Arthritis, and Ankylosing Spondylitis**: Maximum daily dose is 5mg twice daily OR 11mg once daily if requesting XR.
- **Ulcerative Colitis**: Maximum daily dose is 10mg twice daily for up to 16 weeks (induction dose) then 5mg twice daily for maintenance. For XR formulation, 22mg once daily for up to 16 weeks (induction dose) then 11mg once daily for maintenance.
  - If member loses response: 10mg twice daily or XR 22mg once daily may be considered for the shortest duration possible.

Initial authorization will be issued for 1 year

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2. **Polyarticular Course Juvenile Idiopathic Arthritis**

a. Member has a diagnosis of Polyarticular Course Juvenile Idiopathic Arthritis: ☐ Yes ☐ No
b. Member is 2 years of age or older: ☐ Yes ☐ No
c. Medication is prescribed by or in consultation with: ☐ Rheumatologist
   Action Required: If not in a specialty clinic or written by a specialist, copy of annual specialty consult with an appropriate specialist is required (please attach copy of consult):
   Name of Specialist: _____ Contact Date: _____
d. Member has trialed and had an inadequate response, or contraindication to a preferred TNF with the same indication from the Montana Healthcare Programs Preferred Drug List: ☐ Yes ☐ No
   Drug Name: _____ Dates: _____
e. Provider attests that they have reviewed the black box warning: ☐ Yes ☐ No
f. Provider attests that member will not use Xeljanz®/Xeljanz® oral solution concomitantly with other biologics: ☐ Yes ☐ No

Limitations:

- Maximum daily dose is 5mg twice daily or weight-based equivalent twice daily of tablets or oral solution

Initial authorization will be issued for 1 year

☐ **CONTINUATION OF THERAPY**

1. **Rheumatoid Arthritis, Psoriatic Arthritis, Ulcerative Colitis, and Ankylosing Spondylitis**
   a. Member has documentation of positive clinical response to Xeljanz®/Xeljanz® XR**:** ☐ Yes ☐ No
   b. Annual specialist consult attached if prescriber is not a specialist: ☐ Yes ☐ No ☐ N/A prescriber is a specialist
   c. Provider attests that member will not use Xeljanz®/Xeljanz® XR concomitantly with other biologics: ☐ Yes ☐ No

2. **Polyarticular Course Juvenile Idiopathic Arthritis*:***
   a. Member has documentation of positive clinical response to Xeljanz®/Xeljanz® Oral Solution: ☐ Yes ☐ No
   b. Annual specialist consult attached if prescriber is not a specialist: ☐ Yes ☐ No ☐ N/A prescriber is specialist
   c. Provider attests that member will not use Xeljanz®/Xeljanz® oral solution concomitantly with other biologics: ☐ Yes ☐ No

Reauthorization will be issued for 1 year

Please complete form, including required attachments and fax to:
Drug Prior Authorization Unit @ 1-800-294-1350

02/2023