Prescriber Criteria Form Rinvoq 2024 PA Fax 3186-A v2 010124.docx Rinvoq (upadacitinib) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Rinvoq (upadacitinib).

Drug Name: Rinvoq (upadacitinib)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Has the patient previously received the requested drug for one of the following conditions: A) rheumatoid arthritis, B) psoriatic arthritis, C) ulcerative colitis, D) ankylosing spondylitis, E) non-radiographic axial spondyloarthritis? [If yes, then no further questions.]	Yes	No
2	Does the patient have a diagnosis of moderately to severely active rheumatoid arthritis? [If no, then skip to question 4.]	Yes	No
3	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., Enbrel [etanercept], Humira [adalimumab])? [No further questions.]	Yes	No
4	Does the patient have a diagnosis of active psoriatic arthritis? [If no, then skip to question 6.]	Yes	No
5	Has the patient experienced inadequate treatment response, intolerance, or does the patient have a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., Enbrel [etanercept], Humira [adalimumab])? [No further questions.]	Yes	No
6	Has the patient been diagnosed with refractory, moderate to severe atopic dermatitis? [If no, then skip to question 12.]	Yes	No

7	Is the patient currently receiving therapy with the requested drug? [If no, then skip to question 10.]	Yes	No
8	Has the patient achieved or maintained a positive clinical response? [If no, then no further questions.]	Yes	No
9	Is the patient 12 years of age or older? [No further questions.]	Yes	No
10	Does the patient meet any of the following: A) patient has had an inadequate response to treatment with other systemic drug products, including biologics, B) use of other systemic drug products, including biologics, is not advisable? [If no, then no further questions.]	Yes	No
11	Is the patient 12 years of age or older? [No further questions.]	Yes	No
12	Does the patient have a diagnosis of moderately to severely active ulcerative colitis? [If no, then skip to question 14.]	Yes	No
13	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., Humira [adalimumab])? [No further questions.]	Yes	No
14	Does the patient have a diagnosis of active ankylosing spondylitis? [If no, then skip to question 16.]	Yes	No
15	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., Enbrel [etanercept], Humira [adalimumab])? [No further questions.]	Yes	No
16	Does the patient have a diagnosis of active non-radiographic axial spondyloarthritis? [If no, then no further questions.]	Yes	No
17	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to at least one tumor necrosis factor (TNF) inhibitor?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____