Xeljanz, Xeljanz XR

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What is the prescribed dose and frequency?

a) **Loading dose:**

- ❑ Xeljanz 5 mg Quantity and frequency: _____
- ❑ Xeljanz 10 mg Quantity and frequency: _____
- ❑ Xeljanz XR 11 mg Quantity and frequency: _____
- ❑ Xeljanz XR 22 mg Quantity and frequency: _____
- ❑ Xeljanz 1 mg/mL Quantity and frequency: _____
- ❑ Other _____

b) **Maintenance dose:**

- ❑ Xeljanz 5 mg Quantity and frequency: _____
- ❑ Xeljanz 10 mg Quantity and frequency: _____
- ❑ Xeljanz XR 11 mg Quantity and frequency: _____
- ❑ Xeljanz XR 22 mg Quantity and frequency: _____
- ❑ Xeljanz 1 mg/mL Quantity and frequency: _____
- ❑ Other _____

2. What is the diagnosis?

- ❑ Moderately to severely active rheumatoid arthritis (RA)
- ❑ Moderately to severely active ulcerative colitis (UC)
- ❑ Active ankylosing spondylitis
- ❑ Polyarticular juvenile idiopathic arthritis
- ❑ Active articular juvenile idiopathic arthritis, *please specify:*_____
- ❑ Other _____
- ❑ Active psoriatic arthritis (PsA)
- ❑ Immune checkpoint inhibitor-related colitis
- ❑ Active axial spondyloarthritis
- ❑ Oligoarticular juvenile idiopathic arthritis

3. What is the ICD-10 code? _____

4. What is patient's weight? _____ kg

Section A: Preferred Product

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

5. These are the preferred products for which coverage is provided for the treatment of the following indications:
   a) Ankylosing spondylitis: **Cosentyx, Enbrel, Humira, Remicade, Rinvoq, Simponi Aria, Cimzia syringe (secondary)***
   b) Psoriatic arthritis: **Cosentyx, Enbrel, Humira, Otezla, Remicade, Rinvoq, Simponi Aria, Skyrizi (SC), Stelara (SC), Tremfya, Cimzia syringe (secondary)***
   Note: Secondary preferred product option only applies to members who have had a documented inadequate response or intolerable adverse event with two primary preferred products.
   Can the patient's treatment be switched to a preferred product?
   ❑ Yes - Please indicate:_____ ***If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.***
   ❑ No ❑ Not applicable - Request for condition not listed above, *skip to Section B: All Requests*

6. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #8*

7. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes. ❑ Yes ❑ No *If No, skip to Section B: All Requests*

8. Does the patient have a documented inadequate response or intolerable adverse event to any of the following products? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** *Indicate ALL that apply.*

❑ Cimzia syringe:	❑ Inadequate response	Intolerable adverse event
❑ Cosentyx:	❑ Inadequate response	❑ Intolerable adverse event
❑ Enbrel:	❑ Inadequate response	❑ Intolerable adverse event
❑ Humira:	❑ Inadequate response	❑ Intolerable adverse event
❑ Otezla:	❑ Inadequate response	❑ Intolerable adverse event
❑ Rinvoq:	❑ Inadequate response	❑ Intolerable adverse event
❑ Skyrizi (SC):	❑ Inadequate response	❑ Intolerable adverse event
❑ Stelara (SC):	❑ Inadequate response	❑ Intolerable adverse event
❑ Tremfya:	❑ Inadequate response	❑ Intolerable adverse event

   ❑ No - None of the above

9. Does the patient have one of the following documented clinical reasons to avoid all of the preferred products that are TNF inhibitors (Cimzia syringe, Enbrel, and Humira)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).***
   ❑ Yes - History of demyelinating disorder, *please specify product(s):* _____
   ❑ Yes - History of congestive heart failure, *please specify product(s):* _____
   ❑ Yes - History of hepatitis B virus infection, *please specify product(s):* _____
   ❑ Yes - Autoantibody formation/lupus-like syndrome (attributed to TNF inhibitor), *please specify product(s):* _____
   ❑ Yes - History or risk of lymphoma or other malignancy, *please specify product(s):* _____
   ❑ Yes - History of being a primary non-responder to a TNF inhibitor (i.e., no clinical response with initial treatment), *please specify product(s):* _____
   ❑ No - None of the above

10. Does the patient have one of the following documented clinical reasons to avoid both of the preferred products that are JAK inhibitors (Rinvoq and Xeljanz/Xeljanz XR)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** *Indicate all that apply.*
    ❑ History or risk of lymphoma, lung cancer, non-melanoma skin cancer, or other malignancy
    ❑ History or risk of major adverse cardiovascular events (MI, stroke, etc.)
    ❑ History or risk of thrombotic events (PE, DVT, arterial thrombosis, etc)
    ❑ History of hepatitis B or hepatitis C virus infection
    ❑ History of being a primary non-responder to a JAK inhibitor (i.e., no clinical response with initial treatment)
    ❑ None of the above.

Section B: All Requests

11. Will the requested drug be used in combination with any other biologic drug (e.g., Humira), targeted synthetic drug (e.g., Otezla, Rinvoq, Olumiant), or potent immunosuppressant such as azathioprine or cyclosporine?
❑ Yes ❑ No

12. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Olumiant) associated with an increased risk of tuberculosis? *If Yes, skip to #16* ❑ Yes ❑ No

13. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [PPD], interferon-release assay [IGRA], chest x-ray) within 6 months of initiating therapy? ❑ Yes ❑ No

14. What were the results of the tuberculosis (TB) test?
❑ Positive for TB ❑ Negative for TB, *skip to #16* ❑ Unknown

15. Which of the following applies to the patient?
❑ Patient has latent TB and treatment for latent TB has been initiated
❑ Patient has latent TB and treatment for latent TB has been completed
❑ Patient has latent TB and treatment for latent TB has not been initiated
❑ Patient has active TB

16. Is the requested drug being prescribed by or in consultation with one of the following?
❑ Yes - Dermatologist ❑ Yes - Gastroenterologist ❑ Yes - Hematologist ❑ Yes - Oncologist
❑ Yes - Rheumatologist ❑ No - None of the above

17. Is this request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #21*

18. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #21* ❑ Yes ❑ No ❑ Unknown

19. *If the diagnosis is rheumatoid arthritis,* has the patient achieved or maintained positive clinical response since starting treatment with the requested drug? ❑ Yes ❑ No *Skip to diagnosis section.*

20. *For all diagnoses EXCEPT rheumatoid arthritis,* has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug? ❑ Yes ❑ No *Skip to diagnosis section, if applicable.*

21. *For all diagnoses EXCEPT immune checkpoint inhibitor-related colitis,* has the patient experienced an inadequate response or intolerance to at least one tumor necrosis factor (TNF) inhibitor (e.g., Humira)?
ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. ❑ Yes ❑ No

Complete the following section based on the patient's diagnosis, if applicable.

Section C: Rheumatoid Arthritis

Continuation

22. Has the patient experienced substantial disease activity improvement (e.g., at least 20% from baseline) in tender joint count, swollen joint count, pain, or disability? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation supporting positive clinical response and substantial disease activity improvement.***
❑ Yes ❑ No

Initiation

23. Has the patient ever received (including current utilizers) a biologic (other than a TNF inhibitor, e.g., Actemra, Orencia) or targeted synthetic drug (e.g., Rinvoq, Olumiant) that is indicated for moderately to severely active rheumatoid arthritis? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.*** ❑ Yes ❑ No

Section D: Ulcerative Colitis

Continuation

24. Has the patient achieved or maintained remission? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of remission and skip to #26.*** ❑ Yes ❑ No

25. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response to therapy.***
❑ Stool frequency ❑ Rectal bleeding ❑ Urgency of defecation
❑ C-reactive protein (CRP) ❑ Fecal calprotectin (FC) ❑ Endoscopic appearance of the mucosa
❑ Improvement on a disease activity scoring tool (e.g., Ulcerative Colitis Endoscopic Index of Severity [UCEIS], Mayo Score])
❑ None of the above

26. *If the prescribed dose and frequency for the maintenance treatment exceeds 5 mg twice daily for immediate release tablet OR 11 mg once daily for extended release (ER) tablet,* did the patient experience a loss of response during treatment for maintenance of remission? ❑ Yes ❑ No

27. *If the prescribed dose and frequency for the maintenance treatment exceeds 5 mg twice daily for immediate release tablet OR 11 mg once daily for extended release (ER) tablet,*will the lowest effective dose be utilized and limited to the shortest duration needed? ❑ Yes ❑ No

Initiation

28. Has the patient ever received (including current utilizers) a biologic (other than a tumor necrosis factor [TNF] inhibitor, e.g., Entyvio, Stelara) or targeted synthetic drug (e.g., Rinvoq) indicated for the treatment of moderately to severely active ulcerative colitis? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.*** ❑ Yes ❑ No

Section E: Articular Juvenile Idiopathic Arthritis

Continuation

29. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response.***
❑ Number of joints with active arthritis (e.g., swelling, pain, limitation of motion) ❑ Functional ability
❑ Number of joints with limitation of movement ❑ None of the above

Initiation

30. Has the patient ever received (including current utilizers) a biologic (other than a TNF inhibitor, e.g., Actemra, Orencia) or targeted synthetic drug indicated for active articular juvenile idiopathic arthritis?
ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried. ❑ Yes ❑ No

Section F: Immune Checkpoint Inhibitor-Related Colitis

31. Has the patient experienced an inadequate response to infliximab or vedolizumab? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and skip to #34.*** ❑ Yes ❑ No

32. Has the patient experienced an intolerance to infliximab or vedolizumab? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and skip to #34.*** ❑ Yes ❑ No

33. Does the patient have a contraindication to infliximab or vedolizumab? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

34. Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)? ❑ Yes ❑ No

Section G: Ankylosing Spondylitis, Axial Spondyloarthritis

Continuation

35. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response.***
❑ Functional status ❑ Total spinal pain ❑ Inflammation (e.g., morning stiffness) ❑ None of the above

Initiation

36. Has the patient ever received (including current utilizers) a biologic (other than a TNF inhibitor, e.g., Cosentyx, Taltz) or targeted synthetic drug (e.g., Rinvoq) indicated for active ankylosing spondylitis or active axial spondyloarthritis? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.*** ❑ Yes ❑ No

Section H: Psoriatic Arthritis

Continuation

37. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response.***
    ❑ Number of swollen joints ❑ Number of tender joints ❑ Dactylitis
    ❑ Enthesitis ❑ Axial disease ❑ Skin and/or nail involvement
    ❑ None of the above

Initiation

38. Will the requested drug be used in combination with a conventional synthetic drug (e.g., methotrexate, leflunomide, sulfasalazine)? ❑ Yes ❑ No

39. Has the patient ever received (including current utilizers) a biologic (other than a TNF inhibitor, e.g., Cosentyx, Orencia) or targeted synthetic drug (e.g., Rinvoq, Otezla) that is indicated for active psoriatic arthritis? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.*** ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155