USFHP Prior Authorization Request Form for upadacitinib **(Rinvoq)**

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 855-273-5735

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

https://www.usfamilyhealth.org/for-providers/pharmacy-information/

For Atopic Dermatitis, prior authorization expires after 12 months. Renewal PA criteria will be approved indefinitely. For renewal of therapy an initial Tricare prior authorization approval is required.

For Rheumatoid Arthritis, Psoriatic Arthritis, Polyarticular Juvenile Idiopathic Arthritis, Ankylosing Spondylitis, Non-Radiographic Axial Spondyloarthritis, Ulcerative Colitis, Crohn's Disease, or Giant cell arteritis the prior authorization is approved indefinitely.

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. Has the patient received this medication under the TRICARE benefit in the last 6 months for treatment of atopic dermatitis? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Rinvoq.*	☐ Yes (subject to verification) proceed to question **2**	☐ No proceed to question **3**
2. For atopic dermatitis, has the patient's disease severity improved and stabilized to warrant continued therapy?	☐ Yes (subject to verification) **Sign and date below**	☐ No **STOP** **Coverage not approved**
3. What is the indication or diagnosis?	☐ Moderate To Severely Active Rheumatoid Arthritis – proceed to question **4** ☐ Active Psoriatic Arthritis – proceed to question **4** ☐ Ankylosing Spondylitis – proceed to question **4** ☐ Non-Radiographic Axial Spondyloarthritis – proceed to question **4** ☐ Active Polyarticular Juvenile Idiopathic Arthritis – proceed to question **4** ☐ Moderately To Severely Active Ulcerative Colitis – proceed to question **4** ☐ Moderately To Severely Active Crohn's Disease – proceed to question **4**	

	☐ Giant cell arteritis – proceed to question **8** ☐ Moderate to severe atopic Dermatitis – proceed to question **8** ☐ Other indication or diagnosis – **STOP: Coverage not approved**	
4. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	☐ Yes proceed to question **5**	☐ No proceed to question **7**
5. Has the patient had an inadequate response to Humira?	☐ Yes proceed to question **8**	☐ No proceed to question **6**
6. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes proceed to question **8**	☐ No **STOP** **Coverage not approved**
7. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. What is the patient's age?	☐ 18 years of age or older –proceed to question **9** ☐ 17 years of age or younger –proceed to question **10**	
9. What is the indication or diagnosis for this adult patient?	☐ Moderate to severe active rheumatoid arthritis – proceed to question **11** ☐ Active psoriatic arthritis - proceed to question **12** ☐ Ankylosing spondylitis – proceed to question **14** ☐ Non-radiographic axial spondyloarthritis– proceed to question **14** ☐ Active polyarticular juvenile idiopathic arthritis– proceed to question **23** ☐ Moderately to severely active ulcerative colitis- proceed to question **23** ☐ Moderately to severely active Crohn's disease - proceed to question **23** ☐ Giant cell arteritis - proceed to question **16** ☐ Moderate to severe Atopic Dermatitis - proceed to question **19** ☐ Other indication or diagnosis – **STOP: Coverage not approved**	
10. What is the indication or diagnosis for this pediatric patient?	☐ Active psoriatic arthritis - proceed to question **12** ☐ Active polyarticular juvenile idiopathic arthritis– proceed to question **23** ☐ Moderate to severe Atopic Dermatitis - proceed to question **18** ☐ Other indication or diagnosis – **STOP: Coverage not approved**	

11. Has the patient had an inadequate response or adverse reaction or a contraindication to Xeljanz or Xeljanz XR or Olumiant?	☐ Yes proceed to question **13**	☐ No **STOP** **Coverage not approved**
12. Has the patient experienced an inadequate response or adverse reaction or contraindication to Xeljanz or Xeljanz XR?	☐ Yes proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Has the patient had an inadequate response, intolerance, or contraindication to non-biologic systemic therapy (for example, methotrexate, sulfasalazine, mesalamine, corticosteroids, immunosuppressants)?	☐ Yes proceed to question **23**	☐ No **STOP** **Coverage not approved**
14. Has the patient experienced an inadequate response to at least TWO nonsteroidal anti-inflammatory drugs (e.g. ibuprofen, naproxen, diclofenac) over a period of at least two months?	☐ Yes proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. Has the patient experienced an inadequate response or adverse reaction or contraindication to Taltz?	☐ Yes proceed to question **23**	☐ No **STOP** **Coverage not approved**
16. Is the requested medication being prescribed by or in consultation with a rheumatologist?	☐ Yes proceed to question **17**	☐ No **STOP** **Coverage not approved**
17. Has the patient experienced an inadequate response or adverse reaction or contraindication to BOTH of the following: (a) glucocorticoid AND (b) tocilizumab (Tyenne)?	☐ Yes proceed to question **23**	☐ No **STOP** **Coverage not approved**
18. Is the patient 12 years of age or older?	☐ Yes proceed to question **19**	☐ No **STOP** **Coverage not approved**
19. Is the requested medication prescribed by a dermatologist, allergist, or immunologist?	☐ Yes proceed to question **20**	☐ No **STOP** **Coverage not approved**
20. Does the patient have a contraindication to, intolerability to, or have they failed treatment with ONE medication in EACH of the following two categories: • **Topical Corticosteroids: Patients 12 to 17 years of age,** can be any topical corticosteroid. **Patients 18 years or older,** high potency/class 1 topical corticosteroids (e.g., clobetasol propionate 0.05% ointment/cream) is required. • **Topical calcineurin inhibitor (for example, pimecrolimus, tacrolimus)?**	☐ Yes proceed to question **21**	☐ No **STOP** **Coverage not approved**
21. Is the patient's disease adequately controlled with other systemic drug products including biologics (for example, Dupixent)?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **22**

22. Does the patient have a contraindication to, intolerability to, inability to access treatment, or has failed treatment with Narrowband UVB phototherapy?	☐ Yes proceed to question **23**	☐ No **STOP** **Coverage not approved**

23. Will the patient be receiving other targeted immunomodulatory biologics with Rinvoq, except for Otezla, including but not limited to the following: TNF inhibitors, IL-1, IL-6, IL-17, IL-23, IL-36, S1p, or JAK inhibitors?	☐ 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 _____