**PRIORITY PARTNERS**
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Rinvoq - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**. Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Rinvoq - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Rinvoq (upadacitinib)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

**Diagnosis:** _____ **ICD Code:** _____

Comments: _____

**Please circle the appropriate answer for each question.**

1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.

[If yes, skip to question 8.]

2. Does the patient have a diagnosis of moderate to severe rheumatoid arthritis? Y N

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| | NOTE: Submission of medical records is required. | | |
| | [If no, no further questions.] | | |
| 3. | Has the patient tried and had insufficient response to methotrexate monotherapy? | Y N | |
| | NOTE: Submission of medical records is required. | | |
| | [If no, no further questions.] | | |
| 4. | Has the patient tried and had insufficient response to Enbrel, Humira, or Xeljanz? | Y N | |
| | NOTE: Submission of medical records is required. | | |
| | [If no, no further questions.] | | |
| 5. | Will the requested drug be used concurrently with a biologic disease-modifying antirheumatic drug (DMARD)? | Y N | |
| | [If yes, no further questions.] | | |
| 6. | Will the requested drug be used in combination with other or janus kinase (JAK) inhibitors or potent immunosuppressants (such as azathioprine and cyclosporine)? | Y N | |
| | [If yes, no further questions.] | | |
| 7. | Is the patient 18 years of age or older? | Y N | |
| | [No further questions.] | | |
| 8. | Is the patient experiencing continual benefit from treatment? | Y N | |
| | NOTE: Submission of medical records is required. | | |

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

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| **Prescriber (Or Authorized) Signature and Date** |