SENTARA COMMUNITY PLAN
(MEDICAID)

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 1-800-750-9692**. 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: select one drug below

❑ **Rinvoq®** (upadacitinib)	❑ **Rinvoq® LQ** (upadacitinib)

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

Member Name: _____

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

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

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

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

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

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

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.

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

- ❑ Member is at least 18 years of age and have a diagnosis of rheumatoid arthritis (RA)
- ❑ Member is **NOT** receiving Rinvoq in combination with other JAK inhibitors, biologic DMRDs, or potent immunomodulators such as azathioprine or cyclosporine
- ❑ Trial and failure of, contraindication, or adverse reaction to methotrexate
- ❑ Trial and failure of **TWO (2)** of the preferred drugs below:

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ **Diagnosis: Active Psoriatic Arthritis**

Dosing: Oral: Rinvoq® or Rinvoq® LQ

Patient Age	Patient Weight	Rinvoq® LQ	Rinvoq®
2 to < 18 years of age	10 kg to < 20 kg	3 mg (3 mL) twice daily	Not Recommended
	20 kg to < 30 kg	4 mg (4 mL) twice daily	Not Recommended
	> 30 kg	6 mg (6 mL) twice daily	15 mg once daily
≥ 18 years of age	N/A	N/A	15 mg once daily

- ❑ Member has a diagnosis of active **psoriatic arthritis**
- ❑ Member is 2 years of age or older
- ❑ Member is **NOT** receiving Rinvoq in combination with other JAK inhibitors, biologic DMRDs, or potent immunomodulators such as azathioprine or cyclosporine
- ❑ Trial and failure of, contraindication, or adverse reaction to methotrexate
- ❑ Trial and failure of **TWO (2)** of the preferred drugs below:

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ **Diagnosis: Moderate-to-Severe Atopic Dermatitis**
Dosing: Oral: Rinvoq® 15 mg once daily; may increase to 30 mg once daily if inadequate response

- ❑ Member is 12 years of age or older weighing at least 40kg
- ❑ Prior documented trial and failure of 8 weeks for each trial (or contraindication) of:
  - ❑ One (1) topical corticosteroid of medium to high potency (e.g., mometasone, fluocinolone)
  - ❑ One (1) topical calcineurin inhibitors (tacrolimus or pimecrolimus)
  - ❑ Trial and failure of Eucrisa™

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❑ **Diagnosis: Active Non-Radiographic Axia Spondylarthritis**
Dosing: Oral: Rinvoq® 15 mg once daily

- ❑ Member is at least 18 years of age and have a diagnosis of axial spondylarthritis
- ❑ Trial and failure of **BOTH** of the **PREFERRED** drugs below:

❑ Humira®	❑ Infliximab

- ❑ Member is **NOT** receiving Rinvoq in combination with other JAK inhibitors, biologic DMRDs, or potent immunomodulators such as azathioprine or cyclosporine

❑ **Diagnosis: Polyarticular Juvenile Idiopathic Arthritis**

Dosing: Oral: Rinvoq® or Rinvoq® LQ

Patient Age	Patient Weight	Rinvoq® LQ	Rinvoq®
2 to < 18 years of age	10 kg to < 20 kg	3 mg (3 mL) twice daily	Not Recommended
	20 kg to < 30 kg	4 mg (4 mL) twice daily	Not Recommended
	> 30 kg	6 mg (6 mL) twice daily	15 mg once daily
≥ 18 years of age	N/A	N/A	15 mg once daily

- ❑ Member has a diagnosis of polyarticular **juvenile idiopathic arthritis**
- ❑ Member is 2 years of age or older
- ❑ Member is **NOT** receiving Rinvoq in combination with other JAK inhibitors, biologic DMRDs, or potent immunomodulators such as azathioprine or cyclosporine
- ❑ Trial and failure of, contraindication, or adverse reaction to methotrexate
- ❑ Trial and failure of **TWO** (2) of the preferred drugs below:

❑ Humira®	❑ Enbrel®	❑ Infliximab

Medication being provided by Specialty Pharmacy - PropriumRx

*****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.***

***Approved by Pharmacy and Therapeutics Committee**: ~~10/17/2019; 11/18/2022;~~ **8/17/2023**
REVISED/UPDATED/REFORMATTED: ~~11/20/2019 3/1/2022; 3/16/2022; 4/25/2022; 6/6/2022; 8/22/2022; 11/22/2022; 12/23/2022; 4/21/2023; 8/13/2023,12/29/2023, 8/28/2024;~~ **12/13/2024**