

Partnering within our communities to provide solutions for better health

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

Prescriber Name/Specialty if applicable:	M	ember Name:	DOB:	Date:	
Dosage Requested:	M	ember ID:	Prescriber Pho	ne:	
Please complete below information for applicable situation, Initiation or Continuation of therapy: INITIATION OF THERAPY	Pı	escriber Name/Specialty if applicable:	Prescriber Fax	:	
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 Active psoriatic arthritis Active ankylosing spondylitis Moderately to severely active ulcerative colitis Active ankylosing spondylitis Member is 18 years of age or older:	D	osage Requested:			
Please check appropriate diagnosis and complete corresponding information: Rheumatoid Arthritis, Psoriatic Arthritis, Ulcerative Colitis, and Ankylosing Spondylitis Active psoriatic arthritis Moderately to severely active rheumatoid arthritis Active psoriatic arthritis Active psoriatic arthritis Active ankylosing spondylitis Moderately to severely active ulcerative colitis Active ankylosing spondylitis Member is 18 years of age or older: Yes No 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 co an appropriate specialist is required (please attach copy of consult): Name of Specialist: Contact Date: Contact Date: d. Member has trialed and had an inadequate response, or contraindication to a preferred TNF with the same infrom 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 Limitations: e. Rheumatoid Arthritis, Psoriatic Arthritis, and Ankylosing Spondylitis: Maximum daily dose is 5mg daily OR 11mg once daily if requesting XR. e. Ulcerative Colitis: Maximum daily dose is 10mg twice daily for up to 16 weeks (induction dose) then 5 daily for maintenance. For XR formulation, 22mg once daily for up to 16 weeks (induction dose) then 1 daily for maintenance. o. If member loses response: 10mg twice daily or XR 22mg once daily may be considered for the s duration possible.	Pleas	e complete below information for applicable situation, <u>In</u>] <u>itiation</u> or <u>Conti</u>	nuation of therapy:	
1. Rheumatoid Arthritis, Psoriatic Arthritis, Ulcerative Colitis, and Ankylosing Spondylitis a. Member has a diagnosis of:		NITIATION OF THERAPY			
a. Member has a diagnosis of:	Pleas	e check appropriate diagnosis and complete corresponding	information:		
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 Limitations: • Rheumatoid Arthritis, Psoriatic Arthritis, and Ankylosing Spondylitis: Maximum daily dose is 5mg 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 5 daily for maintenance. For XR formulation, 22mg once daily for up to 16 weeks (induction dose) then 11 daily for maintenance. • If member loses response: 10mg twice daily or XR 22mg once daily may be considered for the s duration possible.	a	Member has a diagnosis of: ☐ Moderately to severely active rheumatoid arthritis ☐ Active psoriatic arthritis ☐ Moderately to severely active ulcerative colitis ☐ Active ankylosing spondylitis ☐ Member is 18 years of age or older: ☐ Yes ☐ No Medication is prescribed by or in consultation with: ☐ Action Required: If not in a specialty clinic of an appropriate specialist is required (please as	Gastroenterolo or written by a sp ttach copy of co	gist Rheumatologist pecialist, copy of annual specia nsult):	•
 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 Limitations: Rheumatoid Arthritis, Psoriatic Arthritis, and Ankylosing Spondylitis: Maximum daily dose is 5mg 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 5daily for maintenance. For XR formulation, 22mg once daily for up to 16 weeks (induction dose) then 11daily for maintenance. ○ If member loses response: 10mg twice daily or XR 22mg once daily may be considered for the s duration possible. 	d	from the Montana Healthcare Programs Preferred Drug	List: ☐ Yes ☐	No	me indication
 Limitations: Rheumatoid Arthritis, Psoriatic Arthritis, and Ankylosing Spondylitis: Maximum daily dose is 5mg 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 5 daily for maintenance. For XR formulation, 22mg once daily for up to 16 weeks (induction dose) then 11 daily for maintenance. If member loses response: 10mg twice daily or XR 22mg once daily may be considered for the s duration possible. 		Provider attests that they have reviewed the black box w	varning: Yes	□ No	
 Rheumatoid Arthritis, Psoriatic Arthritis, and Ankylosing Spondylitis: Maximum daily dose is 5mg 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 5th daily for maintenance. For XR formulation, 22mg once daily for up to 16 weeks (induction dose) then 11 daily for maintenance. If member loses response: 10mg twice daily or XR 22mg once daily may be considered for the station possible. 	f.	Provider attests that member will not use Xeljanz [®] /Xelja	anz [®] XR concor	nitantly with other biologics:	l Yes □ No
· · · · · · · · · · · · · · · · · · ·	<u>I</u>	 Rheumatoid Arthritis, Psoriatic Arthritis, and Arthritis OR 11mg once daily if requesting XR. Ulcerative Colitis: Maximum daily dose is 10mg to daily for maintenance. For XR formulation, 22mg or daily for maintenance. If member loses response: 10mg twice daily duration possible. 	vice daily for up nce daily for up or XR 22mg or	to 16 weeks (induction dose) that 16 weeks (induction dose) that ace daily may be considered for	hen 5mg twice nen 11mg once
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Continued on Page 2

	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. f.	Provider attests that they have reviewed the black box warning: \square Yes \square No Provider attests that member will not use Xeljanz®/Xeljanz® oral solution concomitantly with other biologics: \square Yes \square No					
	<u>Lir</u>	 mitations: 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						
$\overline{}$	CC	ONTINUATION OF THERAPY					
		eumatoid Arthritis, Psoriatic Arthritis, Ulcerative Colitis, and Ankylosing Spondylitis					
		Member has documentation of positive clinical response to Xeljanz®/Xeljanz® XR: ☐ Yes ☐ No					
	b.	Annual specialist consult attached if prescriber is not a specialist: \square Yes \square No \square N/A prescriber is a specialist					
	c.	Provider attests that member will not use Xeljanz®/Xeljanz® XR concomitantly with other biologics: ☐ Yes ☐ No					
2.	Pol	yarticular 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: \square Yes \square No					
	Reauthorization will be issued for 1 year						
	Please complete form, including required attachments and fax to:						

02/2023

2