AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization

Janus Kinase (JAK) Inhibitors

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
Provider NPI:	Prescriber name:		Phone:
Prescriber address:			Fax:
Pharmacy name:			
Address:			Phone:
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.			
Pharmacy NPI:		Pharmacy fax:	NDC:

Prior authorization is required for Janus kinase (JAK) inhibitors. Payment will be considered when the following conditions are met: 1) The patient is 18 years of age or older; and 2) Has a diagnosis of moderate to severe rheumatoid arthritis; and 3) Has a documented trial and inadequate response to two preferred oral disease modifying antirheumatic drugs (DMARD) used concurrently. The combination must include methotrexate plus another preferred oral DMARD (hydroxychloroquine, sulfasalazine, leflunomide, or minocycline); and 4) Has a documented trial and inadequate response to two preferred biological DMARDs; and 5) The patient is not using or planning to use tofacitinib in combination with biologic DMARDs or potent immunosuppressants (azathioprine or cyclosporine); and 6) Has been tested for latent tuberculosis prior to initiating therapy and will be monitored for active tuberculosis during treatment; and 7) Recommended laboratory monitoring of lymphocytes, neutrophils, hemoglobin, liver enzymes and lipids are being conducted according to the manufacturer labeling; and 8) Patient does not have a history of malignancy, except those successfully treated for non-melanoma skin cancer (NMSC); and 9) Patient is not at an increased risk of gastrointestinal perforation. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

Non-Preferred: ☐ Xeljanz ☐ Xeljanz XR

Strength: Dosage Instructions: Quantity: Days Supply:

Diagnosis:

Trial Information:

Methotrexate trial:

Dose: Trial Dates: Failure Reason:

Plus preferred oral DMARD trial:

Drug Name & Dose: Trial Dates: Failure Reason:

Preferred Biological DMARD Trial #1:

Drug Name & Dose: Trial Dates: Failure Reason:

Preferred Biological DMARD Trial #2:

Drug Name & Dose: Trial Dates: Failure Reason:

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Will tofacitinib be used in combination with biologic DMARDs or potent immunosuppressants? ☐Yes ☐No

Screening for Latent TB infection: Date: Results:

Will patient be monitored for active tuberculosis during treatment? ☐Yes ☐No

Does patient have a history of malignancy, except successfully treated non-melanoma skin cancer (NMSC)? ☐Yes ☐No

Does patient have an increased risk of gastrointestinal perforation? ☐Yes ☐No

Recommended laboratory monitoring will be conducted according to manufacturer labeling (lymphocytes, neutrophils, hemoglobin, liver enzymes and lipids)? ☐Yes ☐No Date of most recent labs:

Other medical conditions to consider:

Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.	
Prescriber signature: (Must match prescriber listed above.)	Date of submission:

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.