BlueCross BlueShield of Arizona
An Independent Licensee of the Blue Cross and Blue Shield Association

PHARMACY COVERAGE GUIDELINES	**ORIGINAL EFFECTIVE DATE: 1/01/13**
SECTION: DRUGS	**LAST REVIEW DATE: 9/20/18**
	LAST CRITERIA REVISION DATE: 9/20/18
	ARCHIVE DATE:

XELJANZ® (tofacitinib citrate) oral tablet
XELJANZ® XR (tofacitinib citrate extended-release) oral tablet

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Pharmacy Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Pharmacy Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Pharmacy Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Pharmacy Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

This Pharmacy Coverage Guideline does not apply to FEP or other states' Blues Plans.

Information about medications that require precertification is available at www.azblue.com/pharmacy.

Some large (100+) benefit plan groups may customize certain benefits, including adding or deleting precertification requirements.

All applicable benefit plan provisions apply, e.g., waiting periods, limitations, exclusions, waivers and benefit maximums.

Precertification for medication(s) or product(s) indicated in this guideline requires completion of the request form in its entirety with the chart notes as documentation. All requested data must be provided. Once completed the form must be signed by the prescribing provider and faxed back to BCBSAZ Pharmacy Management at (602) 864-3126 or emailed to Pharmacyprecert@azblue.com. **Incomplete forms or forms without the chart notes will be returned.**

XELJANZ® (tofacitinib citrate) oral tablet
XELJANZ® XR (tofacitinib citrate extended-release) oral tablet (cont.)

- **Criteria for initial therapy:** Xeljanz (tofacitinib citrate) or Xeljanz XR (tofacitinib citrate extended release) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

1. Prescriber is a Rheumatologist

2. Individual is 18 years of age or older

3. A confirmed diagnosis of **ONE** of the following:
    - Moderate to severe Rheumatoid arthritis identified by **ONE** of the following:
        - Clinical Disease Activity Index (CDAI) score greater than 10
        - Disease Activity Score 28 (DAS28) of greater than 3.2
        - Patient Activity Scale (PAS) of greater than 3.7
        - Patient Activity Scale II (PASII) of greater than 3.7
        - Routine Assessment of Patient Index Data 3 (RAPID-3) score greater than 2
        - Simplified Disease Activity Index (SDAI) score greater than 11
    - Moderate to severe active psoriatic arthritis
        - Diagnosis identified by **ONE** or more of the following:
            - Predominantly axial disease (i.e. sacroiliitis or spondylitis) as indicated by **ALL** of the following:
                - Radiographic evidence of axial disease (e.g., sacroiliac joint space narrowing or erosions, vertebral syndesmophytes)
                - Symptoms (e.g., limited spinal range of motion, spinal morning stiffness more than 30 minutes) present for more than 3 months' duration
                - Failure or intolerance of 2 or more different NSAIDs (at maximum recommended doses) over total period of at least 4 or more weeks of therapy
            - Predominantly non-axial disease, and failure of, intolerance to, or contraindication to both methotrexate and NSAIDs
        - Individual has failure, contraindication or intolerance to Otezla

4. Individual has failure, contraindication or intolerance to NSAIDs

5. Individual has failure, contraindication or intolerance to methotrexate

6. Individual has failure, contraindication or intolerance to non-biologic DMARDs (disease-modifying anti-rheumatic drugs)

7. Individual has a documented specific phobia of needle phobia as defined by American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (See Definition section)

8. **For Xeljanz XR 11 mg once daily** requests, the individual cannot use **Xeljanz IR 5mg twice daily** due to a documented non-adherence (medical record documentation of problem with adherence must be submitted with the request)

XELJANZ® (tofacitinib citrate) oral tablet
XELJANZ® XR (tofacitinib citrate extended-release) oral tablet (cont.)

9. Individual has failure, contraindication or intolerance to at least **TWO** of the **preferred TNF inhibitor** medications (unless it is not labeled for the indication being prescribed, refer to the **Small Molecules and Biologics Chart** in the ***References*** section) Preferred TNF inhibitors are:
    - Humira
    - Cimzia
    - Simponi
    - Remicade

10. **ALL** of the following baseline tests have been completed before initiation of treatment:
    - Tuberculosis, with a positive latent tuberculosis test, treatment for tuberculosis is initiated prior to use of **Xeljanz** or **Xeljanz XR**
    - Complete blood count with differential that shows **ALL** of the following:
        - Lymphocyte count is greater than 500 cells/cubic mm
        - Absolute neutrophil count is greater than 1,000 cells/cubic mm
        - Hemoglobin is greater than 9 g/dL

Initial approval duration: 12 months

- **Criteria for continuation of coverage (renewal request): Xeljanz** (tofacitinib citrate) or **Xeljanz XR** (tofacitinib citrate extended release) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

1. Individual's condition responded while on therapy
    - **Rheumatoid arthritis** response is defined as 20% improvement over baseline
    - **Psoriatic arthritis** response is defined as either 20% improvement over baseline

2. Individual has been adherent with the medication

3. There are no significant interacting drugs

Renewal duration: 12 months

Description:

Xeljanz (tofacitinib citrate) and Xeljanz XR (tofacitinib citrate extended-release) are indicated for adult individuals with moderately to severely active rheumatoid arthritis (RA) who have had an inadequate response or intolerance to methotrexate. Xeljanz (tofacitinib citrate) and Xeljanz XR (tofacitinib citrate extended-release) are also indicated for the treatment of adult individuals with active psoriatic arthritis who had an inadequate response or intolerance to methotrexate or other disease-modifying anti-rheumatic drugs (DMARDs). Tofacitinib citrate may be used as monotherapy or in combination with methotrexate or other non-biologic DMARDs. However, the efficacy of tofacitinib citrate as monotherapy has not been studied in psoriatic arthritis. Tofacitinib citrate should not be used in combination with biologic DMARDs or with potent immunosuppressive drugs such as azathioprine and cyclosporine.

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Tofacitinib inhibits the Janus family of tyrosine kinases. There are 4 known Janus kinases (JAKs): JAK1, JAK2, JAK3, and tyrosine kinase 2 (TyK2). JAKs are intracellular enzymes that transmit signals coming from cytokine or growth factor-receptor interactions on the cell membrane to influence hematopoiesis and immune cell function. Receptor binding of these kinases initiates intracellular signal pathways that regulate the transcription of genes for several cell products. JAK enzymes transmit signals through pairing of JAKs (such as JAK1/JAK3, JAK1/JAK2, JAK1/TyK2, and JAK2/JAK2). Within the signaling pathway, JAKs phosphorylate and activate Signal Transducers and Activators of Transcription (STATs) which modulate intracellular activity including gene expression. Interruption of these signaling pathways is thought to reduce the inflammatory response of RA. Tofacitinib inhibits the activities of JAK1/JAK2, JAK1/JAK3, JAK2/JAK2, to prevent the phosphorylation and activation of STATs.

Definitions:

The Child-Pugh classification system:
The Child-Pugh classification is a scoring system used to determine the prognosis of individuals with cirrhosis. Scoring is based upon several factors: albumin, ascites, total bilirubin, prothrombin time, and encephalopathy, as follows:

	Score: 1 point	Score: 2 points	Score: 3 points
Serum Albumin (g/dL)	>3.5	3.0 - 3.5	<3.0
Serum Bilirubin (mg/dL)	<2.0	2.0 - 3.0	>3.0
Prothrombin time (seconds)	1 - 4	4 - 6	>6
Ascites	none	moderate	severe
Encephalopathy	none	mild	severe

The three classes and their scores are:
- **Class A** is score 5 – 6: Well compensated
- **Class B** is score 7 – 9: Significant functional compromise
- **Class C** is score >9: Decompensated disease

Diagnosis of Rheumatoid Arthritis identified by ONE of the following:
- Clinical Disease Activity Index (CDAI) score > 10
- Disease Activity Score 28 (DAS28) of > 3.2
- Patient Activity Scale (PAS) > 3.7
- Patient Activity Scale II (PASII) > 3.7
- Routine Assessment of Patient Index Data 3 (RAPID-3) score > 2
- Simplified Disease Activity Index (SDAI) score > 11

Diagnosis active psoriatic arthritis as identified by either:
- Predominantly axial disease (i.e. sacroiliitis or spondylitis), as indicated by **ALL** of the following:
  - Radiographic evidence of axial disease (eg, sacroiliac joint space narrowing or erosions, vertebral syndesmophytes)
  - Symptoms (eg, limited spinal range of motion, spinal morning stiffness more than 30 minutes) present for more than 3 months' duration

- Failure or intolerance of 2 or more different NSAIDs (at maximum recommended doses) over total period of at least 4 or more weeks of therapy
- Predominantly non-axial disease, and failure of, intolerance to, or contraindication to both methotrexate and NSAIDs

Diagnostic criteria for specific phobia

For a specific phobia to be diagnosed, a number of criteria need to be met:

- The individual suffers from a persistent fear that is either unreasonable or excessive, caused by the presence or anticipation of a specific object or situation
- Exposure to the stimulus usually results in an anxiety response, often taking the form of a panic attack in adults, or a tantrum, clinging, crying or freezing in children
- The sufferer recognizes that their fear is disproportionate to the perceived threat or danger (not always present in children)
- Individuals take steps to avoid the object or situation they fear, or endure the experience with intense distress or anxiety
- The reaction, anticipation or avoidance interferes with the individual's normal routine and relationships, or causes significant distress
- The phobia has persisted for a period of time, usually six months or longer
- The symptoms cannot be attributed to another mental condition, such as obsessive-compulsive disorder or post-traumatic stress disorder

Symptoms

Specific phobia is characterized by a deep and persistent fear of an object or situation, resulting in symptoms of anxiety. Symptoms may also arise from anticipating the presence of the stimulus. Someone suffering from a specific disorder will also display avoidance behavior, taking steps to avoid having to confront the object or situation. Individuals may display symptoms of anxiety and experience:

- Palpitations
- Dizziness or unsteadiness
- Nausea
- Sweating
- Shaking or trembling
- An upset stomach
- Breathlessness

Resources:

"Small Molecules and Biologics Chart AP94", BCBSAZ Administrative Procedure Guideline when preferred TNF medications are otherwise contraindicated or not labeled for the indication being prescribed.

Xeljanz®/Xeljanz XR®. Package Insert. Revised by manufacturer 12/2017. Accessed 2/20/18.

BlueCross BlueShield Association Technology Evaluation Center Specialty Pharmacy Report #9-2012: Tofacitinib.

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Fax completed prior authorization request form to 602-864-3126 or email to pharmacyprecert@azblue.com.
Call 866-325-1794 to check the status of a request.
All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned.**
Pharmacy Coverage Guidelines are available at www.azblue.com/pharmacy.

Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.
REQUIRED: Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Member Information

Member Name (first & last):	Date of Birth:	Gender:	BCBSAZ ID#:
Address:	City:	State:	Zip Code:

Prescribing Provider Information

Provider Name (first & last):	Specialty:	NPI#:	DEA#:
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone:	Office Fax:	

Dispensing Pharmacy Information

Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information

Medication Name:	Strength:	Dosage Form:
Directions for Use:	Quantity: / Refills:	Duration of Therapy/Use:

☐ Check if requesting **brand** only ☐ Check if requesting **generic**

☐ Check if requesting continuation of therapy (prior authorization approved by BCBSAZ expired)

Turn-Around Time For Review

☐ Standard ☐ Urgent. Sign here: _____ ☐ Exigent (requires prescriber to include a written statement)

Clinical Information

1. **What is the diagnosis? Please specify below.**

   ICD-10 Code: _____ **Diagnosis Description:** _____

2. ☐ Yes ☐ No **Was this medication started on a recent hospital discharge or emergency room visit?**

3. ☐ Yes ☐ No **There is absence of ALL contraindications.**

4. **What medication(s) has the individual tried and failed for this diagnosis? Please specify below.**
Important note: Samples provided by the provider are not accepted as continuation of therapy or as an adequate trial and failure.

Medication Name, Strength, Frequency	Dates started and stopped or Approximate Duration	Describe response, reason for failure, or allergy

5. **Are there any supporting labs or test results? Please specify below.**

Date	Test	Value

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Pharmacy Prior Authorization Request Form

6. Is there any additional information the prescribing provider feels is important to this review? Please specify below.
For example, explain the negative impact on medical condition, safety issue, reason formulary agent is not suitable to a specific medical condition, expected adverse clinical outcome from use of formulary agent, or reason different dosage form or dose is needed.

Signature affirms that information given on this form is true and accurate and reflects office notes

Prescribing Provider's Signature: Date:

Please note: Some medications may require completion of a drug-specific request form.

Incomplete forms or forms without the chart notes will be returned.

Office notes, labs, and medical testing relevant to the request that show medical justification are required.