Fax completed form to Navitus at: 855-668-8553
For questions, please call: 877-908-6023

TEXAS MEDICAID

Drug Prior Authorization
Cytokine & Cell-adhesion Molecule (CAM) Antagonists: tofacitinib (XELJANZ)

Request Information (required)
This request is: ☐ **Expedited* (Urgent)** ☐ **Standard (Non-Urgent)** *Expedited means the standard review time may seriously harm the member's life, health, or ability to regain maximum function.

Member Information (required)			Prescriber Information (required)		
Member Name:			Prescriber Name:		
Member Insurance ID #:			NPI # :	Specialty:	
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:

Please fill out the following information:	
1.	Medication Requested (Name): (Go to #2)

2. Quantity Requested:
(Go to #3)

3. Dose Requested (Strength):
(Go to #4)

4. Dosing Instructions:
(Go to #5)

Required Criteria

5. Provide primary diagnosis including ICD-10 code(s):
(Go to #6)

6. Please indicate the requested drug's formulary status: *(Formulary available at www.txvendordrug.com)

Non-Preferred Drug (NPD or NAP)
(Go to #7)

Preferred Drug (PDL)
(Go to #10)

No Status, Drug is not in a Market Basket
(Go to #10)

N/A as this request is for a CHIP/PERINATE member
(Go to #10)

Preferred Drug List (PDL) Criteria (required for non-preferred products)

7. Has the member failed a 30-day treatment trial with at least one (1) preferred agent in the last 180 days?

Yes
(Go to #10)

No
(Go to #8)

8. Is there a documented allergy or contraindication to preferred agents in this class?

Yes
(Go to #10)

No
(Go to #9)

9. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

Yes
(Go to #10)

No (Deny)
(Go to #10)

Clinical Criteria (required)

10. Is the member greater than or equal to (≥) two (2) years of age?

    Yes
    (Go to #11)

    No (Deny)
    (Go to #11)

11. Does the member have a diagnosis of juvenile idiopathic arthritis (JIA) in the last 730 days?

    Yes
    (Go to #14)

    No (And request is for Xeljanz/Xeljanz XR tablets)
    (Go to #12)

    No (And request is for Xeljanz oral solution, deny)
    (Go to #12)

12. Is the member greater than or equal to (≥) 18 years of age?

    Yes
    (Go to #13)

    No (Deny)
    (Go to #13)

13. Does the member have a diagnosis of ankylosing spondylitis (AS), psoriatic arthritis (PsA), rheumatoid arthritis (RA) or ulcerative colitis (UC) in the last 730 days?

    Yes
    (Go to #14)

    No (Deny)
    (Go to #14)

14. Has the member had therapy with one (1) or more tumor necrosis factor (TNF)-blockers in the last 90 days?

    Examples of a TNF-blocker include: CIMZIA, ENBREL, HUMIRA, and SIMPONI.

    Yes
    (Go to #15)

    No (Deny)
    (Go to #15)

15. Will the member have concurrent therapy with a biological disease-modifying antirheumatic drug (DMARD) or potent immunosuppressant?

    Examples of biological DMARDs include: ACTEMRA, CIMZIA, COSENTYX, ENBREL, HUMIRA, ILARIS, KEVZARA, KINERET, ORENCIA, OTEZLA, SILIQ, SIMPONI, STELARA, TALTZ, and TREMFYA.

    Examples of potent immunosuppressants include: azathioprine (IMURAN), cyclosporine (GENGRAF, NEORAL, SANDIMMUNE), mycophenolate (CELLCEPT), mycophenolic acid (MYFORTIC), and tacrolimus (ASTAGRAF XL, PROGRAF).

    Yes (Deny)
    (Go to #16)

    No
    (Go to #16)

16. Does the member have one (1) claim for a strong CYP3A4 inducer in the last 60 days?

    Examples of strong CYP3A4 inducers include: ACTOPLUS, ACTOS, APTIOM, ATRIPLA, bexarotene (TARGRETIN), carbamazepine (CARBATROL, EPITOL, EQUETRO, TEGRETOL), DUETACT, INTELENCE, LYSODREN, modafinil (PROVIGIL), rifabutin (MYCOBUTIN), primidone (MYSOLINE), nevirapine (VIRAMUNE), ORKAMBI, OSENI, phenobarbital, phenytoin (DILANTIN, PHENYTEK), PRIFTIN, RIFAMATE, rifampin (RIFADIN), RIFATER, SUSTIVA, TAFINLAR, TRACLEER and XTANDI.

    Yes (Deny)
    (Go to #17)

    No
    (Go to #17)

17. Does the member have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

Yes (Deny)
(Go to #18)

No (Approve - 365 days)
(Go to #18)

Additional Information

18. Please provide any additional information we should consider (or attach any supporting documents):
(END)

Submission Information (required)

Prescriber Signature: ______________________________ **Date:** ______________

** PLEASE FAX COMPLETED FORM TO: 855-668-8553 **

If criteria not met, submit chart documentation with form citing complex medical circumstances.
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