

BlueShield. RINVOQ Federal Employee Program. PRIOR APPROVAL REQUEST

Send completed form to: Service Benefit Plan Prior Approval P.O. Box 52080 MC 139 Phoenix, AZ 85072-2080 Attn. Clinical Services Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Pa	itient Inform	ation (required)		Provide	r Infor	mation (req	uired)
Date:				Provider Name:			
Patient Name:				Specialty:		NPI:	
Date of Birth:		Sex: Male	□Female	Office Phone:		Office Fax:	
Street Address:				Office Street Address:	-		
City:		State:	Zip:	City:	Sta	nte:	Zip:
Patient ID: R	1 1	1 1 1	1 1	Physician Signature:			
]	PHYSICIAN	COMPLETES			
			Rinvoq (upadacitinib)			
		NOTE: Form n	nust be comple	ted in its entirety for proces	ssing		
Dlagge goleet strov	ath and nuavid	la anantitu	_	· · ·			
Please select strer		per 90	n dave	□45 mg tablet	auani	tity	per 90 days
□30 mg tablet		per 90	•	□1 mg/mL oral solution	_	-	per 90 days
**Check www.fepblu	e.org/formulary to	confirm which medi	cation is part of tl	ne patient's benefit			
☐ YES – this is ☐ NO – this is 2. Is this request f 3. Has the prescril smoking histor 4. Has the patient *If YES, was	s a PA renewal factor brand or generated to be considered to be cardiovascular been tested for the sthe result of the	for CONTINUATE of therapy, please eric? Brand the risks for maligur risk factors etc. latent tuberculosise test positive or a	TION of therape answer the question and major and major and determine to (TB)? ☐ Yes integrative for TB	or adverse cardiovascular eved that Rinvoq therapy is ap * □No 6 infection? □Positive*	ons on <u>P</u> vents (M. propriate	ACE) (such a e?	us advanced age, 1 No
*If POSIT	TIVE, has the part	tient completed tre	eatment or is the	patient currently receiving to	eatment	for latent TB?	□Yes □No
5. Does the patien	t have severe he	epatic impairment	t (Child-Pugh C	Class C)? □Yes □No			
6. Does the patien	t have a lympho	ocyte count less th	nan 500 cells pe	er cubic millimeter (cells/mi	n3)? 🔲	Yes □No	
-		-		than 1000 cells per cubic m	illimeter	(cells/mm3)?	? □Yes □No
8. Does the patien	t have a hemogl	lobin less than 8 g	grams per decili	ter (g/dL) ? \square Yes \square No			
9. Does the patient	have a history of	f thrombotic event	s including deep	vein thrombosis (DVT) or p	oulmonar	y embolism (P	E)? □Yes □No
10. Does the patie	nt have any acti	ve bacterial, inva	sive fungal, vir	al, or other opportunistic in	fections 1	present? $\Box Y$	es □No
11. Will the patien	nt be given live	vaccines while or	this therapy?	□Yes □No			
12. Will Rinvoq b	e used in combi	nation with poten	nt immunosuppi	ressants such as azathioprin	e or cycl	osporine?	Yes □No
* <i>If YES</i> , plo	ease specify the	medication:		DMARD or a targeted synti			

PLEASE PROCEED TO PAGE 2 FOR DIAGNOSES

Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.

Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq,

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PAGE 2 - PHYSICIAN COMPLETES						
Patient Name:	DOB:	Patient	ID: R			
14. What is the patient's diagnosis?						
☐Ankylosing spondylitis (AS)						
a. Does the patient have active a	nkylosing spondylitis (AS)?	□Yes □No				
 b. Does the patient have an intol non-steroidal anti-inflammato 			nadequate trea	tment response to at least two		
 c. Does the patient have an intol TNF blocker such as Cimzia, 				tment response to at least one □No		
d. Standard/Basic Option pati	ent, <u>for claims adjudicated</u>	through the pharn	nacy benefit:	Is this medication being		
requested as a change from or			their copay b	enefit: Bimzelx, Cimzia,		
Cosentyx, Simponi, or Xeljan		lNo				
	cation: □Bimzelx □Cim	nzia	□Simponi	□Xeljanz/Xeljanz XR		
☐ Atopic dermatitis (eczema) a. Does the patient have modera	to to sovere etopic dermetitis	(aczoma)? DVac	□No			
b. Does the patient have an intol	_			tment response to at least two		
systemic atopic dermatitis me		•		•		
Dupixent, etc.)? \(\square\)Yes \(\square\)N		s (e.g., oral corticos	icroids, frydro.	xyzme, Adory, Cromqo,		
c. Will Rinvoq be used in combi	nation with another *non-top	pical Prior Authoriz	ation (PA) me	dication for atopic		
dermatitis? \(\text{Yes} \) \(\text{No} \)	a madiaation.					
	e medication: tions: Adbry (tralokinumab-ldri		ih) Dumin aut ((demilere ab)		
□Crohn's disease (CD)	ions: Adory (tratokinumao-tari	m), Civinqo (avrocuir	но), Биріхені (аириитав)		
a. Does the patient have modera	te to severely active Crohn's	disease (CD)? □Y	es 🗆 No			
b. Does the patient have an intol conventional therapy option?	erance or contraindication or			tment response to at least one		
c. Does the patient have an intol TNF blocker such as Cimzia,	erance or contraindication or		adequate treat	tment response to at least one		
d. Standard/Basic Option pati requested as a change from C $\square Yes* \square No *If YES, pl$	imzia, Entyvio, Omvoh, or Z	Zymfentra to allow the	ne member acc			
☐Giant cell arteritis				3v. D.v		
a. Has the patient had an inadeq	•					
b. Will Rinvoq be used in comb of corticosteroids? □Yes □	ination with a tapering course INo	e of corticosteroids	or as monothe	rapy following discontinuation		
■Non-radiographic axial spondyloa a. Does the patient have active r		yloarthritis (nr-axSp	A)? □Yes	□No		
b. Does the patient have objective	ve signs of inflammation? \Box	lYes □No				
 c. Does the patient have an intol non-steroidal anti-inflammato 		have they had an ir \bullet No	adequate treat	tment response to at least two		
d. Does the patient have an intol TNF blocker such as Cimzia?		have they had an ir	nadequate trea	tment response to at least one		
e. Standard/Basic Option pati change from Bimzelx or Cose * If YES , please select medi	entyx to allow the member ac	ccess to their copay				

PLEASE PROCEED TO PAGE 3 FOR ADDITIONAL DIAGNOSES

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Patient Name:	PAGE 3 - PHYSICIAL DOB:		
Tuttent Nume.		Tatient ID: N	
☐Polyarticular juvenile idiop a. Does the patient have	pathic arthritis (pJIA) active polyarticular juvenile idiopatl	nic arthritis (pJIA)? □Yes □	l No
	an intolerance or contraindication or nventional disease modifying antirhe		
	an intolerance or contraindication or Enbrel, Humira, Remicade, or Simpo		reatment response to at least one
requested as a change	on patient, <u>for claims adjudicated</u> from Actemra SC or an Actemra SC penefit? □Yes* □No		
*If YES, please sele	ect medication: Actemra SC/Acte	mra SC biosimilar □Cimzia	□Kevzara □Orencia SC
☐Psoriatic arthritis (PsA) a. Does the patient have	active psoriatic arthritis (PsA)? \square Y	es □No	
	an intolerance or contraindication or enventional disease modifying antirhe		
	an intolerance or contraindication or Cimzia, Enbrel, Humira, Remicade, o		
requested as a change Cosentyx, Orencia SC	from one of the following to allow to simponi? \(\sigma Yes * \square No \)	he member access to their copa	y benefit: Bimzelx, Cimzia,
v / 1	ect medication: □Bimzelx □Cim	zia UCosentyx UOrencia	SC □Simponi
□Rheumatoid arthritis (RA)			
-	moderate to severely active rheumat		
trial of at least one con	an intolerance or contraindication or nventional disease modifying antirhe	umatic drug (DMARD)? TYe	es 🗆 No
TNF blocker such as (an intolerance or contraindication or Cimzia, Enbrel, Humira, Remicade, or	or Simponi/Simponi Aria? 🏻 Y	es □No
requested as a change Actemra SC biosimila	from one of the following to allow the firm one of the firm one of the firm of	he member access to their copa nt, Orencia SC, or Simponi?	y benefit: Actemra SC or an Yes* □No
□Ulcerative colitis (UC)			
a. Does the patient have	moderate to severely active ulcerative	ve colitis (UC)? \(\bar{\text{U}}\)Yes \(\bar{\text{U}}\)No	
	an intolerance or contraindication of option? □Yes □No	have they had an inadequate to	reatment response to at least one
	an intolerance or contraindication of Humira, Remicade, or Simponi?		reatment response to at least one
requested as a change Simponi, Xeljanz/Xelj	on patient, <u>for claims adjudicated</u> from one of the following to allow t janz XR, Velsipity, Zeposia, or Zymet medication: □Entyvio □Omvet	he member access to their copa fentra? □Yes* □No	y benefit: Entyvio, Omvoh,
v /1	□Zeposia □Zymf		
☐Other (please specify):			

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RINVOQ

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physician portion and submit this completed form.			Fax: 1-011-310-4121		
Patient Information (required)			Provider Information (required)		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: □Male □Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: R I I	1 1 1	1 1	Physician Signature:		
PHYSICIAN COMPLETES					

CONTINUATION OF THERAPY (PA RENEWAL)

Rinvog (unadacitinih)

		Kiliyo	q (upadaciumb)		
	<u>N</u> 0	OTE: Form must be com	pleted in its entirety for process	ing	
Please select streng	gth and provide q	uantity:			
□15 mg tablet		per 90 days	□45 mg tablet	quantity	per 90 days
□30 mg tablet	quantity	per 90 days	☐1 mg/mL oral solution	quantity	per 90 days
**Check www.fepblue.	.org/formulary to confi	irm which medication is part	of the patient's benefit		
1. Has the patient b	been on this medica	tion continuously for the	last 6 months excluding sample	es? Please select o	answer below:
\square NO – this is I	INITIATION of th	erapy, please answer the	questions on PAGE 1		
\Box YES – this is	a PA renewal for C	CONTINUATION of the	erapy, please answer the question	ns below:	
2. Is this request fo	or brand or generic?	☐ Brand ☐ Generic			
3. What is the patie	ent's diagnosis?				
□Ankylosing sp	pondylitis (AS)		□Polyarticular juvenile	idiopathic arthriti	s (рЛА)
□Crohn's disea	ise (CD)		☐Psoriatic arthritis (PsA	L)	
☐Giant cell arte			□Rheumatoid arthritis (*	
		oarthritis (nr-axSpA)	□Ulcerative colitis (UC))	
☐Atopic derma	,				
	voq be used in com s? □Yes* □No	bination with another *no	on-topical Prior Authorization (F	PA) medication fo	or atopic
•		e medication:			
*Non	ı-Topical PA Medica	tions: Adbry (tralokinumab	-ldrm), Cibinqo (abrocitinib), Dup	ixent (dupilumab)	
Other (please s	specify):				
			najor adverse cardiovascular evenined that Rinvoq therapy is appr		
5. Has the patient's	s condition improve	ed or stabilized with thera	py? □Yes □No		
6. Has the patient de	eveloped any thromb	ootic events, including deep	p vein thrombosis (DVT) or pulme	onary embolisms ((PE)? □Yes □No
7. Does the patient	have any active ba	cterial, invasive fungal, v	riral, or other opportunistic infec	tions present?	IYes □No
8. Will the patient	be given live vaccin	nes while on this therapy	? □Yes □No		
9. Will Rinvoq be	used in combination	n with potent immunosup	pressants such as azathioprine o	r cyclosporine?	□Yes □No
10. Will Rinvoq be	e used in combination	on with any other biologi	c *DMARD or a targeted synthe	etic DMARD?	Yes* □No
*If YES, plea	se specify the medi	cation:			
			zelx, Cimzia, Cosentyx, Enbrel, En		

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Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.