TRICARE Prior Authorization Request Form for upadacitinib **(Rinvoq)**

6458

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

PLEASE NOTE: For Active Duty Service Members, even if coverage will NOT BE APPROVED per this form, it still must be initially submitted to the TPharm Contractor for review. Subsequent reconsideration is allowed at the appropriate Military Treatment Facility.

For initial review by the TPharm Contractor;

- The provider may **call**: **1-866-684-4488**
  or the completed form may be **faxed** to:
  1-866-684-4477

- The patient may attach the completed form
  to the prescription and **mail** it to: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954**
  or **email** the form only to:
  TPharmPA@express-scripts.com

For Atopic Dermatitis, prior authorization expires after 12 months. Renewal PA criteria will be approved indefinitely. For renewal of therapy an initial Tricare prior authorization approval is required.

For Rheumatoid Arthritis, Psoriatic Arthritis, Polyarticular Juvenile Idiopathic Arthritis, Ankylosing Spondylitis, Non-Radiographic Axial Spondyloarthritis, Ulcerative Colitis, or Crohn's Disease the prior authorization is approved indefinitely.

Step 1

Please complete patient and physician information (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2

Please complete clinical assessment:

1. Is the requested medication being used for atopic dermatitis?	☐ Yes proceed to question **2**	☐ No proceed to question **9**
2. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Rinvoq.*	☐ Yes (subject to verification) proceed to question **3**	☐ No proceed to question **4**
3. For atopic dermatitis, has the patient's disease severity improved and stabilized to warrant continued therapy?	☐ Yes (subject to verification) **Sign and date below**	☐ No **STOP** **Coverage not approved**
4. Is the patient greater than or equal to 12 years of age?	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Is the requested medication prescribed by a dermatologist, allergist, or immunologist?	☐ Yes proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Is the patient's disease adequately controlled with other systemic drug products including biologics (for example, Dupixent)?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **7**

7. Does the patient have a contraindication to, intolerability to, or have they failed treatment with ONE medication in EACH of the following two categories: • **Topical Corticosteroids (**NOTE: **For patients 12 to 17 years of age,** can be any topical corticosteroid. **For patients 18 years of age or older,** high potency/class 1 topical corticosteroids (for example, clobetasol propionate 0.05% ointment/cream, fluocinonide 0.05% ointment/cream) is required. • **Topical calcineurin inhibitor (for example, pimecrolimus, tacrolimus)?**	☐ Yes proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Does the patient have a contraindication to, intolerability to, inability to access treatment, or has failed treatment with Narrowband UVB phototherapy?	☐ Yes proceed to question **23**	☐ No **STOP** **Coverage not approved**
9. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	☐ Yes proceed to question **10**	☐ No proceed to question **12**
10. Has the patient had an inadequate response to Humira?	☐ Yes proceed to question **13**	☐ No proceed to question **11**
11. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes proceed to question **13**	☐ No **STOP** **Coverage not approved**
12. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Is the patient 18 years of age or older?	☐ Yes proceed to question **14**	☐ No proceed to question **15**
14. What is the indication or diagnosis for this adult patient?	☐ Moderate to severe active rheumatoid arthritis – proceed to question **16** ☐ Active psoriatic arthritis- proceed to question **17** ☐ Moderately to severely active ulcerative colitis - proceed to question **20** ☐ Ankylosing spondylitis – proceed to question **21** ☐ Non-radiographic axial spondyloarthritis – proceed to question **21** ☐ Moderately to severely active Crohn's disease - proceed to question **23** ☐ Other indication or diagnosis – **STOP: Coverage not approved**	
15. What is the indication or diagnosis for this pediatric patient?	☐ Active psoriatic arthritis - proceed to question **19** ☐ Active polyarticular juvenile idiopathic arthritis – proceed to question **19** ☐ Other indication or diagnosis – **STOP: Coverage not approved**	

16. The provider acknowledges that for rheumatoid arthritis a trial of Xeljanz or Olumiant is required before Rinvoq. Has the patient had an inadequate response or adverse reaction or a contraindication to Xeljanz OR Xeljanz XR OR Olumiant?	☐ Yes proceed to question **18**	☐ No **STOP** **Coverage not approved**
17. The provider acknowledges that for psoriatic arthritis a trial of Xeljanz is required before Rinvoq. Has the patient experienced an inadequate response or adverse reaction or contraindication to Xeljanz OR Xeljanz XR?	☐ Yes proceed to question **18**	☐ No **STOP** **Coverage not approved**
18. Has the patient had an inadequate response or an intolerance to methotrexate or other nonbiologic disease-modifying antirheumatic drugs (DMARDs)?	☐ Yes proceed to question **23**	☐ No **STOP** **Coverage not approved**
19. Is the patient 2 to 17 years of age?	☐ Yes proceed to question **23**	☐ No **STOP** **Coverage not approved**
20. Has the patient had an inadequate response to non-biologic systemic therapy (for example – methotrexate, aminosalicylates (for example, sulfasalazine, mesalamine), corticosteroids, immunosuppressants (for example, azathioprine), etc.?	☐ Yes proceed to question **23**	☐ No **STOP** **Coverage not approved**
21. Has the patient experienced an inadequate response to at least TWO Nonsteroidal anti-inflammatory drugs (NSAIDs) (for example: ibuprofen, naproxen, diclofenac) over a period of at least two months?	☐ Yes proceed to question **22**	☐ No **STOP** **Coverage not approved**
22. The provider acknowledges that for ankylosing spondylitis or non-radiographic axial spondyloarthritis a trial of Cosentyx is required before Rinvoq. Has the patient experienced an inadequate response or adverse reaction or contraindication to Cosentyx?	☐ Yes proceed to question **23**	☐ No **STOP** **Coverage not approved**
23. Will the patient be receiving other targeted immunomodulatory biologics with Rinvoq, except for Otezla, including but not limited to the following: Actemra, Cimzia, Cosentyx, Enbrel, Humira, Ilumya, Kevzara, Kineret, Olumiant, Orencia, Remicade, Rituxan, Siliq, Stelara, Taltz, Xeljanz or Xeljanz XR or Tremfya?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **24**
24. Is the provider aware of the FDA safety alerts and boxed warnings?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature _____ Date _____