AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Rinvoq® (upadacitinib)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Weight: _____ **Date:** _____

NOTE: The health plan considers the use of concomitant therapy with more than one biologic immunomodulator (e.g., Dupixent, Entyvio, Humira, Rinvoq, Stelara) prescribed for the same or different indications to be experimental and investigational. Safety and efficacy of these combinations has **NOT** been established and will **NOT** be permitted.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ **Diagnosis: Moderate-to-Severe Rheumatoid Arthritis**
  Dosing: Oral: 15 mg once daily

  - ❑ Member has a diagnosis of moderate-to-severe **rheumatoid arthritis**
  - ❑ Prescribed by or in consultation with **a Rheumatologist**

(Continued on next page)

- ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**
  - ❑ hydroxychloroquine
  - ❑ leflunomide
  - ❑ methotrexate
  - ❑ sulfasalazine
- ❑ Member meets **ONE** of the following:
  - ❑ Member tried and failed, has a contraindication, or intolerance to **ONE** of the following **PREFERRED** biologics:
    - ❑ **ONE** of the following adalimumab products:
      - ❑ Humira®
      - ❑ Cyltezo®
      - ❑ Hyrimoz®
    - ❑ Enbrel®
  - ❑ Member has been established on Rinvoq® for at least 90 days **AND** prescription claims history indicates **at least a 90-day supply of Rinvoq was dispensed within the past 130 days (verified by chart notes or pharmacy paid claims)**
- ❑ Member is **NOT** receiving Rinvoq® in combination with other JAK inhibitors, biologic immunomodulators, or with other immunosuppressants

❑ Diagnosis: Active Psoriatic Arthritis

Dosing: Oral: 15 mg once daily

- ❑ Member has a diagnosis of active **psoriatic arthritis**
- ❑ Prescribed by or in consultation with **a Rheumatologist**
- ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**
  - ❑ cyclosporine
  - ❑ leflunomide
  - ❑ methotrexate
  - ❑ sulfasalazine
- ❑ Member meets **ONE** of the following:
  - ❑ Member tried and failed, has a contraindication, or intolerance to **ONE** of the following **PREFERRED** biologics:
    - ❑ **ONE** of the following adalimumab products:
      - ❑ Humira®
      - ❑ Cyltezo®
      - ❑ Hyrimoz®
    - ❑ Enbrel®

(Continued on next page)

- ❑ Member has been established on Rinvoq® for at least 90 days **AND** prescription claims history indicates **at least a 90-day supply of Rinvoq was dispensed within the past 130 days (verified by chart notes or pharmacy paid claims)**

- ❑ Member is **NOT** receiving Rinvoq® in combination with other JAK inhibitors, biologic immunomodulators, or with other immunosuppressants

❑ Diagnosis: Moderate-to-Severe Atopic Dermatitis

Dosing: Oral: 15 mg once daily; may increase to 30 mg once daily if inadequate response

- ❑ Member has a diagnosis of **moderate to severe atopic dermatitis** with disease activity confirmed by **ONE** of the following **(chart notes documenting disease severity and BSA involvement must be included):**
  - ❑ Body Surface Area (BSA) involvement >10%
  - ❑ Eczema Area and Severity Index (EASI) score ≥ 16
  - ❑ Investigator's Global Assessment (IGA) score ≥ 3
  - ❑ Scoring Atopic Dermatitis (SCORAD) score ≥ 25
- ❑ Prescribed by or in consultation with an **Allergist, Dermatologist or Immunologist**
- ❑ Member is 12 years of age or older
- ❑ Member weighs at least 40 kg
- ❑ Member is **NOT** receiving Rinvoq® in combination with other JAK inhibitors, biologic immunomodulators, or with other immunosuppressants
- ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**
  - ❑ azathioprine
  - ❑ cyclosporine
  - ❑ methotrexate
  - ❑ mycophenolate mofetil
- ❑ Member tried and failed, has a contraindication, or intolerance to **ONE** of the following topical therapies **(chart notes documenting contraindication(s) or intolerance must be attached; trials will be verified using pharmacy claims and/or submitted chart notes)**:
  - ❑ 30 days (14 days for very high potency) of therapy with **ONE** medium to very-high potency topical corticosteroid in the past 180 days
  - ❑ 30 days of therapy with **ONE** of the following topical calcineurin inhibitors in the past 180 days:
    - ❑ tacrolimus 0.03 % or 0.1% ointment
    - ❑ pimecrolimus 1% cream (requires prior authorization)

(Continued on next page)

❑ Diagnosis: Moderate-to-Severe Ulcerative Colitis (UC)

Dosing: Oral: Induction - 45 mg once daily for 8 weeks; Maintenance -15 mg once daily; may increase to 30 mg once daily in patients with refractory, severe, or extensive disease. Discontinue if an adequate response is not achieved with the 30 mg dose; use the lowest effective dose needed to maintain response.

- ❑ Member has a diagnosis of moderate-to-severe **ulcerative colitis**
- ❑ Prescribed by or in consultation with a **Gastroenterologist**
- ❑ Member meets **ONE** of the following:
  - ❑ Member has tried and failed budesonide or high dose steroids (40-60 mg prednisone)
  - ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**
    - ❑ 5-aminosalicylates (balsalazide, olsalazine, sulfasalazine)
    - ❑ oral mesalamine (Apriso, Asacol/HD, Delzicol, Lialda, Pentasa)
- ❑ Member meets **ONE** of the following:
  - ❑ Member tried and failed, has a contraindication, or intolerance to **ONE** of the following **PREFERRED** adalimumab products:
    - ❑ Humira®
    - ❑ Cyltezo®
    - ❑ Hyrimoz®
  - ❑ Member has been established on Rinvoq® for at least 90 days **AND** prescription claims history indicates **at least a 90-day supply of Rinvoq was dispensed within the past 130 days (verified by chart notes or pharmacy paid claims)**
- ❑ Member is **NOT** receiving Rinvoq® in combination with other JAK inhibitors, biologic immunomodulators, or with other immunosuppressants

❑ Diagnosis: Moderate-to-Severe Active Crohn's Disease (CD)

Dosing: Oral: Induction - 45 mg once daily for 12 weeks; Maintenance -15 mg once daily; may increase to 30 mg once daily in patients with refractory, severe, or extensive disease. Discontinue if an adequate response is not achieved with the 30 mg dose; use the lowest effective dose needed to maintain response.

- ❑ Member has a diagnosis of moderate-to-severe **Crohn's disease**
- ❑ Prescribed by or in consultation with a **Gastroenterologist**
- ❑ Member meets **ONE** of the following:
  - ❑ Member has tried and failed budesonide or high dose steroids (40-60 mg prednisone)
  - ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**
    - ❑ 5-aminosalicylates (balsalazide, olsalazine, sulfasalazine)
    - ❑ oral mesalamine (Apriso, Asacol/HD, Delzicol, Lialda, Pentasa)

(Continued on next page)

- ❑ Member meets **ONE** of the following:
  - ❑ Member tried and failed, has a contraindication, or intolerance to **ONE** of the following **PREFERRED** adalimumab products:
    - ❑ Humira®
    - ❑ Cyltezo®
    - ❑ Hyrimoz®
  - ❑ Member has been established on Rinvoq® for at least 90 days **AND** prescription claims history indicates **at least a 90-day supply of Rinvoq was dispensed within the past 130 days (verified by chart notes or pharmacy paid claims)**
- ❑ Member is **NOT** receiving Rinvoq® in combination with other JAK inhibitors, biologic immunomodulators, or with other immunosuppressants

❑ Diagnosis: Active Ankylosing Spondylitis
Dosing: Oral: 15 mg once daily

- ❑ Member has a diagnosis of active **ankylosing spondylitis**
- ❑ Prescribed by or in consultation with a **Rheumatologist**
- ❑ Member tried and failed, has a contraindication, or intolerance to **TWO** NSAIDs
- ❑ Member meets **ONE** of the following:
  - ❑ Member tried and failed, has a contraindication, or intolerance to **ONE** of the following **PREFERRED** biologics:
    - ❑ **ONE** of the following adalimumab products:
      - ❑ Humira®
      - ❑ Cyltezo®
      - ❑ Hyrimoz®
    - ❑ Enbrel®
  - ❑ Member has been established on Rinvoq® for at least 90 days **AND** prescription claims history indicates **at least a 90-day supply of Rinvoq was dispensed within the past 130 days (verified by chart notes or pharmacy paid claims)**
- ❑ Member is **NOT** receiving Rinvoq® in combination with other JAK inhibitors, biologic immunomodulators, or with other immunosuppressants

❑ Diagnosis: Active Non-Radiographic Axial Spondyloarthritis
Dosing: Oral: 15 mg once daily

- ❑ Member has a diagnosis of active **non-radiographic axial spondyloarthritis**
- ❑ Prescribed by or in consultation with a **Rheumatologist**

(Continued on next page)

- ❑ Member has at least **ONE** of the following objective signs of inflammation:
  - ❑ C-reactive protein [CRP] levels above the upper limit of normal
  - ❑ Sacroiliitis on magnetic resonance imaging [MRI] (indicative of inflammatory disease, but without definitive radiographic evidence of structural damage on sacroiliac joints)
- ❑ Member tried and failed, has a contraindication, or intolerance to **TWO** NSAIDs
- ❑ Member meets **ONE** of the following:
  - ❑ Member tried and failed, has a contraindication, or intolerance to **Cimzia®**
  - ❑ Member has been established on Rinvoq® for at least 90 days **AND** prescription claims history indicates **at least a 90-day supply of Rinvoq was dispensed within the past 130 days (verified by chart notes or pharmacy paid claims)**
- ❑ Member is **NOT** receiving Rinvoq® in combination with other JAK inhibitors, biologic immunomodulators, or with other immunosuppressants

Medication being provided by Specialty Pharmacy – Proprium Rx

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****