JAK INHIBITORS

Included Products: Rinvoq (upadacitinib), Xeljanz (tofacitinib), and Xeljanz XR (tofactinib)

Created: 11/14/2024 *Revised*: 11/14/2024 *Reviewed*: 11/14/2024 *Updated*: 12/01/2024

All Diagnoses

Initial Criteria: All Diagnoses		If yes	If no
1.	Is the requested agent indicated for or supported for use in the submitted diagnosis for the member's age?	Continue to #2.	Do not approve.
2.	Is the request for maintenance of remission in a patient who already achieved remission with the requested product or has already initiated therapy?	Continue to renewal criteria for the submitted diagnosis.	Continue to #3.
4.	Has the treatment been initiated by or is an appropriate specialist currently supervising it? a. Ankylosing Spondylitis and Axial Spondyloarthritis: Rheumatologist b. Crohn's Disease: Gastroenterologist c. Juvenile Idiopathic Arthritis: Rheumatologist d. Plaque Psoriasis: Dermatologist e. Psoriatic Arthritis: Dermatologist or Rheumatologist f. Ulcerative Colitis: Gastroenterologist	Continue to #5	Do not approve.
5.	Is the requested agent to be used in combination with another biologic or Otezla?	Do not approve.	Continue to #6.
6.	Has the member failed or have contraindications to infliximab?	Continue to #9.	Continue to #7.
7.	Is the member under 21 years old?	Continue to #8.	Do not approve.
8.	Has the member failed a TNF inhibitor or have or have contraindications to all TNF inhibitors?	Continue to #9.	Do not approve.

9.	Proceed to specific criteria for the submitted indication.		

Ankylosing Spondylitis and Axial Spondyloarthritis

Initial Criteria		If yes	If no
1.	Does the member have ankylosing spondylitis or axial spondyloarthritis (radiographic or non-radiographic)? Diagnosis is definitive if the following are met: a. Back pain and stiffness for more than 3 months AND b. Signs of active inflammation on MRI OR radiological evidence of sacroiliitis OR HLA-B27 positive.	Continue to #2.	Do not approve.
2.	Does the member have moderate to severe active disease at baseline, as evidenced by an objective test such as the BASDAI?	Continue to #3.	Do not approve.
3.	Is the member transitioning to the requested treatment from a different biologic product?	Continue to #5.	Continue to #4.
4.	Has the member tried and failed conventional therapy with both of the following: a. At least two NSAIDs for 3 months at maximum recommended or tolerated anti-inflammatory dose unless contraindicated, and b. Physical therapy/exercise program	Continue to #5.	Do not approve.
5.	Approve for 6 months.		
Renewal Criteria		**If yes**	**If no**
1.	Does the member have significant improvement in signs and symptoms of AS/SpA and/or functioning, such as ASAS40 or 2-point improvement in BASDAI?	Continue to #2.	Do not approve.

2.	Approve for 12 months.		

Crohn's Disease

Initial Criteria		If yes	If no
1.	Is the member transitioning to the requested treatment from a different biologic product?	Continue to #3.	Continue to #2.
2.	Does the member have moderate to severe Crohn's disease?	Continue to #3.	Do not approve.
3.	Has the member tried and failed the following biologics? a. Infliximab, AND b. Adalimumab	Continue to #4.	Do not approve.
4.	Approve for 6 months.		
Renewal Criteria		**If yes**	**If no**
1.	Has the member experienced a decrease in symptoms, reduction in enterocutaneous fistulas or clinical remission?	Continue to #2.	Do not approve.
2.	Approve for 12 months.		

Psoriatic Arthritis

Initial Criteria		If yes	If no
1.	Does the member have psoriatic arthritis based on at least 3 out of 5 of the following? a. Psoriasis (1 point for personal or family history, 2 points for current) b. Psoriatic nail dystrophy c. Negative test result for RF d. Dactylitis (current or history) e. Radiological evidence of juxta-articular new bone formation	Continue to #2.	Do not approve.
2.	Is the member transitioning to the requested treatment from a different biologic product?	Continue to #4.	Continue to #3.
3.	Has the member failed or have contraindications to conventional	Continue to #4.	Do not approve.

	management with all of the following? a. NSAIDs, and b. Methotrexate or other DMARD such as leflunomide, sulfasalazine, or cyclosporine.		
5.	Approve for 6 months.		
Renewal Criteria		If yes	If no
1.	Has the member experienced 20% or greater improvement in tender joint count and swollen joint count?	Continue to #2.	Do not approve.
2.	Approve for 12 months.		

Juvenile Idiopathic Arthritis

Initial Criteria		If yes	If no
1.	Does the member have juvenile idiopathic arthritis with active systemic features of JIA, with a physician global assessment of 5 or higher (or any systemic activity in the absence of active joint involvement)?	Continue to #3.	Continue to #2.
2.	Does the member have juvenile idiopathic arthritis without active systemic features of JIA?	Continue to #4.	Do not approve.
3.	Has the member tried and failed systemic corticosteroids?	Continue to #4.	Do not approve.
4.	Has the member tried and failed methotrexate or leflunomide for at least 3 months (or have a contraindication to both)?	Continue to #5.	Do not approve.
5.	Has the member tried and failed Actemra/Tyenne?	Continue to #6	Do not approve.
6.	Has the member tried and failed Cosentyx?	Continue to #7.	Do not approve.
7.	Approve for 6 months.		
Renewal Criteria		If yes	If no
1.	Has the member experienced 20% or greater improvement in tender joint count and swollen joint count or stabilization of active systemic activity?	Continue to #2.	Do not approve.
2.	Approve for 12 months.		

Rheumatoid Arthritis

Initial Criteria		If yes	If no
1.	Does the member have a baseline of moderate to high disease activity of rheumatoid arthritis measured as such by an accepted assessment instrument (PAS, PASII, RAPID3, CDAI, DAS28, SDAI)?	Continue to #2.	Do not approve.
2.	Is the member transitioning to the requested treatment from a different biologic product?	Continue to #5.	Continue to #3.
3.	Has the member tried and failed or have contraindications to methotrexate dosed at least 20mg per week for at least 8 weeks?	Continue to #4.	Do not approve.
4.	Has the member tried and failed or have contraindications to the following: leflunomide, hydroxychloroquine, or sulfasalazine?	Continue to #5.	Do not approve.
5.	Has the member tried and failed or have a contraindication to infliximab and adalimumab?	Continue to #6.	Do not approve.
7.	Approve for 6 months		
Renewal Criteria		**If yes**	**If no**
1.	Has the member experienced 20% or greater improvement in tender joint count and swollen joint?	Continue to #2.	Do not approve.
2.	Approve for 12 months.		

Ulcerative Colitis

Initial Criteria		If yes	If no
1.	Is the member transitioning to the requested treatment from a different biologic product?	Continue to #3.	Continue to #2.
2.	Does the member have a diagnosis of moderate to severe ulcerative colitis defined by the following criteria? a. Moderate = greater than or equal to 4 stools daily. b. Severe = greater than or equal to 6 bloody stools daily and evidence of toxicity such as fever, anemia, elevated ESR, or tachycardia.	Continue to #3.	Do not approve.
3.	Has the member tried and failed or have a	Continue to #4.	Do not approve.

	contraindication to ALL of the following? a. Infliximab, AND b. Adalimumab, AND		
4.	Approve for 6 months.		
Renewal Criteria		If yes	If no
1.	Has the member demonstrated a significant response including the following? a. Decrease in bloody stools per day and/or b. Elimination of signs of toxicity	Continue to #2.	Do not approve.
2.	Approve for 12 months.		

Atopic Dermatitis

Initial Criteria		If yes	If no
1.	Is the member under the age of 21?	Continue to #2.	Continue to #4.
2.	Does the member meet all of the following: a. Has chronic, moderate to severe atopic dermatitis (10% BSA, or hand, foot, face or mucous membrane involvement) with functional impairment; AND b. Failure of a combination of steroid and nonsteroid topical medications.	Continue to #6.	Continue to #3.
3.	Has a medical director reviewed to confirm it is medically necessary and appropriate to treat Dupixent?	Continue to #6.	Do not approve based on medical necessity or appropriateness.
4.	Does the member meet all of the following: a. Has chronic, moderate to severe atopic dermatitis (10% BSA, or hand, foot, face or mucous membrane involvement) with functional impairment; AND b. Failure of TWO of the following: i. a combination of steroid and nonsteroid topical medications; OR ii. An oral DMARD such as methotrexate or cyclosporine; OR iii. Phototherapy.	Continue to #5.	Do not approve.
5.	Has the member tried and failed Dupixent or Adbry?	Continue to #6	Do not approve.

6.	Approve for 6 months.		
Renewal Criteria		If yes	If no
1.	Has the member experienced a 50% reduction in eczema and/or is there evidence of significant functional improvement?	Continue to #2.	Do not approve.
2.	Approve for 12 months		