US Family Health Plan
Prior Authorization Request Form for
upadacitinib **(Rinvoq ER)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1

Please complete patient and physician information (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2

Please complete clinical assessment:

1. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	☐ Yes proceed to question **2**	☐ No proceed to question **4**
2. Has the patient had an inadequate response to Humira?	☐ Yes proceed to question **5**	☐ No proceed to question **3**
3. Has the patient experienced an adverse reaction toHumira that is not expected to occur with the requested agent?	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
4. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Has the patient experienced an inadequate response or adverse reaction to Xeljanz OR Xeljanz XR OR Olumiant?	☐ Yes proceed to question **7**	☐ No proceed to question **6**
6. Does the patient have a contraindication to Xeljanz OR Xeljanz XR OR Olumiant?	☐ Yes proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Is the patient 18 years of age or older?	☐ Yes proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Does the patient have a hemoglobin level LESS THAN 8 g/dL?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **9**
9. Does the patient have an absolute neutrophil count (ANC) LESS THAN 1,000/mm^3?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **10**

10. Does the patient have an absolute lymphocyte count (ALC) LESS THAN 500/mm^3?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **11**
11. What is the indication or diagnosis?	☐ Moderate to severe active **rheumatoid arthritis** – proceed to question **12** ☐ Other indication or diagnosis – STOP: **Coverage not approved.**	
12. Has the patient had an inadequate response or an intolerance to methotrexate or other nonbiologic disease-modifying antirheumatic drugs (DMARDs)?	☐ Yes proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Will the patient be receiving other biologic DMARDs or potent immunosuppressants (for example, azathioprine and cyclosporine) at the same time (concomitantly)?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **14**
14. Does the patient have a history of thromboembolic disease?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **15**
15. Does the patient has evidence of a negative TB test result in the past 12 months (or TB is adequately managed)?	☐ Yes proceed to question **16**	☐ No **STOP** **Coverage not approved**
16. Will the patient be receiving other targeted immunomodulatory biologics with Rinvoq ER, including but not limited to the following: Actemra, Cimzia, Cosentyx, Enbrel, Humira, Ilumya, Kevzara, Kineret, Olumiant, Orencia, Remicade, Rituxan, Siliq, Simponi, Stelara, Taltz, Xeljanz or Xeljanz XR, or Tremfya?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

_____ _____

Prescriber Signature Date