



**Xeljanz® (tofacitinib)
Xeljanz XR® (tofacitinib)
Effective 06/01/2022**

Plan	<input type="checkbox"/> MassHealth <input checked="" type="checkbox"/> MassHealth (PUF) <input type="checkbox"/> Commercial/Exchange	Program Type	<input checked="" type="checkbox"/> Prior Authorization <input checked="" type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
Benefit	<input checked="" type="checkbox"/> Pharmacy Benefit <input type="checkbox"/> Medical Benefit (NLX)		
Specialty Limitations	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	Specialty Medications		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	Non-Specialty Medications		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	Medical Specialty Medications (NLX)		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
Exceptions	N/A		

Overview

Tofacitinib inhibits Janus kinase (JAK) enzymes, which are intracellular enzymes involved in stimulating hematopoiesis and immune cell function through a signaling pathway. Inhibition of JAKs interrupts this pathway and proinflammatory cytokines.

FDA-Approved Indications

1. Moderately to severely active rheumatoid arthritis (RA)
2. Active psoriatic arthritis (PsA)
3. Moderately to severely active ulcerative colitis (UC)
4. Moderate to severely active juvenile idiopathic arthritis (pJIA) – Xeljanz only

Coverage Guidelines

Authorization may be reviewed on a case-by-case basis for members new to AllWays Health Partners who are currently receiving treatment with Xeljanz or Xeljanz XR excluding when the product is obtained as samples or via manufacturer’s patient assistance programs.

OR

Authorization may be granted for members when ALL the following criteria are met, and documentation is provided:

Moderate to Severe Rheumatoid Arthritis (RA), Psoriatic arthritis (PsA), Moderate to severe Ulcerative Colitis (UC)

Prescriber provides documentation of **ALL** of the following:

1. Appropriate diagnosis



2. **ONE** of the following:
 - a. Paid claims or physician documented inadequate response or adverse reaction to **ONE** traditional DMARD or contraindication to traditional DMARDs
 - b. Paid claims or physician documented inadequate response or adverse reaction to **ONE** biologic DMARD that is FDA-approved for the requested indication
3. **ONE** of the following:
 - a. If the request is for Xeljanz[®], quantity requested is ≤ 2 tablets/day
 - b. If the request is for Xeljanz XR[®], quantity requested is ≤ 1 tablet/day

Please note: Xeljanz solution is only FDA approved for PJIA. Requests for all other indications can be denied non-FDA approved indication

Moderate to severe plaque psoriasis

Prescriber provides documentation of **ALL** of the following:

1. Appropriate diagnosis
2. **ONE** of the following:
 - a. Paid claims or physician documented inadequate response or adverse reaction to **ONE conventional therapy** (see appendix):
 - i. topical agent
 - ii. phototherapy
 - iii. systemic agent
 - c. Contraindication to **ALL conventional therapies** (topical agents, phototherapy, and systemic agents)
 - b. Paid claims or physician documented inadequate response or adverse reaction to **ONE** biologic DMARD that is FDA-approved for plaque psoriasis
3. Appropriate dosing

Moderate to severe polyarticular juvenile idiopathic arthritis (pJIA)

Prescriber provides documentation of **ALL** of the following:

1. Appropriate diagnosis
2. **ONE** of the following:
 - a. Paid claims or physician documented inadequate response or adverse reaction to **ONE** traditional DMARD or contraindication to traditional DMARDs
 - b. Paid claims or physician documented inadequate response or adverse reaction to **ONE** biologic DMARD that is FDA-approved for the requested indication
3. **ONE** of the following:
 - a. If the request is for Xeljanz[®], quantity requested is ≤ 2 tablets/day
 - b. If the request is for Xeljanz[®] solution, quantity requested is ≤ 10 mL/day

Continuation of Therapy

Reauthorization requires physician documentation of continuation of therapy, positive response to therapy, FDA approved indication and appropriate dosing.

Limitations

1. Initial approvals will be granted for 6 months.
2. Reauthorizations will be granted for 12 months
3. The following quantity limits apply:

Xeljanz [®] 5mg and 10mg	60 tablets per 30 days
Xeljanz [®] XR 22mg	30 tablets per 30 days

Appendices

Appendix A: Traditional DMARDS

Traditional DMARDS*	
azathioprine	methotrexate*
cyclosporine	sulfasalazine*
hydroxychloroquine*	thalidomide
leflunomide	
If a member has a contraindication to ALL of the most commonly used traditional DMARDS* (methotrexate, sulfasalazine, and hydroxychloroquine), a trial with a traditional DMARD may be bypassed.	

Appendix B. Conventional Therapies for Plaque Psoriasis

Conventional Treatment Lines	Agents Used
Topical Agents	emollients, keratolytics, corticosteroids, coal tar, anthralin, calcipotriene, tazarotene, calcitriol, calcineurin inhibitors
Systemic Agents	Traditional DMARDS: methotrexate, apremilast, acitretin,
Phototherapy	ultraviolet A and topical psoralens (topical PUVA), ultraviolet A and oral psoralens (systemic PUVA), narrow band UV-B (NUVB)

Appendix C: Off-Label Indications

More frequent/Higher doses

Requests more frequent or higher doses of injectable biologics, may be approved if **ALL** of the following is provided:

1. Documentation of severe disease
2. **ONE** of the following:
 - a. Inadequate response or adverse reaction to **ONE** other injectable biologic which is FDA-approved for the requested indication*
 - b. Contraindication to **ALL** other injectable biologics which are FDA-approved for the requested indication
3. Documented partial response to FDA-approved dosing of current biologic therapy
4. Documentation of specialist consult for the requested indication

Atopic Dermatitis (moderate-to-severe)

Prescriber documents **ALL** of the following:

1. Paid claim or physician attestation of inadequate response, adverse reaction or contraindication to phototherapy
2. Paid claim or physician attestation of response, adverse reaction or contraindication to **TWO** traditional DMARDS (cyclosporine, methotrexate, mycophenolate, azathioprine) or a contraindication to all traditional DMARDS

References

1. Xeljanz/Xeljanz XR (tofacitinib) [prescribing information]. New York, NY: Pfizer; October 2018
2. Singh JA, Saag KG, Bridges SL Jr, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Rheumatol*. 2016;68(1)1-26.



3. Smolen JS, Landewé R, Billsma J, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2016 update. *Ann Rheum Dis.* 2017;*0*:1-18.
4. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Section 6: Guidelines of care for the treatment of psoriasis and psoriatic arthritis: case-based presentations and evidence-based conclusions. *J Am Acad Dermatol.* 2011;*65*(1):137-174.
5. Gossec L, Smolen JS, Ramiro S, et al. European League Against Rheumatism (EULAR) recommendations for the management of psoriatic arthritis with pharmacological therapies: 2015 update. *Ann Rheum Dis.* 2016;*75*(3):499-510.
6. Sandborn WJ, Su C, Sands BE, et al. Tofacitinib as Induction and Maintenance Therapy for Ulcerative Colitis. *N Engl J Med* 2017; *376*:1723.

Review History

06/24/2013: Reviewed

02/24/2014: Reviewed

02/23/2015: Reviewed

02/22/2016: Reviewed

02/27/2017: Adopted SGM & Step

03/01/2018: Adopted MH RS

02/20/2019: Reviewed P&T Mtg

03/18/2020: Updated (Included Ulcerative colitis indication to coverage guidelines); removed dosing

4/15/2020: MH unified drug list to prefer Xeljanz and Xeljanz XR ; change previous use of ONE biologic DMARD to inadequate response to Enbrel OR Humira. Change effective 6/22/20.

10/21/2020 – Reviewed and Updated; separated out Comm/Exch vs. MassHealth. Matched MassHealth Preferred Unified Formulary for implementation 1/1/2021

03/17/2021 – Reviewed and Updated; added moderate to severe polyarticular juvenile idiopathic arthritis (pJIA). Effective 06/01/2021

11/17/2021 –Reviewed and Updated for Nov P&T; matched MH UPPL for 1/1/2022 implementation; added appendix with higher dose/more frequent dosing and off label indication. Effective 01/01/2022.

05/18/2022 – Reviewed and Updated for May P&T; the guideline was updated to reflect the preferred drug status of Xeljanz® (tofacitinib oral solution) which was recently added to the supplemental rebate contract; added indication for PJIA and criteria for moderate to severe plaque psoriasis. Matched MH UPPL effective 6/1/2022

Disclaimer

AllWays Health Partners complies with applicable federal civil rights laws and does not discriminate or exclude people on the basis of race, color, national origin, age, disability, or sex.