

Rinvoq Liquid (upadacitinib)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

URGENT

MEMBER INFORMATION	
LAST NAME:	FIRST NAME:
PHONE NUMBER:	DATE OF BIRTH:
STREET ADDRESS:	
CITY:	STATE: ZIP CODE:
PATIENT INSURANCE ID NUMBER:	

MALE **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: [PRIMETHERAPEUTICS.COM/NOPP](https://www.primetherapeutics.com/nopp)

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	FIRST NAME:
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:
NPI NUMBER:	DEA NUMBER:
PHONE NUMBER:	FAX NUMBER:
STREET ADDRESS:	
CITY:	STATE: ZIP CODE:
REQUESTER (if different than prescriber):	OFFICE CONTACT PERSON:

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
<input type="checkbox"/> NEW THERAPY <input type="checkbox"/> RENEWAL IF RENEWAL: DATE THERAPY INITIATED:			
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page



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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES:		ICD-10:
<input type="checkbox"/> Rheumatoid arthritis(RA) <input type="checkbox"/> Moderate to severe Atopic Dermatitis (AD) <input type="checkbox"/> Psoriatic Arthritis (PsA) <input type="checkbox"/> Ulcerative Colitis(UC) <input type="checkbox"/> Crohn's Disease(CD) <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Non-radiographic Axial Spondylarthritis <input type="checkbox"/> Atopic Dermatitis <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s):		
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.		
Is patient going to be using drug in combination with a clinical trial? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does patient have difficulty swallowing? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i>		
Does patient have an enteral feeding tube? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i>		
Is patient taking any other oral tablets or capsules(*sprinkle caps ok)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i>		
Is the patient currently being treated with another biologic or immunomodulatory agent? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If on another biologic therapy, will that biologic be stopped when starting the RinvoqER? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has the patient tried and had an inadequate response to a three (3) month trial of the biosimilar for Humira-adalimumab-aacf? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation with dates of treatment.</i>		
For diagnosis of <u>Rheumatoid Arthritis</u> only:		
Is the prescriber a rheumatologist? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does the patient have a diagnosis of moderately to severely active rheumatoid arthritis? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has the patient had a trial of methotrexate or another oral non-biologic disease modifying anti-rheumatic agent (DMARD) such as Imuran, Ridaura, Plaquenil, sulfasalazine or Arava? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation with dates of service.</i>		



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Does patient have chronic alcohol abuse/alcoholism, chronic liver disease such as chronic hepatitis, fatty liver, nonalcoholic steatohepatitis/NASH, elevated liver enzymes) (Please provide documentation.)? Yes No *Please submit documentation.*

For renewal only:

Does the patient continue to have a positive clinical response and remission of disease maintained with continued use of the medication? Yes No *Please submit chart documentation.*

Is the patient currently being treated with another biologic or immunomodulatory agent? Yes No

Is the prescriber a rheumatologist? Yes No

For diagnosis of Atopic Dermatitis only:

Is the prescriber a dermatologist or allergist? Yes No

Has the patient had the diagnosis of atopic dermatitis for at least 12 months? Yes No **Please submit documentation.*

Does the patient have atopic dermatitis on at least 10% or more of their body surface area? Yes No **Please submit documentation.*

Has the patient tried at least two different topical steroids? Yes No **Please submit documentation.*

If patient has not had at least 2 different topical steroids, has the patient tried at least one topical steroid AND one topical calcineurin inhibitor (tacrolimus or pimecrolimus)? Yes No **Please submit documentation.*

If patient has not had at least 2 different topical steroids, has the patient tried at least one topical steroid AND Eucrisa(crisaborole)? Yes No **Please submit documentation.*

If patient has not had at least 2 different topical steroids, has the patient tried at least one topical steroid AND Zoryve(roflumilast)? Yes No **Please submit documentation.*

If patient has not had at least 2 different topical steroids, has the patient tried at least one topical steroid AND Vtama(tapinarof)? Yes No **Please submit documentation.*

Has patient tried and failed a 3-month trial of Dupixent(dupilumab)? Yes No **Please submit documentation.*

Has patient tried and failed a 3-month trial of Adbry(tralokinumab-ldrm)? Yes No **Please submit documentation.*

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Has patient tried and failed a 3-month trial of Cibinqo(abrocitinib)? Yes No **Please submit documentation.*

Will RinvoqER(upadacitinib) be used in combination with Cibinqo(abrocitinib), Olumiant(baracitinib), Opzelura(ruxolitinib), Dupixent(dupilumab), Adbry(tralokinumab), Xolair(omalizumab), Nucala(mepolizumab) or Fasenra(benralizumab)? Yes No

For renewal only:

Does the patient continue to have a positive clinical response and remission of disease maintained with continued use of the medication? Yes No *Please submit chart documentation.*

Is the patient currently being treated with another biologic or immunomodulatory agent? Yes No

Is RinvoqER(upadacitinib) being used in combination with Cibinqo(abrocitinib), Olumiant(baracitinib), Opzelura(ruxolitinib), Dupixent(dupilumab), Adbry(tralokinumab), Xolair(omalizumab), Nucala(mepolizumab) or Fasenra(benralizumab)? Yes No

Is the prescriber a dermatologist or allergist? Yes No

For diagnosis of Psoriatic Arthritis only:

Is the prescriber a rheumatologist or dermatologist? Yes No

Does the patient have documented moderately to severely active disease? Yes No *Please submit documentation*

Has the patient had a trial and failed previous therapy with oral disease modifying anti-rheumatic agents (DMARDs, e.g., methotrexate, sulfasalazine (Azulfidine), leflunamide (Arava), or cyclosporine)? Yes No
Please submit documentation with dates of service.

For renewal only:

Does the patient continue to have a positive clinical response and remission of disease maintained with continued use of the medication? Yes No *Please submit chart documentation.*

Is the patient currently being treated with another biologic or immunomodulatory agent? Yes No

Is the prescriber a rheumatologist or dermatologist? Yes No

For diagnosis of Ulcerative Colitis and Crohn's Disease Only:

Is prescriber a gastroenterologist? Yes No

Has patient tried and failed at least one of the following three therapies: corticosteroids, azathioprine, and/or 6-mercaptopurine? Yes No

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Has patient tried and failed at least three months of another intravenous, subcutaneous or oral therapy? Yes No *Please submit documentation with dates of treatment.*

For renewal only:

Does the patient continue to have a positive clinical response and remission of disease maintained with continued use of the medication? Yes No *Please submit chart documentation.*

Is the patient currently being treated with another biologic or immunomodulatory agent? Yes No

Is the prescriber a rheumatologist or gastroenterologist? Yes No

For diagnosis of Ankylosing Spondylitis only:

Is the prescriber a rheumatologist? Yes No

Does the patient have documented active disease? Yes No *Please submit documentation*

Has the patient had a trial and failed previous therapy with at least two (2) non-steroidal anti-inflammatory agents (NSAIDs), unless use is contraindicated? Yes No
Please submit documentation with dates of service.

For renewal only:

Does the patient continue to have a positive clinical response and remission of disease maintained with continued use of the medication? Yes No *Please submit chart documentation.*

Is the patient currently being treated with another biologic or immunomodulatory agent? Yes No

Is the prescriber a rheumatologist? Yes No

For diagnosis of Non-radiographic Axial Spondyloarthritis only:

Is the prescriber a rheumatologist? Yes No

Does the patient have objective signs of inflammation by presence of sacroiliitis on MRI imaging results and/or elevated C-reactive protein level? Yes No *Please submit imaging and/or lab report.*

Has patient had an inadequate response to at least two different NSAIDs? Yes No *Please submit documentation.*

Has patient tried and failed or had a contraindication or intolerance to a 3-month trial with at least one biologic DMARD that is either a TNF inhibitor or an IL-17 inhibitor? Yes No *Please submit documentation.*

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Does the patient continue to have a positive clinical response and remission of disease maintained with continued use of the medication? Yes No *Please submit chart documentation.*

Is the patient currently being treated with another biologic or immunomodulatory agent? Yes No

Is the prescriber a rheumatologist? Yes No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

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FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program

Attn: CP-4201

P.O. Box 64811

St. Paul, MN 55164-0811

Phone: 877-228-7909