

## **Clinical Policy: Tofacitinib (Xeljanz, Xeljanz XR)**

Reference Number: CP.PHAR.267

Effective Date: 01.30.18

Last Review Date: 05.18

Line of Business: HIM\*, Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### **Description**

Tofacitinib (Xeljanz<sup>®</sup>, Xeljanz<sup>®</sup> XR) is a Janus kinase (JAK) inhibitor.

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*\*For Health Insurance Marketplace (HIM), Xeljanz XR is non-formulary and cannot be approved using these criteria; refer to the formulary exception policy, HIM.PA.103.*

### **FDA Approved Indication(s)**

Xeljanz and Xeljanz XR are indicated for the treatment of:

- Adult patients with moderately to severely active rheumatoid arthritis (RA) who have had an inadequate response or intolerance to methotrexate (MTX). They may be used as monotherapy or in combination with MTX or other nonbiologic disease-modifying antirheumatic drugs (DMARDs).
- Adult patients with active psoriatic arthritis (PsA) who have had an inadequate response or intolerance to methotrexate or other DMARDs.

Limitation(s) of use: Use of Xeljanz/Xeljanz XR in combination with biologic DMARDs or potent immunosuppressants such as azathioprine and cyclosporine is not recommended.

### **Policy/Criteria**

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that Xeljanz and Xeljanz XR are **medically necessary** when the following criteria are met:

#### **I. Initial Approval Criteria**

##### **A. Rheumatoid Arthritis (must meet all):**

1. Diagnosis of RA;
2. Prescribed by or in consultation with a rheumatologist;
3. Age  $\geq$  18 years;
4. Member meets one of the following (a or b):
  - a. Failure of a  $\geq$  3 consecutive month trial of MTX at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
  - b. If intolerance or contraindication to MTX (*see Appendix C*), failure of a  $\geq$  3 consecutive month trial of at least ONE conventional DMARD (e.g., sulfasalazine, leflunomide, hydroxychloroquine) at up to maximally indicated

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doses, unless contraindicated or clinically significant adverse effects are experienced;

5. Failure of etanercept (*Enbrel*<sup>®</sup> is preferred) AND adalimumab (*Humira*<sup>®</sup> is preferred), each used for  $\geq 3$  consecutive months, unless contraindicated or clinically significant adverse effects are experienced;  
*\*Prior authorization is required for etanercept and adalimumab*
6. Dose does not exceed one of the following (a or b):
  - a. Xeljanz: 10 mg per day;
  - b. Xeljanz XR: 11 mg per day.

**Approval duration:**

**Medicaid** – 6 months

**HIM** – 6 months for Xeljanz XR (*refer to HIM.PA.103 for Xeljanz XR*)

**B. Psoriatic Arthritis (must meet all):**

1. Diagnosis of PsA;
2. Prescribed by or in consultation with a dermatologist or rheumatologist;
3. Age  $\geq 18$  years;
4. Member meets one of the following (a or b):
  - a. Failure of a  $\geq 3$  consecutive month trial of MTX at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
  - b. If intolerance or contraindication to MTX (*see Appendix C*), failure of a 3-month trial of cyclosporine, sulfasalazine, leflunomide, at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
5. Failure of etanercept (*Enbrel is preferred*) and adalimumab (*Humira is preferred*), each used for  $\geq 3$  consecutive months, unless contraindicated or clinically significant adverse effects are experienced;  
*\*Prior authorization is required for etanercept and adalimumab*
6. Dose does not exceed one of the following (a or b):
  - a. Xeljanz: 10 mg per day;
  - b. Xeljanz XR: 11 mg per day.

**Approval duration:**

**Medicaid** – 6 months

**HIM** – 6 months for Xeljanz XR (*refer to HIM.PA.103 for Xeljanz XR*)

**C. Other diagnoses/indications**

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid.

**II. Continued Therapy****A. All Indications in Section I (must meet all):**

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1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed one of the following (a or b):
  - a. Xeljanz: 10 mg per day;
  - b. Xeljanz XR: 11 mg per day.

**Approval duration:**

**Medicaid** – 12 months

**HIM** – 12 months for Xeljanz XR (*refer to HIM.PA.103 for Xeljanz XR*)

**B. Other diagnoses/indications (must meet 1 or 2):**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

**Approval duration: Duration of request or 6 months (whichever is less);** or

2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid.

**III. Diagnoses/Indications for which coverage is NOT authorized:**

- A.** Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid or evidence of coverage documents.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

DMARDs: disease-modifying

antirheumatic drugs

FDA: Food and Drug Administration

JAK: Janus kinase

MTX: methotrexate

RA: rheumatoid arthritis

PsA: psoriatic arthritis

*Appendix B: Therapeutic Alternatives*

*This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.*

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
azathioprine (Azasan <sup>®</sup> , Imuran <sup>®</sup> )	<b>RA</b> 1 mg/kg/day PO QD or divided BID	2.5 mg/kg/day
Cuprimine <sup>®</sup> (d-penicillamine)	<b>RA*</b> <u>Initial dose:</u> 125 or 250 mg PO QD <u>Maintenance dose:</u>	1,500 mg/day

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Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	500 – 750 mg/day PO QD	
cyclosporine (Sandimmune <sup>®</sup> , Neoral <sup>®</sup> )	<b>PsA*</b> 2.5-3 mg/kg/day PO QD  <b>RA</b> 2.5 – 4 mg/kg/day PO divided BID	PsA: 3 mg/kg/day  RA: 4 mg/kg/day
hydroxychloroquine (Plaquenil <sup>®</sup> )	<b>RA*</b> <u>Initial dose:</u> 400 – 600 mg/day PO QD <u>Maintenance dose:</u> 200 – 400 mg/day PO QD	600 mg/day
leflunomide (Arava <sup>®</sup> )	<b>PsA*</b> 100 mg/day PO loading dose for 3 days followed by 20 mg/day PO QD  <b>RA</b> 100 mg PO QD for 3 days, then 20 mg PO QD	20 mg/day
methotrexate (Rheumatrex <sup>®</sup> )	<b>PsA*</b> 7.5 – 15 mg/week PO  <b>RA</b> 7.5 mg/week PO, SC, or IM or 2.5 mg PO Q12 hr for 3 doses/week	30 mg/week
Ridaura <sup>®</sup> (auranofin)	<b>RA</b> 6 mg PO QD or 3 mg PO BID	9 mg/day (3 mg TID)
sulfasalazine (Azulfidine <sup>®</sup> )	<b>PsA*</b> 2 g/day PO QD  <b>RA</b> 2 g/day PO in divided doses	PsA: 5 g/day  RA: 3 g/day
Enbrel <sup>®</sup> (etanercept)	<b>PsA, RA</b> 25 mg SC twice weekly or 50 mg SC once weekly	50 mg/week
Humira <sup>®</sup> (adalimumab)	<b>PsA</b> 40 mg SC every other week  <b>RA</b> 40 mg SC every other week (may increase to once weekly)	PsA: 40 mg every other week  RA: 40 mg/week

Therapeutic alternatives are listed as Brand name<sup>®</sup> (generic) when the drug is available by brand name only and generic (Brand name<sup>®</sup>) when the drug is available by both brand and generic.

\*Off-label

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#### Appendix D: General Information

- Definition of failure of MTX or DMARDs
  - Child-bearing age is not considered a contraindication for use of MTX. Each drug has risks in pregnancy. An educated patient and family planning would allow use of MTX in patients who have no intention of immediate pregnancy.
  - Social use of alcohol is not considered a contraindication for use of MTX. MTX may only be contraindicated if patients choose to drink over 14 units of alcohol per week. However, excessive alcohol drinking can lead to worsening of the condition, so patients who are serious about clinical response to therapy should refrain from excessive alcohol consumption.
- Examples of positive response to therapy may include, but are not limited to:
  - Reduction in joint pain/swelling/tenderness
  - Improvement in erythrocyte sedimentation rates/C-reactive protein (ESR/CRP) levels
  - Improvements in activities of daily living

#### V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Tofacitinib (Xeljanz)	PsA	5 mg PO BID	10 mg/day
	RA		
Tofacitinib extended-release (Xeljanz XR)	PsA	11 mg PO QD	11 mg/day
	RA		

#### VI. Product Availability

Drug Name	Availability
Tofacitinib (Xeljanz)	Tablets: 5 mg
Tofacitinib extended-release (Xeljanz XR)	Tablets: 11 mg

#### VII. References

1. Xeljanz/Xeljanz XR Prescribing Information. New York, NY: Pfizer Labs. December 2017. Available at: [www.xeljanz.com](http://www.xeljanz.com). Accessed February 27, 2017.
2. Singh JA, Furst DE, Bharat A, et al. 2012 Update of the 2008 American College of Rheumatology recommendations for the use of disease-modifying antirheumatic drugs and biologic agents in the treatment of rheumatoid arthritis. *Arthritis Care Res.* 2012;64(5):625-639.
3. Singh JA, Saag KG, Bridges SL, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Rheumatology* 2016. 68(1):1-26.
4. Van Vollenhoven RF, Fleischmann R, Cohen S, et al. Tofacitinib or adalimumab versus placebo in rheumatoid arthritis. *N Engl J Med.* 2012;367:508-519.
5. Fleischmann R, Kremer J, Cush J, et al. Placebo-controlled trial of tofacitinib monotherapy in rheumatoid arthritis. *N Engl J Med.* 2012;367:495-507.

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Reviews, Revisions, and Approvals	Date	P&T Approval Date
<p>Medicaid: Policy split from CP.PHAR.86 Rheumatoid &amp; Juvenile Arthritis &amp; Ankylosing Spondylitis Treatments. Policy converted to new template.</p> <p>Removed contraindications of HBV and malignant disease; added dosing requirements; modified criteria to require trial of methotrexate, unless contraindicated; added sulfasalazine as an alternative to MTX if MTX is contraindicated; added requirement for trial and failure of PDL Enbrel and Humira, unless contraindicated; Added the XR formulation to policy.</p> <p>Re-auth: added dosing and reasons to discontinue.</p> <p>Modified approval duration to 6 months for initial and 12 months for renewal; Updated reasons for discontinuation to contraindications and warning and precautions when initiating treatment should be avoided per PI.</p>	06.16	07.16
<p>Medicaid: Converted to new template. Revised criteria for confirmation of RA diagnosis per 2010 ACR Criteria. Removed safety requirements per updated CPAC Safety Precaution in PA Policies approach.</p>	07.17	07.17
<p>2Q 2018 annual review: criteria added for new FDA indication: psoriatic arthritis; added HIM ; removed TB testing requirement for RA; references reviewed and updated.</p>	02.27.18	05.18

#### **Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

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This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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**Note:**

**For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

**For Health Insurance Marketplace members**, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy.

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