Rinvoq Liquid (upadacitinib)
Prior Authorization Request Form

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

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: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

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:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL**		**IF RENEWAL:** DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

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Magellan Rx Management – Commercial Clients.
Revision Date: 6/15/24 CAT0295

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
□ Rheumatoid arthritis(RA) □ Moderate to severe Atopic Dermatitis (AD) □ Psoriatic Arthritis (PsA) □ Ulcerative Colitis(UC) □ Crohn's Disease(CD) □ Ankylosing Spondylitis □ Non-radiographic Axial Spondylarthritis □ Atopic Dermatitis □ Other diagnosis: _____ICD-10_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Is this drug being prescribed to this patient as part of a treatment regimen specified within a sponsored clinical trial? □ Yes □ No

Does patient have difficulty swallowing? □ Yes □ No *Please submit documentation.*

Does patient have an enteral feeding tube? □ Yes □ No *Please submit documentation.*

Is patient taking any other oral tablets or capsules(*sprinkle caps ok)? □ Yes □ No *Please submit documentation.*

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

If on another biologic therapy, will that biologic be stopped when starting the RinvoqER? □ Yes □ No

Has the patient tried and had an inadequate response to a three (3) month trial of the biosimilar for Humira-adalimumab-aacf? □ Yes □ No *Please submit documentation with dates of treatment.*

For diagnosis of <u>Rheumatoid Arthritis</u> only:

Is the prescriber a rheumatologist? □ Yes □ No

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) (Please provide documentation.)? □ Yes □ No *Please submit documentation.*

<u>For renewal only</u>:

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 <u>Atopic Dermatitis</u> 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.*

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 Fasenra(benralizumab? □ Yes □ No

<u>For renewal only</u>:
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

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

<u>For diagnosis of Non-radiographic Axial Spondyloarthritis only</u>:
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.

<u>For renewal only</u>:
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: _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP – 4201 P.O. Box 64811
St. Paul, MN 55164-0811