Mountain Pacific
INNOVATING BETTER HEALTH
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Montana Healthcare Programs Prior Authorization Request Form for Use of Rinvoq® (upadacitinib)

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	
Prescriber Name/Specialty if applicable:	Prescriber Fax:	
Dosage Requested:		

Please complete below information for applicable situation, Initiation or Continuation of therapy:

☐ INITIATION OF THERAPY

Please check appropriate diagnosis and complete corresponding information:

1. **Rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, non-radiographic axial spondyloarthritis, ulcerative colitis and Crohn's disease:**

   a. Member has a diagnosis of:

      ☐ Moderately to severely active rheumatoid arthritis

      ☐ Active psoriatic arthritis

      ☐ Active ankylosing spondylitis

      ☐ Active non-radiographic axial spondyloarthritis with objective signs of inflammation

      ☐ Moderately to severely active ulcerative colitis

      ☐ Moderately to severely active Crohn's disease

   b. Member is 18 years of age or older: ☐ Yes ☐ No

   c. Medication is prescribed by or in consultation with: ☐ Gastroenterologist ☐ Dermatologist ☐ Rheumatologist

      Action required: If not in a specialty clinic or written by a specialist, copy of annual specialty consult with an appropriate specialist is required (please attach copy of consult):

      Name of specialist: _____ **Contact date:** _____

   d. Member has trialed and had an inadequate response or intolerance to a preferred tumor necrosis factor (TNF) blocker: ☐ Yes ☐ No

      Drug name: _____ **Dates:** _____

   e. Provider attests they have reviewed the black box warning: ☐ Yes ☐ No

   f. Provider attests the member will not use Rinvoq® concomitantly with other Janus kinase (JAK) inhibitors, biologic therapies or potent immunosuppressants: ☐ Yes ☐ No

LIMITATIONS:

- **Rheumatoid arthritis, psoriatic arthritis and ankylosing spondylitis**: Maximum daily dose is 15mg per day.
- **Ulcerative colitis**: 45mg daily for 8 weeks (induction dose) then 15mg per day thereafter. May increase to 30mg daily for refractory, severe or extensive disease.
- **Crohn's disease**: 45mg daily for 12 weeks (induction dose) then 15mg per day thereafter. May increase to 30mg daily for refractory, severe or extensive disease.

Initial authorization will be issued for 6 months.

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2. Atopic Dermatitis

a. Member is 12 years of age or older: ☐ Yes ☐ No

b. Member has a diagnosis of refractory, moderate-to-severe atopic dermatitis: ☐ Yes ☐ No

c. Prescriber practices in one of the following specialty clinics: ☐ Allergy ☐ Dermatology

Action required: If not in a specialty clinic or written by a specialist, copy of annual specialty consult with an appropriate specialist is required (please attach copy of consult):

Name of specialist: _____ **Contact date:** _____

d. Member has clinical documentation of functional impairment due to atopic dermatitis, which may include but is not limited to limitations to activities of daily living (ADLs), such as skin infections or sleep disturbances, and a baseline assessment has been made to allow for documentation of positive clinical response: ☐ Yes ☐ No

e. Member must have had an inadequate treatment response, intolerance or contraindication to **all** the following:

A preferred high-potency topical corticosteroid: ☐ Yes ☐ No

Name: _____ **Dates:** _____

A topical immunomodulator (tacrolimus or pimecrolimus): ☐ Yes ☐ No

Name: _____ **Dates:** _____

Another biologic with preferable safety profile (i.e., Dupixent®): ☐ Yes ☐ No

Name: _____ **Dates:** _____

NOTE: Inadequate treatment response to topical therapy is defined as failure to achieve and maintain remission or a low disease activity state despite treatment with a daily regimen, applied for ≥ 28 days or for the maximum duration recommended by the product prescribing information (e.g., 14 days for high or very-high potency topical corticosteroids).

g. Provider attests they have reviewed the black box warning: ☐ Yes ☐ No

h. Provider attests member will not use Rinvoq® concomitantly with other JAK inhibitors, biologic therapies or potent immunosuppressants: ☐ Yes ☐ No

LIMITATIONS:
Maximum quantity limit is 30mg per day.

Initial authorization will be issued for 6 months.

☐ **CONTINUATION OF THERAPY**

1. **Rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, non-radiographic axial spondyloarthritis, ulcerative colitis and Crohn's disease:**

   a. Member has documentation of positive clinical response to Rinvoq® therapy: ☐ Yes ☐ No

   b. Annual specialist consult attached if prescriber is not a specialist: ☐ Yes ☐ No ☐ N/A – Prescriber is a specialist.

   c. Provider attests that member will not use Rinvoq® concomitantly with other JAK inhibitors, biologic therapies or potent immunosuppressants: ☐ Yes ☐ No

2. **Atopic dermatitis*:***

   a. Member has documentation of positive clinical response to Rinvoq® therapy (e.g., reduction in body surface area involvement, reduction in pruritus severity or decrease in severity index using a scoring tool)? ☐ Yes ☐ No

   b. Annual specialist consult attached if prescriber is not a specialist. ☐ Yes ☐ No ☐ N/A – Prescriber is a specialist.

   c. Provider attests the member will not use Rinvoq® concomitantly with other JAK inhibitors, biologic therapies or potent immunosuppressants: ☐ Yes ☐ No

Reauthorization will be issued for 1 year.

Please complete form, including required attachments, and fax to:
Drug Prior Authorization Unit at 1-800-294-1350

10/2023