SENTARA HEALTH PLANS

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.

- Will the member be discontinuing a previously prescribed biologic if approved for requested medication?
  ❑ Yes **OR** ❑ No
- If yes, please list the medication that will be discontinued and the medication that will be initiated upon approval along with the corresponding effective date.

  Medication to be discontinued: _____ **Effective date:** _____

  Medication to be initiated: _____ **Effective date:** _____

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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: Rinvoq® 15 mg once daily

- ❑ Member has a diagnosis of moderate-to-severe **rheumatoid 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**
  - ❑ hydroxychloroquine
  - ❑ leflunomide
  - ❑ methotrexate
  - ❑ sulfasalazine
- ❑ Member meets **ONE** of the following:
  - ❑ Member tried and failed, has a contraindication, or intolerance to **ONE** of the following:
    - ❑ **ONE** preferred adalimumab product
    - ❑ Enbrel®
    - ❑ Other Tumor Necrosis Factor (TNF) blocker medication approved for treatment of Moderate-to-Severe Rheumatoid Arthritis: _____
  - ❑ 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: 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	6 mg (6 mL) twice daily	15 mg once daily

- ❑ Member has a diagnosis of active **psoriatic arthritis**
- ❑ Prescribed by or in consultation with **a Rheumatologist or Dermatologist**

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- ❑ Member is 2 years of age or older
- ❑ 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:
    - ❑ **ONE** preferred adalimumab product
    - ❑ Enbrel®
    - ❑ Other Tumor Necrosis Factor (TNF) blocker medication approved for treatment of Active Psoriatic Arthritis: _____
  - ❑ 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: Rinvoq® 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

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- ❑ Member has tried and failed at least **TWO** of the following therapies **(check all that apply; verified by chart notes or pharmacy paid claims)**:
  - ❑ 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** topical calcineurin inhibitor in the past 180 days (e.g., tacrolimus ointment, pimecrolimus cream*) (***requires prior authorization**)
  - ❑ 30 days of therapy with **ONE** topical phosphodiesterase-4 enzyme inhibitor in the past 180 days (e.g., Eucrisa*, Zoryve 0.15% cream*) **(*requires prior authorization)**
  - ❑ 30 days of therapy with **ONE** topical janus kinase inhibitor in the past 180 days (e.g., Opzelura*) **(*requires prior authorization)**
  - ❑ 90 days of therapy with **ONE** generic oral DMARD (e.g., azathioprine, cyclosporine, methotrexate, mycophenolate mofetil)

❑ **Diagnosis: Moderate-to-Severe Ulcerative Colitis (UC)**
Dosing: Oral: Rinvoq®: Induction - 45 mg once daily for 8 weeks; Maintenance - 15 mg once daily. A dosage of 30 mg once daily may be considered for 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 tried and failed, has a contraindication, or intolerance to **ONE** preferred adalimumab product
  - ❑ Member tried and failed, has a contraindication, or intolerance to **ONE** other Tumor Necrosis Factor (TNF) blocker medication approved for treatment of Moderate-to-Severe Ulcerative Colitis (UC):
    _____
  - ❑ TNF blockers are clinically inadvisable for this member and meets **ONE** of the following:
    - ❑ Member has tried and failed corticosteroids
    - ❑ Member has tried and failed at least **ONE** of the following DMARD therapies:
      - ❑ 5-aminosalicylates (balsalazide, olsalazine, sulfasalazine)
      - ❑ oral mesalamine (Apriso, Asacol/HD, Delzicol, Lialda, Pentasa)
      - ❑ Other immunosuppressant drug: _____
    - ❑ Member has tried and failed another biologic medication (e.g., Skyrizi, Tremfya, ustekinumab)
  - ❑ 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

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

Dosing: Oral: Rinvoq®: Induction - 45 mg once daily for 12 weeks; Maintenance - 15 mg once daily. A dosage of 30 mg once daily may be considered for 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 tried and failed, has a contraindication, or intolerance to **ONE** preferred adalimumab product
  - ❑ Member tried and failed, has a contraindication, or intolerance to **ONE** other Tumor Necrosis Factor (TNF) blocker medication approved for treatment of Moderate-to-Severe Active Crohn's Disease: _____
  - ❑ TNF blockers are clinically inadvisable for this member and meets **ONE** of the following:
    - ❑ Member has tried and failed corticosteroids
    - ❑ Member has tried and failed at least one conventional systemic therapy (e.g., azathioprine, 6-mercaptopurine, or methotrexate)
    - ❑ Member has tried and failed another biologic medication (e.g., Skyrizi, Tremfya, ustekinumab)
  - ❑ 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: Rinvoq® 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 **ONE** NSAIDs
- ❑ Member meets **ONE** of the following:
  - ❑ Member tried and failed, has a contraindication, or intolerance to **ONE** of the following:
    - ❑ **ONE** preferred adalimumab product
    - ❑ Enbrel®
    - ❑ Other Tumor Necrosis Factor (TNF) blocker medication approved for treatment of Active Ankylosing Spondylitis: _____
  - ❑ 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)**

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- ❑ 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: Rinvoq® 15 mg once daily

- ❑ Member has a diagnosis of active **non-radiographic axial spondyloarthritis**
- ❑ Prescribed by or in consultation with a **Rheumatologist**
- ❑ 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 **ONE** of the following:
    - ❑ Cimzia®
    - ❑ Other Tumor Necrosis Factor (TNF) blocker medication approved for treatment of Active Non-Radiographic Axial Spondyloarthritis: _____
  - ❑ 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 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	6 mg (6 mL) twice daily	15 mg once daily

- ❑ Member has a diagnosis of polyarticular **juvenile idiopathic arthritis**
- ❑ Prescribed by or in consultation with a **Rheumatologist**
- ❑ Member is 2 years of age or older

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- ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**
  - ❑ cyclosporine
  - ❑ hydroxychloroquine
  - ❑ leflunomide
  - ❑ methotrexate
  - ❑ sulfasalazine
- ❑ Member meets **ONE** of the following:
  - ❑ Member tried and failed, has a contraindication, or intolerance to **ONE** of the following:
    - ❑ **ONE** preferred adalimumab product
    - ❑ Enbrel®
    - ❑ Other Tumor Necrosis Factor (TNF) blocker medication approved for treatment of Active Polyarticular Juvenile Idiopathic Arthritis: _____
  - ❑ 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)**

❑ **Diagnosis: Giant Cell Arteritis**
Dosing: Oral: Rinvoq® 15 mg once daily

Initial Authorization: 12 months

- ❑ Prescribed by or in consultation with **ONE** of the following:
  - ❑ Neurologist
  - ❑ Ophthalmologist
  - ❑ Rheumatologist
- ❑ Member has diagnosis of Giant Cell Arteritis (GCA) with large vessel arteritis that has at some point been verified with biopsy or with imaging of the large vessels (e.g., color Doppler ultrasound [CDUS], MRI, PET-CT, or CT angiography)
- ❑ Member is at least 18 years of age
- ❑ Member has tried one systemic corticosteroid

Reauthorization: 12 months. 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.

- ❑ Member has experienced disease response as indicated by improvement in signs and symptoms compared to baseline such as headache, temporal artery tenderness, visual symptoms, inflammatory parameters (e.g., erythrocyte sedimentation rate [ESR], C-reactive protein), improvement of periodic imaging studies (color Doppler ultrasound [CDUS], MRI, PET-CT, or CT angiography

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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.*

***Approved by Pharmacy and Therapeutics Committee**: ~~10/17/2019; 11/18/2022; 8/17/2023; 7/26/2024; 11/21/2024; 7/24/2025;~~ **1/22/2026**
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; 8/23/2024; 12/23/2024, 2/20/2025; 7/7/2025; 7/14/2025; 9/4/2025; 9/23/2025;~~ **2/18/2026**