maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Rinvoq

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	Will the requested medication be used in combination with a biologic or targeted synthetic disease modifying antirheumatic drugs (DMARDS)? [Note: Examples of biologics include but are not limited to adalimumab SC products (Humira, biosimilars), Actemra (IV or SC), Cimzia, Cosentyx, an etanercept SC product (for example, Enbrel, biosimilars), Ilumya, Skyrizi, Kevzara, Kineret, Orencia (IV or SC), infliximab IV products (for example, Remicade, biosimilars), rituximab IV products (for example, Rituxan, biosimilars), Siliq, Stelara (IV or SC), Taltz, Tremfya, Entyvio, or Simponi (Aria or SC). Examples of targeted synthetic DMARD include but are not limited to Olumiant, Otezla, Rinvoq or Xeljanz/XR.] [If yes, no further questions.]	Yes	No

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1-888-258-8250

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2	Will the requested medication be used in combination with a biologic immunomodulator? [Note: Examples of biologic immunomodulators include Adbry, Cinqair, Dupixent, Fasenra, Nucala, Tezspire, and Xolair.] [If yes, no further questions.]	Yes	No
3	Will the requested medication be used in combination with other Janus Kinase Inhibitors (JAKis)? [Note: Examples of JAKis include but are not limited to Cibinqo, Xeljanz/XR, Olumiant.] [If yes, no further questions.]	Yes	No
4	Will the requested medication be used in combination with other potent immunosuppressants (for example, azathioprine, cyclosporine)? [Note: This does not include the use of requested medication with methotrexate.] [If yes, no further questions.]	Yes	No
5	Is the patient currently receiving the requested medication? [If no, skip to question 28.]	Yes	No
6	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 28.]	Yes	No
7	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 9.]	Yes	No
8	Has the patient been established on therapy for at least 3 months? [if yes, skip to question 10.] [If no, skip to question 28.]	Yes	No
9	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 28.] [If no, no further questions.]	Yes	No
10	What is the diagnosis or indication? [] Ankylosing spondylitis (If checked, go to 11) [] Atopic dermatitis (If checked, go to 14) [] Psoriatic arthritis (If checked, go to 15) [] Rheumatoid arthritis (If checked, go to 17) [] Ulcerative colitis (If checked, go to 19)		

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[] Non-radiographic axial spondyloarthritis (If checked, go to 22)

[] Crohn's disease (If checked, go to 25)

[] COVID-19 (Coronavirus Disease 2019) [Note: This includes requests for cytokine release syndrome associated with COVID-19.] (If checked, no further questions)

[] Other (If checked, no further questions)

11	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
12	Has documentation been submitted to confirm that the patient has experienced a beneficial clinical response from baseline when assessed by at least one objective measure? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of objective measures include Ankylosing Spondylitis Disease Activity Score (ASDAS), Ankylosing Spondylitis Quality of Life Scale (ASQoL), Bath Ankylosing Spondylitis Disease Activity Index (BASDAI), Bath Ankylosing Spondylitis Functional Index (BASFI), Bath Ankylosing Spondylitis Global Score (BAS-G), Bath Ankylosing Spondylitis Metrology Index (BASMI), Dougados Functional Index (DFI), Health Assessment Questionnaire for the Spondylarthropathies (HAQ-S), and/or serum markers (for example, C-reactive protein, erythrocyte sedimentation rate).] [If yes, no further questions.]	Yes	No
13	Compared with baseline, has the patient experienced an improvement in at least one symptom, such as decreased pain or stiffness, or improvement in function or activities of daily living? [No further questions.]	Yes	No
14	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
15	Has the patient experienced a beneficial clinical response from baseline when assessed by at least one objective measure? [Note: Examples of objective measures of disease activity include Disease Activity Index for Psoriatic Arthritis (DAPSA), Composite Psoriatic Disease Activity Index (CPDAI), Psoriatic Arthritis Disease Activity Score (PsA DAS), Grace Index, Leeds Enthesitis Score (LEI), Spondyloarthritis Consortium of Canada (SPARCC) enthesitis score, Leeds Dactylitis Instrument Score, Minimal Disease Activity (MDA), Psoriatic Arthritis Impact of Disease (PsAID-12), and/or serum markers (for example, C-reactive protein, erythrocyte sedimentation rate).] [If yes, no further questions.]	Yes	No

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16	Compared with baseline, has the patient experienced an improvement in at least one symptom, such as decreased pain or stiffness, or improvement in function or activities of daily living? [No further questions.]	Yes	No
17	Has the patient experienced a beneficial clinical response when assessed by at least one objective measure? [Note: Examples of standardized and validated measures of disease activity include Clinical Disease Activity Index (CDAI), Disease Activity Score (DAS) 28 using erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP), Patient Activity Scale (PAS)-II, Rapid Assessment of Patient Index Data 3 (RAPID-3), and/or Simplified Disease Activity Index (SDAI).] [If yes, no further questions.]	Yes	No
18	Has the patient experienced an improvement in at least one symptom, such as decreased joint pain, morning stiffness or fatigue, improved function or activities of daily living, or decreased soft tissue swelling in joints or tendon sheaths? [No further questions.]	Yes	No
19	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
20	Has documentation been submitted to confirm that the patient has experienced a beneficial clinical response from baseline when assessed by at least one objective measure? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of objective measures include fecal markers (for example, fecal calprotectin), serum markers (for example, C-reactive protein), endoscopic assessment, and/or reduced dose of corticosteroids.] [If yes, no further questions.]	Yes	No
21	Has documentation been submitted to confirm that compared with baseline, the patient has a clinical improvement in at least one symptom, such as decreased pain, fatigue, stool frequency, and/or rectal bleeding? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
22	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
23	Has the patient experienced a beneficial clinical response from baseline when assessed by at least one objective measure? [Note: Examples of objective measures include Ankylosing Spondylitis Disease Activity Score (ASDAS), Ankylosing Spondylitis Quality of Life Scale (ASQoL), Bath Ankylosing Spondylitis Disease Activity Index (BASDAI), Bath Ankylosing	Yes	No

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	Spondylitis Functional Index (BASFI), Bath Ankylosing Spondylitis Global Score (BAS-G), Bath Ankylosing Spondylitis Metrology Index (BASMI), Dougados Functional Index (DFI), Health Assessment Questionnaire for the Spondylarthropathies (HAQ-S), and/or serum markers (for example, C-reactive protein, erythrocyte sedimentation rate).] [If yes, no further questions.]		
24	Compared with baseline, has the patient experienced an improvement in at least one symptom, such as decreased pain or stiffness, or improvement in function or activities of daily living? [No further questions.]	Yes	No
25	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
26	Has the patient experienced a beneficial clinical response from baseline (prior to initiating the requested medication) when assessed by at least one objective measure? [Note: Examples of objective measures include fecal markers (for example, fecal calprotectin), serum markers (for example, C-reactive protein), imaging studies (for example, magnetic resonance enterography, computed tomography enterography), endoscopic assessment, and/or reduced dose of corticosteroids.] [If yes, no further questions.]	Yes	No
27	Compared with baseline (prior to initiating the requested medication), has the patient experienced an improvement in at least one symptom, such as decreased pain, fatigue, stool frequency, and/or blood in stool? [No further questions.]	Yes	No
28	What is the diagnosis or indication? [] Ankylosing spondylitis (If checked, go to 29) [] Atopic dermatitis (If checked, go to 35) [] Psoriatic arthritis (If checked, go to 47) [] Rheumatoid arthritis (If checked, go to 48) [] Ulcerative colitis (If checked, go to 55) [] Non-radiographic axial spondyloarthritis (If checked, go to 65) [] Crohn's disease (If checked, go to 71) [] COVID-19 (Coronavirus Disease 2019) [Note: This includes requests for cytokine release syndrome associated with COVID-19.] (If checked, no further questions) [] Other (If checked, no further questions)		

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29	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
30	Does the patient have a documented diagnosis of active ankylosing spondylitis? [if no, no further questions.]	Yes	No
31	Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with preferred TNF inhibitors, Enbrel (etanercept) and an adalimumab product (Hadlima, Yusimry, or adalimumab- adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
32	Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with Xeljanz (tofacitinib)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
33	Is the requested medication being prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
34	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the requested indication? [No further questions.]	Yes	No
35	Is the patient greater than or equal to 12 years of age? [If no, no further questions.]	Yes	No
36	Does the patient have a documented diagnosis of refractory, moderate to severe atopic dermatitis? [If no, no further questions.]	Yes	No
37	Has the patient tried at least TWO traditional systemic therapies for at least 3 months? [Note: Examples of traditional systemic therapies include methotrexate, azathioprine, cyclosporine, and mycophenolate mofetil.] [If yes, skip to question 45.]	Yes	No
38	Has documentation been submitted to confirm that the patient has an intolerance to at least two traditional systemic therapy agents? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of traditional systemic therapies include methotrexate, azathioprine, cyclosporine, and mycophenolate mofetil.] [If yes, skip to question 45.]	Yes	No
39	Has the patient tried Dupixent (dupilumab subcutaneous injection) or Adbry (tralokinumab-ldrm subcutaneous injection)? [If yes, skip to question 45.]	Yes	No

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40	Does the provider attest that the patient has tried at least two medium-, medium-high, high-, and/or super-high potency prescription topical corticosteroids or is the request to treat the face or eyes/eyelid area? [If no, skip to question 44.]	Yes	No
41	Does the provider attest that the patient has tried tacrolimus ointment for at least 28 consecutive days and inadequate efficacy was demonstrated? [If no, skip to question 44.]	Yes	No
42	Does the provider attest that the patient has tried at least ONE traditional systemic therapy for at least 3 months? [If yes, skip to question 45.]	Yes	No
43	Has documentation been submitted to confirm that the patient has an intolerance to at least one traditional systemic therapy agents? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 45.]	Yes	No
44	Does the patient have disease severity that precludes the use of traditional systemic therapies? [If no, no further questions.]	Yes	No
45	Is the requested medication being prescribed by or in consultation with an allergist, immunologist, or dermatologist? [If no, no further questions.]	Yes	No
46	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the requested indication? [No further questions.]	Yes	No
47	Is the requested medication being prescribed by or in consultation with a rheumatologist or a dermatologist? [If yes, skip to question 49.] [If no, no further questions.]	Yes	No
48	Is the requested medication being prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
49	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
50	Has the patient tried at least TWO conventional synthetic disease-modifying antirheumatic drugs (DMARD) for at least 3 months? [Note: Examples of conventional synthetic DMARDs include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.] [If yes, skip to question 52.]	Yes	No

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51	Has documentation been submitted to confirm that the patient has an intolerance to at least two of the DMARD agents? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of conventional synthetic DMARDs include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.] [If no, no further questions.]	Yes	No
52	Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with preferred TNF inhibitors, Enbrel (etanercept) and an adalimumab product (Hadlima, Yusimry, or adalimumab- adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
53	Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with Xeljanz (tofacitinib)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
54	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the requested indication? [No further questions.]	Yes	No
55	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
56	Does the patient have a documented diagnosis of moderately to severely active ulcerative colitis? [If no, no further questions.]	Yes	No
57	Has the patient tried at least TWO traditional systemic therapies for at least 3 months? [Note: Examples include 6- mercaptopurine, azathioprine, cyclosporine, tacrolimus, or a corticosteroid such as prednisone or methylprednisolone.] [If yes, skip to question 61.]	Yes	No
58	Has documentation been submitted to confirm that the patient has an intolerance to at least two traditional systemic therapy agents? ACTION REQUIRED: Submit supporting documentation. [Note: Examples include 6-mercaptopurine, azathioprine, cyclosporine, tacrolimus, or a corticosteroid such as prednisone or methylprednisolone.] [If yes, skip to question 61.]	Yes	No
59	Does the patient have pouchitis? [If no, no further questions.]	Yes	No
60	Has the patient tried therapy with an antibiotic, probiotic, corticosteroid enema, or Rowasa (mesalamine) enema? [Note: Examples of antibiotics include metronidazole and ciprofloxacin. Examples	Yes	No

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	of corticosteroid enemas include hydrocortisone enema (Cortenema, generics).] [If no, no further questions.]		
61	Has documentation been submitted to confirm that the patient has had an intolerance, contraindication to, or failed treatment for at least 3 months with the preferred TNF inhibitor, an adalimumab product (Hadlima, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
62	Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with Xeljanz (tofacitinib)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
63	Is the requested medication being prescribed by or in consultation with a gastroenterologist? [If no, no further questions.]	Yes	No
64	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the requested indication? [No further questions.]	Yes	No
65	Does the patient have a documented diagnosis of non-radiographic axial spondyloarthritis? [If no, no further questions.]	Yes	No
66	Does the patient have objective signs of inflammation, defined as C-reactive protein elevated beyond the upper limit of normal for the reporting laboratory? [If yes, skip to question 68.]	Yes	No
67	Does the patient have objective signs of inflammation, defined as sacroiliitis reported on magnetic resonance imaging? [If no, no further questions.]	Yes	No
68	Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with preferred TNF inhibitors, Enbrel (etanercept) and an adalimumab product (Hadlima, Yusimry, or adalimumab- adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
69	Is the requested medication being prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
70	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the requested indication? [No further questions.]	Yes	No

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71	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
72	Has documentation been submitted to confirm that the patient has a diagnosis of moderate to severe Crohn's disease? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
73	Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment with a corticosteroid (such as, prednisone or methylprednisolone)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
74	Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with at least TWO conventional systemic therapies (such as azathioprine, 6-mercaptopurine, or methotrexate)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
75	Has documentation been submitted to confirm that the patient has had an intolerance, contraindication to, or failed treatment for at least 3 months with the preferred TNF inhibitor, an adalimumab product (Hadlima, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
76	Is the requested medication being prescribed by or in consultation with a gastroenterologist? [If no, no further questions.]	Yes	No
77	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the requested indication?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

If you have any questions, call: 1-888-258-8250

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Medicaid with a Heart

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FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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