Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Xeljanz (tofacitinib) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Xeljanz (tofacitinib) .** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete.**

The KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Is the prescriber a Rheumatologist, Gastroenterologist, or Dermatologist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

Gastroenterology:

1. Member has diagnosis of ulcerative colitis,
   □ No □ Yes

2. **AND** member has had an inadequate response to at least one anti-TNF agent (e.g. infliximab, adalimumab)
   □ No □ Yes

Rheumatology:

1. Member has diagnosis of moderate-to-severe rheumatoid arthritis**,**
   □ No □ Yes

2. **AND** member has inadequate response or intolerance to oral methotrexate AND intolerance or inadequate response after a 3-month minimum trial of one of the following:
   - Methotrexate (subcutaneous)
   - Hydroxychloroquine
   - Leflunomide
   - Sulfasalazine
   □ No □ Yes

3. **AND** patient has had an inadequate response after a 3-month minimum trial to at least one anti-TNF agent (e.g. infliximab, adalimumab biosimilars (Amjevita preferred) or Humira)
   □ No □ Yes

--OR--

1. Member has diagnosis of psoriatic arthritis**,**
   □ No □ Yes

2. **AND** member has had an inadequate response or intolerance after a 3-month trial to:
   - One nonbiologic DMARD (methotrexate, sulfasalazine, hydroxychloroquine, leflunomide),
   - OR a biologic medication (e.g., adalimumab biosimilars (Amjevita preferred) or Humira, certolizumab, etanercept, golimumab, infliximab, secukinumab, ustekinumab) or apremilast
   □ No □ Yes

--OR--

1. Member has diagnosis of ankylosing spondylitis,
   □ No □ Yes

2. **AND** member has had an inadequate response after a 3-month minimum trial to at least one of the preferred anti-TNF agents [i.e. adalimumab-atto (Amjevita) or infliximab-dyyb (Inflectra)]
   □ No □ Yes

--OR--

1. Member has diagnosis of polyarticular juvenile idiopathic arthritis,
   □ No □ Yes

2. **AND** intolerance or inadequate response after a 3-month minimum trial of **one** of the following:
    a. Methotrexate
    b. Leflunomide
    c. Sulfasalazine

    □ No □ Yes

3. **AND** patient has had an inadequate response after a 3-month minimum trial to at least one of the preferred anti-TNF agents [i.e. adalimumab-atto (Amjevita) or infliximab-dyyb (Inflectra)]

    □ No □ Yes

Dermatology:

1. Patient has diagnosis of alopecia areata (with <50% scalp involvement, mild facial involvement, not rapidly progressive, not alopecia totalis/universalis),

    □ No □ Yes

2. **AND** has tried a 2-month trial of all of the following unless clinically significant adverse effects, contraindication, or clinical reason to avoid treatment:
    - Topical corticosteroid,
    - AND topical calcineurin inhibitor,
    - AND topical minoxidil,
    - AND intralesional Kenalog,
    - AND topical JAK inhibitor

    □ No □ Yes

3. **AND** patient has tried a 3-month trial of at least one of the systemic immunosuppressants such as methotrexate or cyclosporine unless clinically significant adverse effects, contraindication, or clinical reason to avoid treatment

    □ No □ Yes

--OR--

1. Patient has diagnosis of alopecia areata (with >50% scalp involvement, disfiguring facial involvement, rapidly progressive, alopecia totalis/universalis),

    □ No □ Yes

2. **AND** patient has tried a 3-month trial of at least one of the systemic immunosuppressants such as methotrexate or cyclosporine unless clinically significant adverse effects, contraindication, or clinical reason to avoid treatment

    □ No □ Yes

For Continuation of Therapy, please respond to additional questions below:

1. Member has documented a positive clinical response to Xeljanz,

    □ No □ Yes

2. **AND** specialist follow-up occurred in past 12 months since last review

    □ No □ Yes

7 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**

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