

**RinvoqER (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	
<b>LAST NAME:</b>	<b>FIRST NAME:</b>
<b>PHONE NUMBER:</b>	<b>DATE OF BIRTH:</b>
<b>STREET ADDRESS:</b>	
<b>CITY:</b>	<b>STATE:</b> <b>ZIP CODE:</b>
<b>PATIENT INSURANCE ID NUMBER:</b>	

**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](http://PRIMETHERAPEUTICS.COM/NOPP)**

**PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE):** \_\_\_\_\_  
**AUTHORIZED REPRESENTATIVE'S PHONE NUMBER:** \_\_\_\_\_

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

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

*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		
<b>MEDICATION/THERAPY</b> (SPECIFY DRUG NAME AND DOSAGE):	<b>DURATION OF THERAPY</b> (SPECIFY DATES):	<b>RESPONSE/REASON FOR FAILURE/ALLERGY:</b>
2. LIST DIAGNOSES:		ICD-10:
<input type="checkbox"/> Rheumatoid arthritis(RA) <input type="checkbox"/> Polyarticular Juvenile idiopathic arthritis(pJIA) <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"/> Giant Cell Arteritis <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		
Is the prescriber a rheumatologist? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the prescriber a gastroenterologist? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the prescriber a dermatologist or allergist? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Will the patient use drug in combination with another biologic response modifier or immunomodulatory agent? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has the patient tried and had an inadequate response to a three month trial of the <u>biosimilar</u> for Humira- <u>adalimumab-aacf</u> ? <input type="checkbox"/> Yes <input type="checkbox"/> No Please submit documentation.		
Does patient have a absolute contraindication to the biosimilar for Humira- adalimumab-aacf? <input type="checkbox"/> Yes <input type="checkbox"/> No Please submit documentation.		
Has the patient tried and had an inadequate response to a trial of the <u>biosimilar</u> for Actemra, Tyenne(tocilizumab-aazg)? <input type="checkbox"/> Yes <input type="checkbox"/> No Please submit documentation.		
Does patient have a absolute contraindication to the biosimilar for Actemra, Tyenne(tocilizumab-aazg)? <input type="checkbox"/> Yes <input type="checkbox"/> No Please submit documentation.		



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Has the patient tried and had an inadequate response to a 4- month trial of the biosimilar for Stelara-Otulfi(ustekinumb-aauz)?  Yes  No Please submit documentation.

Does patient have a absolute contraindication to the biosimilar for Stelara-Otulfi(ustekinumb-aauz)?  
 Yes  No Please submit documentation.

Has patient been previously treated with infliximab and/or vedolizumab(Entyvio)?  Yes  No  
Please submit documentation with dates of service.

For diagnosis of Rheumatoid Arthritis only:

Does the patient have a diagnosis of moderately to severely active rheumatoid arthritis?  Yes  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?  Yes  No  
*Please submit documentation with dates of service.*

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

For diagnosis of Polyarticular Juvenile idiopathic arthritis(pJIA):

Has patient tried and failed previous therapy with oral disease modifying anti-rheumatic agents (DMARDs) [e.g. for JIA: methotrexate or sulfasalazine or leflunamide]?  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.*

Will the patient use drug in combination with another biologic or immunomodulatory agent?  Yes  No

Is the prescriber a rheumatologist?  Yes  No  
Is the prescriber a gastroenterologist?  Yes  No

For diagnosis of Atopic Dermatitis only:

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

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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.*

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 Fasentra(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 Fasentra(benralizumab)?  Yes  No

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Is the prescriber a dermatologist or allergist?  Yes  No

For diagnosis of Psoriatic Arthritis only:

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

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.*

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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

**For diagnosis of Non-radiographic Axial Spondyloarthritis only:**

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.*

**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 Giant Cell Arteritis:**

Does patient have a diagnosis of Giant Cell Arteritis?  Yes  No *Please submit chart documentation*

Is patient currently on a tapering dose of corticosteroids?  Yes  No

Will Rinvoq be used as monotherapy?  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 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?

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**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:** \_\_\_\_\_

**CONFIDENTIALITY NOTICE:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

**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