STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES TELEPHONE:
TELEPHONE: 1-866-409-8386 FAX: 1-866-759-4110

Cytokine and CAM – JAK Inhibitors
Clinical Prior Authorization (PA) Request Form
CT Medical Assistance Program
To Be Completed By Prescriber

Prescriber Information	Patient Information
Prescriber's NPI:	Patient's Medicaid ID Number:
Prescriber Name:	Patient Name:
Prescriber Subspecialty:	Patient DOB:
Phone ( )	Patient Current Weight:
Fax ( )	Patient Primary ICD Diagnosis Code:
Prescription Information	
Drug, Strength, and Dosage Form Requested:	Frequency of Dosing:
□ New therapy □ Continuation	Quantity Requested:

Preferred Agents:	Non-Preferred Agents:
XELJANZ IR 5MG & 10MG TABLET †	CIBINQO TABLET
	*OLUMIANT TABLET**
PREFERRED TNFi AGENTS (listed for reference):	*LEQSELVI TABLET**
ADALIMUMAB-ADAZ PEN, SYRINGE	*LITFULO CAPSULE**
ENBREL DISP SYRINGE, KIT, PEN	RINVOQ ER TABLET ‡
ENBREL MINI CARTRIDGE, VIAL	RINVOQ LQ SOLUTION ‡
HADLIMA PUSHTOUCH, SYRINGE	XELJANZ SOLUTION †
HUMIRA KIT, PEN INJECTION KIT	XELJANZ XR TABLET †
INFLIXIMAB VIAL	

**Alopecia Areata Indication Not Covered*
‡Upadacitinib Agents
† Tofacitinib Agents

Clinical Information

(attach supporting documentation, **required**)

Note: Using samples to initiate therapy does not meet authorization requirements

1. Prescribed by or in consultation with a rheumatologist, gastroenterologist, dermatologist, immunologist, allergist or any other specialist familiar with the treated disease state (or as appropriate for diagnosis)? ○ Please specify subspecialty:_____	□ Yes □ No

2. Is patient using in combination with another targeted immunomodulator, immunosuppressants and/or biologic DMARDs? o Please specify alternate agent:_____	□ Yes □ No
3. Does patient have an active TB, Hepatitis B/C or other active infection prior to initiation? o Please specify infection: _____	□ Yes □ No
4. **For diagnosis of Moderate-to-Severe disease activity of ONE of the following:** - **Active Ankylosing Spondylitis (AS)** - **Rheumatoid Arthritis (RA)** - **Polyarticular Juvenile Idiopathic Arthritis (pJIA)** - **Polyarticular Course Juvenile Idiopathic Arthritis (pcJIA) OR** - **Psoriatic Arthritis (PsA)** o Patient has trialed and failed **ONE** tumor necrosis factor inhibitor (TNFi) minimum duration defined by manufacturer **OR** documented adverse event/adverse drug reaction ▪ TNFi agents trialed: _____ ▪ TNFi Trial Dates: _____ ▪ Reason for TNFi Contraindication or Failure: _____ **AND** o Patient has trialed and failed **ONE** trial of preferred TOFACITINIB for a minimum of 30 days **OR** documented adverse event/adverse drug reaction ▪ XELJANZ IR Trial Dates:_____ ▪ Reason for XELJANZ IR Contraindication or Failure: _____	□ Yes □ No □ N/A
5. **For diagnosis of Moderate-to-Severe Atopic Dermatitis (AD):** o Patient has trialed and failed **ONE** of the following classes of therapy for a minimum of 30 days **AND** documentation in attached chart notes: ▪ Topical Corticosteroid ▪ Topical Calcineurin Inhibitor ▪ PDE – 4 Inhibitor ▪ Oral corticosteroids ▪ Oral immunosuppressant	□ Yes □ No □ N/A

▪ Phototherapy o Class of therapy trialed: _____ o Trial Dates: _____ o Reason for Failure: _____	
6. **For diagnosis of Active Non-Radiographic Axial Spondyloarthritis (nr-axSpA):** o Request is for a non-preferred upadacitinib formulation **AND** patient received an adequate trial of a TNF inhibitor as defined by manufacturer **OR** documented ADE/ADR ▪ Agent trialed: _____ ▪ Trial Dates: _____ ▪ Reason for Contraindication or Failure: _____	□ Yes □ No □ N/A
7. **For diagnosis of Moderate-to-Severe Crohn's Disease (CD):** o Request is for a non-preferred upadacitinib formulation **AND** patient received an adequate trial of a TNF inhibitor as defined by manufacturer **OR** documented ADE/ADR ▪ TNFi agent trialed: _____ ▪ Trial Dates: _____ ▪ Reason for Contraindication or Failure: _____ **OR** o Provider attests that a TNF inhibitor is not advisable (must provide documentation of medical reason why patient is unable to receive a TNF inhibitor) **AND** patient has tried and failed **ONE** other systemic therapy approved for the treatment of Crohn's disease (must provide documentation of alternate systemic therapy agent(s) trialed and failed) ▪ Systemic therapy agent trialed: _____ ▪ Trial Dates: _____ ▪ Reason for Contraindication or Failure: _____	□ Yes □ No □ N/A
8. **For diagnosis of Giant Cell Arteritis (GCA):** o Request is for a non-preferred upadacitinib formulation **AND** documented trial and failure of Oral Glucocorticoids **OR** documentation of need for a steroid-sparing agent	□ Yes □ No □ N/A

▪ Preferred agent trialed: _____ ▪ Trial Dates: _____ ▪ Reason for Contraindication or Failure: _____ ▪ Explanation of Need for Steroid-Sparing Agent: _____	
9. **For diagnosis of Moderate-to-Severe Ulcerative Colitis (UC):** o Patient has trialed and failed **ONE** tumor necrosis factor inhibitor (TNFi) minimum duration defined by manufacturer **OR** documented adverse event/adverse drug reaction ▪ TNFi agents trialed: _____ ▪ Trial Dates: _____ ▪ Reason for Contraindication or Failure: _____ ▪ **OR for Rinvoq Requests ONLY:** Provider attests that a TNFi is not advisable *(Note: Must provide documentation of medical reason why patient is unable to receive a TNF inhibitor)*: _____ **AND** o Patient has trialed and failed **ONE** trial of preferred TOFACITINIB for a minimum of 30 days **OR** documented adverse event/adverse drug reaction ▪ Xeljanz IR Trial Dates:_____ ▪ Reason for Xeljanz IR Failure:_____	□ Yes □ No □ N/A

For Initial Approval:
Medication Requested and Documented diagnosis of ONE of the following:

(attach supporting documentation, **required**)

Cibinqo (abrocitinib) (Patients 12+ years): • Patient has a documented diagnosis of Moderate-to-Severe Atopic Dermatitis (AD) **AND** • Failure to achieve the desired therapeutic outcome following a trial of at least ONE of the appropriate classes (as outlined above in Question 5 of the Clinical Information section)	□ Yes □ No
Olumiant (baricitinib) (Patients 18+ years): • Patient has a documented diagnosis of Moderate-to-Severe Rheumatoid Arthritis (RA) **AND**	□ Yes □ No

• Failure to achieve the desired therapeutic outcome following a trial of tumor necrosis factor inhibitor (TNFi) **AND** minimum 30-day trial of Preferred Xeljanz IR (as outlined above in Question 4 of the Clinical Information section)	
Rinvoq ER and Rinvoq LQ (upadacitinib) : • Patient has a documented diagnosis of ONE of the following with Moderate-to-Severe disease activity: ◦ Ankylosing Spondylitis (AS) (Patients 18+ years) ◦ Rheumatoid Arthritis (RA) (Patients 18+ years) ◦ Polyarticular Juvenile Idiopathic Arthritis (pJIA) (Patients 2+ years) ◦ Psoriatic Arthritis (PsA) (Patients 2+ years) **AND** ▪ Failure to achieve the desired therapeutic outcome following a trial of tumor necrosis factor inhibitor (TNFi) **AND** minimum 30-day trial of Preferred Xeljanz IR (as outlined above in Question 4 of the Clinical Information section) **OR** o Atopic Dermatitis (AD) (Patients 12+ years) **AND** ▪ Failure to achieve the desired therapeutic outcome following a trial of at least ONE of the appropriate classes (as outlined above in Question 5 of the Clinical Information section) **OR** o Non-Radiographic Axial Spondyloarthritis (nr-axSpA) (Patients 18+ years) **AND** ▪ Documented objective signs of inflammation noted **AND** ▪ Failure to achieve the desired therapeutic outcome after an adequate trial of a TNF inhibitor (as outlined above in Question 6 of the Clinical Information section) o Crohn's Disease (CD) (Patients 18+ years) ▪ Failure to achieve the desired therapeutic outcome after an adequate trial of a TNF inhibitor **OR** attestation (as outlined above in Question 7 of the Clinical Information section) o Giant Cell Arteritis (GCA) (Patients 18+ years) **AND** ▪ Failure to achieve the desired therapeutic outcome after trial and failure of Oral Glucocorticoids and/or steroid-sparing agent (as outlined above in Question 8 of the Clinical Information section) o Ulcerative Colitis (UC) (Patients 18+ years) **AND**	□ Yes □ No

▪ Failure to achieve the desired therapeutic outcome following a trial of tumor necrosis factor inhibitor (TNFi) **AND** minimum 30-day trial of Preferred Xeljanz IR (as outlined above in Question 9 of the Clinical Information section) *NOTES: Rinvoq ER is not recommended for pediatric patients less than 30kg and trial and failure of preferred dosage form is not required for patients unable to swallow solid dosage forms*	
Xeljanz Solution (tofacitinib) : • Patient has a documented diagnosis of ONE of the following with Moderate-to-Severe disease activity: • Ankylosing Spondylitis (AS) (Patients 18+ years) • Rheumatoid Arthritis (RA) (Patients 18+ years) • Polyarticular Course Juvenile Idiopathic Arthritis (pcJIA) (Patients 2+ years) • Psoriatic Arthritis (PsA) (Patients 2+ years) **AND** ▪ Failure to achieve the desired therapeutic outcome following a trial of tumor necrosis factor inhibitor (TNFi) **AND** minimum 30-day trial of Preferred Xeljanz IR (as outlined above in Question 4 of the Clinical Information section) **AND** o Ulcerative Colitis (UC) (Patients 18+ years) ▪ Failure to achieve the desired therapeutic outcome following a trial of tumor necrosis factor inhibitor (TNFi) AND minimum 30-day trial of Preferred Xeljanz IR (as outlined above in Question 9 of the Clinical Information section) **AND** o Documented medical reason why preferred TOFACITINIB formulation cannot be used:_____ *NOTE: Trial and failure of preferred dosage form is not required for patients unable to swallow solid dosage forms*	□ Yes □ No
Xeljanz XR (tofacitinib): • Patient has a documented diagnosis of ONE of the following with Moderate-to-Severe disease activity: • Ankylosing Spondylitis (AS) (Patients 18+ years) • Rheumatoid Arthritis (RA) (Patients 18+ years)	□ Yes □ No

• Psoriatic Arthritis (PsA) (Patients 18+ years) **AND** ▪ Failure to achieve the desired therapeutic outcome following a trial of tumor necrosis factor inhibitor (TNFi) **AND** minimum 30-day trial of Preferred Xeljanz IR (as outlined above in Question 4 of the Clinical Information section) **AND** o Ulcerative Colitis (UC) (Patients 18+ years) ▪ Failure to achieve the desired therapeutic outcome following a trial of tumor necrosis factor inhibitor (TNFi) AND minimum 30-day trial of Preferred Xeljanz IR (as outlined above in Question 9 of the Clinical Information section) **AND** o **For Xeljanz XR 22 mg Tablets**: Documentation of why participant cannot utilize Xeljanz IR or Xeljanz XR 11 mg tablets: _____	

Renewal Information

(attach supporting documentation, **required**)

Note: Using samples to initiate therapy does not meet renewal authorization requirements

• Has the patient previously met the required criteria set forth in Initial Approval Section above? o Previous Approved Prior Authorization Number: _____ o Approval Dates: _____	□ Yes □ No
• Patients' clinical response to treatment and ongoing safety has been documented and monitored	□ Yes □ No
• Prescriber attests that the patient has a continued need for therapy and is compliant with current regimen	□ Yes □ No
• Requested agent is NOT being used for the treatment of Alopecia Areata (indication not covered)	□ Yes □ No □ N/A
• For specific formulation requests: o **For non-preferred TOFACITINIB requests when a therapeutically equivalent TOFACITINIB is preferred:** Provider must provide a documented medical reason the preferred formulation cannot be used: _____	

Please Note: Pharmacies should not be contacting prescribers to provide pre-signed PA forms or submitting pre-signed forms for PA, nor should prescribing providers be requesting that pharmacies perform PA activities for them. PA requests must originate from the prescriber, and only the prescriber should sign the form at the time of PA submission.
I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under section 17b-99 of the Connecticut General Statutes and sections 17-83k-1- to 17-83k-7, inclusive, of the Regulations of Connecticut State Agencies. I certify that the above-referenced member is a patient under my clinic's/practice's ongoing care. I understand that a prior authorization may not exceed one (1) year from the date of fill for non- controlled medications. Authorizations for Early Refill Requests are valid one time only.

Prescriber Signature*:_____Date:_____

*** Mandatory (others may not sign for prescriber). In accordance with federal law, prescribers must be enrolled in the Connecticut Medical Assistance Program (CMAP). CMAP will not pay for prescriptions written by a non-enrolled provider.**