BlueCross BlueShield Federal Employee Program

RINVOQ
PRIOR APPROVAL REQUEST

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.

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

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**			Physician Signature:		
PHYSICIAN COMPLETES					

Rinvoq (upadacitinib)

NOTE: Form must be completed in its **entirety** for processing

Please select strength and provide quantity:

❑15 mg tablet	**quantity _____ 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 confirm which medication is part of the patient's benefit**

1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 4**
   ❑ **NO** – this is **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Has the prescriber considered the risks for malignancy and major adverse cardiovascular events (MACE) (such as advanced age, smoking history, cardiovascular risk factors etc.) and determined that Rinvoq therapy is appropriate? ❑Yes ❑No
4. Has the patient been tested for latent tuberculosis (TB)? ❑Yes* ❑No
   If YES, was the result of the test positive or negative for TB infection? ❑Positive* ❑Negative
   If POSITIVE, has the patient completed treatment or is the patient currently receiving treatment for latent TB? ❑Yes ❑No
5. Does the patient have severe hepatic impairment (Child-Pugh Class C)? ❑Yes ❑No
6. Does the patient have a lymphocyte count less than 500 cells per cubic millimeter (cells/mm3)? ❑Yes ❑No
7. Does the patient have an absolute neutrophil count (ANC) less than 1000 cells per cubic millimeter (cells/mm3)? ❑Yes ❑No
8. Does the patient have a hemoglobin less than 8 grams per deciliter (g/dL)? ❑Yes ❑No
9. Does the patient have a history of thrombotic events including deep vein thrombosis (DVT) or pulmonary embolism (PE)? ❑Yes ❑No
10. Does the patient have any active bacterial, invasive fungal, viral, or other opportunistic infections present? ❑Yes ❑No
11. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
12. Will Rinvoq be used in combination with potent immunosuppressants such as azathioprine or cyclosporine? ❑Yes ❑No
13. Will Rinvoq be used in combination with any other biologic *DMARD or a targeted synthetic DMARD? ❑Yes* ❑No
    If YES, please specify the medication: _____

    DMARDs: Actemra or an Actemra biosimilar, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.

PLEASE PROCEED TO PAGE 2 FOR DIAGNOSES

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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 ankylosing spondylitis (AS)? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least two non-steroidal anti-inflammatory drugs (NSAIDs)? ❑Yes ❑No

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one TNF blocker such as Cimzia, Enbrel, Humira, Remicade, or Simponi/Simponi Aria? ❑Yes ❑No

d. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Is this medication being requested as a change from one of the following to allow the member access to their copay benefit: Bimzelx, Cimzia, Cosentyx, Simponi, or Xeljanz/Xeljanz XR? ❑Yes* ❑No

***If YES,** please select medication: ❑Bimzelx ❑Cimzia ❑Cosentyx ❑Simponi ❑Xeljanz/Xeljanz XR

❑Atopic dermatitis (eczema)

a. Does the patient have moderate to severe atopic dermatitis (eczema)? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least two systemic atopic dermatitis medications, including biologics (e.g., oral corticosteroids, hydroxyzine, Adbry, Cibinqo, Dupixent, etc.)? ❑Yes ❑No

c. Will Rinvoq be used in combination with another *non-topical Prior Authorization (PA) medication for atopic dermatitis? ❑Yes* ❑No

***If YES**, please specify the medication: _____

***Non-Topical PA Medications: Adbry (tralokinumab-ldrm), Cibinqo (abrocitinib), Dupixent (dupilumab)**

❑Crohn's disease (CD)

a. Does the patient have moderate to severely active Crohn's disease (CD)? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one conventional therapy option? ❑Yes ❑No

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one TNF blocker such as Cimzia, Humira, or Remicade? ❑Yes ❑No

d. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Is this medication being requested as a change from Cimzia, Entyvio, Omvoh, or Zymfentra to allow the member access to their copay benefit? ❑Yes* ❑No ***If YES**, please select medication: ❑Cimzia ❑Entyvio ❑Omvoh ❑Zymfentra

❑Giant cell arteritis

a. Has the patient had an inadequate treatment response to a 3-month trial of corticosteroids? ❑Yes ❑No

b. Will Rinvoq be used in combination with a tapering course of corticosteroids or as monotherapy following discontinuation of corticosteroids? ❑Yes ❑No

❑Non-radiographic axial spondyloarthritis (nr-axSpA)

a. Does the patient have active non-radiographic axial spondyloarthritis (nr-axSpA)? ❑Yes ❑No

b. Does the patient have objective signs of inflammation? ❑Yes ❑No

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least two non-steroidal anti-inflammatory drugs (NSAIDs)? ❑Yes ❑No

d. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one TNF blocker such as Cimzia? ❑Yes ❑No

e. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Is Rinvoq being requested as a change from Bimzelx or Cosentyx to allow the member access to their copay benefit? ❑Yes* ❑No

***If YES**, please select medication: ❑Bimzelx ❑Cimzia

PLEASE PROCEED TO <u>PAGE 3</u> FOR ADDITIONAL DIAGNOSES

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PAGE 3 - PHYSICIAN COMPLETES

Patient Name: _____ **DOB:** _____ **Patient ID: R** _____

❑Polyarticular juvenile idiopathic arthritis (pJIA)

a. Does the patient have active polyarticular juvenile idiopathic arthritis (pJIA)? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3-month trial of at least one conventional disease modifying antirheumatic drug (DMARD)? ❑Yes ❑No

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one TNF blocker such as Enbrel, Humira, Remicade, or Simponi Aria? ❑Yes ❑No

d. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Is this medication being requested as a change from Actemra SC or an Actemra SC biosimilar, Cimzia, Kevzara, or Orencia SC to allow the member access to their copay benefit? ❑Yes* ❑No

If YES, please select medication: ❑Actemra SC/Actemra SC biosimilar ❑Cimzia ❑Kevzara ❑Orencia SC

❑Psoriatic arthritis (PsA)

a. Does the patient have active psoriatic arthritis (PsA)? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3-month trial of at least one conventional disease modifying antirheumatic drug (DMARD)? ❑Yes ❑No

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one TNF blocker such as Cimzia, Enbrel, Humira, Remicade, or Simponi/Simponi Aria? ❑Yes ❑No

d. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Is this medication being requested as a change from one of the following to allow the member access to their copay benefit: Bimzelx, Cimzia, Cosentyx, Orencia SC, or Simponi? ❑Yes* ❑No

If YES, please select medication: ❑Bimzelx ❑Cimzia ❑Cosentyx ❑Orencia SC ❑Simponi

❑Rheumatoid arthritis (RA)

a. Does the patient have moderate to severely active rheumatoid arthritis (RA)? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3-month trial of at least one conventional disease modifying antirheumatic drug (DMARD)? ❑Yes ❑No

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one TNF blocker such as Cimzia, Enbrel, Humira, Remicade, or Simponi/Simponi Aria? ❑Yes ❑No

d. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Is this medication being requested as a change from one of the following to allow the member access to their copay benefit: Actemra SC or an Actemra SC biosimilar, Cimzia, Kevzara, Kineret, Olumiant, Orencia SC, or Simponi? ❑Yes* ❑No

If YES, please select medication: ❑Actemra SC/Actemra SC biosimilar ❑Cimzia ❑Kevzara ❑Kineret ❑Olumiant ❑Orencia SC ❑Simponi

❑Ulcerative colitis (UC)

a. Does the patient have moderate to severely active ulcerative colitis (UC)? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one conventional therapy option? ❑Yes ❑No

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one TNF blocker such as Humira, Remicade, or Simponi? ❑Yes ❑No

d. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Is this medication being requested as a change from one of the following to allow the member access to their copay benefit: Entyvio, Omvoh, Simponi, Xeljanz/Xeljanz XR, Velsipity, Zeposia, or Zymfentra? ❑Yes* ❑No

If YES, please select medication: ❑Entyvio ❑Omvoh ❑Simponi ❑Xeljanz/Xeljanz XR ❑Velsipity ❑Zeposia ❑Zymfentra

❑Other ***(please specify)***: _____

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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**			Physician Signature:		
PHYSICIAN COMPLETES					

CONTINUATION OF THERAPY (PA RENEWAL)

Rinvoq (upadacitinib)

NOTE: Form must be completed in its **entirety** for processing

Please select strength and provide quantity:

❑15 mg tablet	**quantity _____ 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**

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1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑ **NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
   ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. What is the patient's diagnosis?
   ❑Ankylosing spondylitis (AS)
   ❑Crohn's disease (CD)
   ❑Giant cell arteritis
   ❑Non-radiographic axial spondyloarthritis (nr-axSpA)
   ❑Atopic dermatitis (eczema)
   ❑Polyarticular juvenile idiopathic arthritis (pJIA)
   ❑Psoriatic arthritis (PsA)
   ❑Rheumatoid arthritis (RA)
   ❑Ulcerative colitis (UC)
   a. Will Rinvoq be used in combination with another *non-topical Prior Authorization (PA) medication for atopic dermatitis? ❑Yes* ❑No
      ***If YES**, please specify the medication: _____
      ***Non-Topical PA Medications: Adbry (tralokinumab-ldrm), Cibinqo (abrocitinib), Dupixent (dupilumab)**
   ❑Other ***(please specify)***: _____
4. Has the prescriber considered the risks for malignancy and major adverse cardiovascular events (MACE) (such as advanced age, smoking history, cardiovascular risk factors etc.) and determined that Rinvoq therapy is appropriate? ❑Yes ❑No
5. Has the patient's condition improved or stabilized with therapy? ❑Yes ❑No
6. Has the patient developed any thrombotic events, including deep vein thrombosis (DVT) or pulmonary embolisms (PE)? ❑Yes ❑No
7. Does the patient have any active bacterial, invasive fungal, viral, or other opportunistic infections present? ❑Yes ❑No
8. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
9. Will Rinvoq be used in combination with potent immunosuppressants such as azathioprine or cyclosporine? ❑Yes ❑No
10. Will Rinvoq be used in combination with any other biologic *DMARD or a targeted synthetic DMARD? ❑Yes* ❑No
    ***If YES**, please specify the medication: _____
    ***DMARDs: Actemra or an Actemra biosimilar, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.**