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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1 Is this request for initial therapy or for a continuation of therapy?

[] Initial (If checked, go to 7)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No
[If no, skip to question 7.]

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3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 7.]	Yes	No
4	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 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	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
7	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
8	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
9	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, and Olumiant.] [If yes, no further questions.]	Yes	No
10	Will the requested medication be used in combination with other potent immunosuppressants (for example, azathioprine, or cyclosporine)? [Note: This does not include the use of requested medication with methotrexate.] [If yes, no further questions.]	Yes	No
11	What is the diagnosis or indication? [] Ankylosing spondylitis (If checked, go to 12)		

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[] Atopic dermatitis (If checked, go to 18)

[] Psoriatic arthritis (If checked, go to 27)

[] Rheumatoid arthritis (If checked, go to 35)

[] Ulcerative colitis (If checked, go to 42)

[] Non-radiographic axial spondyloarthritis (If checked, go to 56)

[] Crohn's disease (If checked, go to 63)

[] Polyarticular juvenile idiopathic arthritis (If checked, go to 70)

[] Giant Cell Arteritis (If checked, go to 78)

[] 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)

12	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
13	Does the patient have a documented diagnosis of active ankylosing spondylitis? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
14	Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with preferred tumor necrosis factor (TNF) inhibitor, an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab- adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
15	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
16	Is the requested medication being prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
17	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the requested indication? [Note: Dosing is 15 mg orally once daily.] [No further questions.]	Yes	No

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18	Is the patient greater than or equal to 12 years of age? [If no, no further questions.]	Yes	No
19	Does the patient have a documented diagnosis of refractory, moderate to severe atopic dermatitis? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
20	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 22.]	Yes	No
21	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 no, no further questions.]	Yes	No
22	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, no further questions.]	Yes	No
23	Does the provider attest that the patient has tried tacrolimus ointment for at least 28 consecutive days and inadequate efficacy was demonstrated? [If no, no further questions.]	Yes	No
24	Has the patient tried Dupixent (dupilumab subcutaneous injection) or Adbry (tralokinumab-ldrm subcutaneous injection)? [If no, no further questions.]	Yes	No
25	Is the requested medication being prescribed by or in consultation with an allergist, immunologist, or dermatologist? [If no, no further questions.]	Yes	No
26	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the requested indication? [Note: Dosing is 15 mg orally once daily.] [No further questions.]	Yes	No
27	Is the patient greater than or equal to 2 years of age? [If no, no further questions.]	Yes	No
28	Has the patient tried at least TWO conventional synthetic disease-modifying antirheumatic drugs (DMARDs) for at least 3 months? [Note: Examples of conventional synthetic DMARDs include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.]	Yes	No

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	[If yes, skip to question 30.]		
29	Has documentation been submitted to confirm that the patient has an intolerance to at least TWO of the conventional synthetic disease-modifying antirheumatic drugs (DMARDs)? 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
30	Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with preferred tumor necrosis factor (TNF) inhibitor, an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab- adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
31	Has documentation been submitted to confirm that the patient has had a treatment failure with a preferred ustekinumab product (Yesintek, Pyzchiva, Stegeyma) for at least 3 months, or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit support 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 or dermatologist? [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? [Note: Dosing is 15 mg orally once daily.] [No further questions.]	Yes	No
35	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
36	Has the patient tried at least TWO conventional synthetic disease-modifying antirheumatic drugs (DMARDs) 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 38.]	Yes	No
37	Has documentation been submitted to confirm that the patient has an intolerance to at least TWO of the conventional synthetic DMARD agents? ACTION REQUIRED: Submit supporting documentation.	Yes	No

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	[Note: Examples of conventional synthetic DMARDs include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.] [If no, no further questions.]		
38	Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with preferred tumor necrosis factor (TNF) inhibitor, an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
39	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
40	Is the requested medication being prescribed by or in consultation with a rheumatologist or dermatologist? [If no, no further questions.]	Yes	No
41	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the requested indication? [Note: Dosing is 15 mg orally once daily.] [No further questions.]	Yes	No
42	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
43	Has the patient tried at least TWO traditional systemic therapies for at least 3 months? [Note: Examples include 6-mercaptopurine, azathioprine, cyclosporine, and tacrolimus.] [If yes, skip to question 45.]	Yes	No
44	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, or tacrolimus.] [If no, no further questions.]	Yes	No
45	Does the patient have pouchitis? [If no, no further questions.]	Yes	No
46	Has the patient tried therapy with an antibiotic, probiotic, corticosteroid enema, or Rowasa (mesalamine) enema? [Note: Examples of antibiotics include metronidazole and ciprofloxacin. Examples of corticosteroid enemas include hydrocortisone enema (Cortenema, generics).] [If no, no further questions.]	Yes	No

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47	Has the patient been diagnosed with moderate to severe ulcerative colitis? [If no, skip to question 50.]	Yes	No
48	Has documentation been submitted to confirm that the patient has moderate to severe symptoms? ACTION REQUIRED: Submit supporting documentation. [Note: Examples include Mayo endoscopy sub-score greater than or equal to 2, greater than 6 bowel movement per day, greater than or equal to 4 bloody stools per day, hemoglobin less than 75% normal (males less than 10 g/dL, females less than 9 g/dL).] [If yes, skip to question 53.]	Yes	No
49	Has documentation been submitted to confirm that the patient has mildly active symptoms with poor prognosis factors for disease severity? ACTION REQUIRED: Submit supporting documentation. [Note: Examples include Mayo endoscopy sub-score of 3, extensive colitis, corticosteroid dependence (unable to taper after 3 months of continuous therapy), elevated C-reactive protein (CRP) greater than or equal to 10 mg/dL, low serum albumin less than 3.4 mg/dL.] [If yes, skip to question 53.]	Yes	No
50	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 tumor necrosis factor (TNF) inhibitor, an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
51	Has documentation been submitted to confirm that the patient has had a treatment failure with a preferred ustekinumab product (Yesintek, Pyzchiva, Steqeyma) for at least 3 months, or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation. [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 Xeljanz (tofacitinib)? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 54.] [If no, no further questions.]	Yes	No
53	Has documentation been submitted to confirm that the patient has had an intolerance, contraindication to, or failed treatment for at least 3 months with a preferred Infliximab product? ACTION REQUIRED: Submit supporting documentation. [Note: Infusion dates and dosages required.] [If no, no further questions.]	Yes	No
54	Is the requested medication being prescribed by or in consultation with a	Yes	No

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	gastroenterologist? [If no, no further questions.]		
55	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the requested indication? [Note: Dosing is 45 mg orally once daily for 8 weeks and then 15 mg once daily thereafter.] [No further questions.]	Yes	No
56	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
57	Does the patient have a documented diagnosis of non-radiographic axial spondyloarthritis? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
58	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 60.]	Yes	No
59	Does the patient have objective signs of inflammation, defined as sacroiliitis reported on magnetic resonance imaging? [If no, no further questions.]	Yes	No
60	Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment for at least 3 months with preferred tumor necrosis factor (TNF) inhibitor, an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
61	Is the requested medication being prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
62	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the requested indication? [Note: Dosing is 15 mg orally once daily.] [No further questions.]	Yes	No
63	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
64	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

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65	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
66	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 tumor necrosis factor (TNF) inhibitor, an adalimumab product (Hadlima, Yusimry, Simlandi, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
67	Has documentation been submitted to confirm that the patient has had a treatment failure with a preferred ustekinumab product (Yesintek, Pyzchiva, or Steqeyma) for at least 3 months, or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
68	Is the requested medication being prescribed by or in consultation with a gastroenterologist? [If no, no further questions.]	Yes	No
69	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the requested indication? [Note: Dosing is 45 mg orally once daily for 12 weeks, and then 15 mg orally once daily thereafter.] [No further questions.]	Yes	No
70	Is the patient greater than or equal to 2 years of age? [If no, no further questions.]	Yes	No
71	Has the patient tried ONE other agent for at least 3 months for the patient's condition? [Note: Examples of other agents for juvenile idiopathic arthritis (JIA) include but not limited to methotrexate (MTX), sulfasalazine, or leflunomide.] [If yes, skip to question 73.]	Yes	No
72	Does the patient have an absolute contraindication to methotrexate (MTX), sulfasalazine, or leflunomide? [Note: Examples of contraindications to MTX include pregnancy, breast feeding, alcoholic liver disease, immunodeficiency syndrome, and blood dyscrasias.] [If no, no further questions.]	Yes	No
73	Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 3 months with preferred tumor necrosis factor (TNF) inhibitor, an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting	Yes	No

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	documentation. [If no, no further questions.]		
74	Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 3 months with an interleukin-6 (IL-6) inhibitor (Actemra)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
75	Does the patient have aggressive disease, as determined by the prescriber? [If no, no further questions.]	Yes	No
76	Is the requested medication being prescribed by or in consultation with a rheumatologist? [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? [Note: Dosing is 15 mg orally once daily.] [No further questions.]	Yes	No
78	Is the patient greater than or equal to 50 years of age? [If no, no further questions.]	Yes	No
79	Has documentation been submitted to confirm that the patient has a diagnosis of new-onset or relapsing giant cell arteritis? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
80	Has documentation been submitted to confirm an erythrocyte sedimentation rate greater than or equal to 50 mm/hour or high sensitive C-reactive protein greater than or equal to 1 mg/dL? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
81	Has documentation been submitted to support cranial symptoms of giant cell arteritis (GCA) or symptoms of polymyalgia rheumatica (PMR)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
82	Has the patient had a temporal artery biopsy that confirms features of giant cell arteritis (GCA)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
83	Does the patient have evidence of large vessel vasculitis confirmed by angiography, ultrasound magnetic resonance imaging, computed tomography or positron emission tomography? ACTION REQUIRED: Submit supporting documentation.	Yes	No

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	[If no, no further questions.]		
84	Has the patient had treatment with an interleukin-6 (IL-6) inhibitor within 4 weeks? [If no, no further questions.]	Yes	No
85	Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 1 month with high-dose daily corticosteroids (greater than or equal to 40 mg/day)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
86	Is the patient currently on a tapering dose of corticosteroids (greater than or equal to 20 mg/day)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
87	Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 3 months with an interleukin-6 (IL-6) inhibitor (Actemra)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
88	Is the requested medication being prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
89	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the requested indication? [Note: Dosing is 15 mg orally once daily.]	Yes	No

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

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

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

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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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