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 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**

For Atopic Dermatitis, prior authorization expires after 12 months. Renewal PA criteria will be approved indefinitely. For renewal of therapy an initial USFHP prior authorization approval is required. Medical documentation must be attached. Failure to provide could result in denial.

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. Is the requested medication being used for rheumatoid arthritis, psoriatic arthritis, ulcerative colitis or ankylosing spondylitis?	☐ Yes proceed to question **2**	☐ No proceed to question **6**
2. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	☐ Yes proceed to question **3**	☐ No proceed to question **5**
3. Has the patient had an inadequate response to Humira?	☐ Yes proceed to question **6**	☐ No proceed to question **4**
4. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes proceed to question **6**	☐ No **STOP** **Coverage not approved**
5. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. What is the indication or diagnosis?	☐ Moderate to severe active rheumatoid arthritis – **proceed to question 7** ☐ Moderate to severe atopic dermatitis - **proceed to question 14** ☐ Active psoriatic arthritis (PsA) - **proceed to question 9** ☐ moderately to severely active ulcerative colitis - **proceed to question 12** ☐ Ankylosing spondylitis – **proceed to question 21** ☐ Other indication or diagnosis – **STOP: Coverage not approved.**	

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7. The provider acknowledges that for rheumatoid arthritis a trial of Xeljanz or Olumiant is required before Rinvoq.	_____ Proceed to question **8**	
8. Has the patient experienced an inadequate response or adverse reaction to Xeljanz OR Xeljanz XR OR Olumiant?	☐ Yes proceed to question **11**	☐ No proceed to question **10**
9. Has the patient experienced an inadequate response or adverse reaction to Xeljanz OR Xeljanz XR?	☐ Yes proceed to question **11**	☐ No proceed to question **10**
10. Does the patient have a contraindication to Xeljanz OR Xeljanz XR OR Olumiant?	☐ Yes proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. 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**
12. Has the patient had an inadequate response to non-biologic systemic therapy (for example – methotrexate, aminosalicylates (for example, sulfasalazine, mesalamine), corticosteroids, immunosuppressants (for example, azathioprine), etc?	☐ Yes proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Is the patient 18 years of age or older?	☐ Yes proceed to question **26**	☐ No **STOP** **Coverage not approved**
14. Has the patient received this medication under the USFHP benefit in the last 6 months? *Please choose "No" if the patient did not previously have a USFHP approved PA for Rinvoq ER.*	☐ Yes (subject to verification) proceed to question **15**	☐ No proceed to question **16**
15. 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**
16. Is the patient greater than or equal to 12 year(s) of age?	☐ Yes proceed to question **17**	☐ No **STOP** **Coverage not approved**
17. Is the requested medication prescribed by a dermatologist, allergist, or immunologist?	☐ Yes proceed to question **18**	☐ No **STOP** **Coverage not approved**
18. Provider acknowledges that the requested medication is to be used for disease that is not adequately controlled with other systemic drug products, including biologics, or when use of those therapies is inadvisable.	☐ **Acknowledged** **proceed to question 19**	

19. 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 AND** NOTE: **For patients 18 years of age or older,** high potency/class 1 topical corticosteroids (for example, clobetasol propionate 0.05% ointment/cream, fluocinonide 0.05% ointment/cream) is required. **For patients 12 to 17 years of age,** can be any topical corticosteroid. • **Topical calcineurin inhibitor (for example, pimecrolimus, tacrolimus)**	☐ Yes **proceed to question 20**	☐ No **STOP** **Coverage not approved**
20. 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 26**	☐ No **STOP** **Coverage not approved**
21. Is the patient 18 years of age or older?	☐ Yes **proceed to question 22**	☐ No **STOP** **Coverage not approved**
22. Has the patient experienced an inadequate response to Cosentyx?	☐ Yes **proceed to question 25**	☐ No **proceed to question 23**
23. Has the patient experienced an adverse reaction to Cosentyx that is not expected to occur with the requested agent?	☐ Yes **proceed to question 25**	☐ No **proceed to question 24**
24. Does the patient have a contraindication to Cosentyx?	☐ Yes **proceed to question 25**	☐ No **STOP** **Coverage not approved**
25. Has the patient experienced an inadequate response to at least TWO NSAIDs (for example: ibuprofen, naproxen, diclofenac) over a period of at least two months?	☐ Yes **proceed to question 26**	☐ No **STOP** **Coverage not approved**
26. Is the provider aware of the FDA safety alerts AND Boxed Warnings?	☐ Yes **proceed to question 27**	☐ No **STOP** **Coverage not approved**
27. Does the patient have a hemoglobin level LESS THAN 8 g/dL?	☐ Yes **STOP** **Coverage not approved**	☐ No **proceed to question 28**
28. Does the patient have an absolute neutrophil count (ANC) LESS THAN 1,000/mm^3?	☐ Yes **STOP** **Coverage not approved**	☐ No **proceed to question 29**

29. Does the patient have an absolute lymphocyte count (ALC) LESS THAN 500/mm^3?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **30**
30. Will the patient be receiving other targeted immunomodulatory biologics with Rinvoq ER, except for Otezla, including but not limited to the following: Actemra, Cimzia, Cosentyx, Enbrel, Humira, Ilumya, Kevzara, Kineret, Olumiant, Orencia, Remicade, Rituxan, Siliq, Stelara, Taltz, Xeljanz or Xeljanz XR or Tremfya and other potent immunosuppressant's (for example: azathioprine, cyclosporine)?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **31**
31. Does the patient have a history of venous thromboembolic (VTE) disease?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **32**
32. Does the patient have evidence of a negative TB test result in the past 12 months (or TB is adequately managed)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

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

Prescriber Signature _____ Date _____