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

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

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. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	☐ Yes proceed to question **2**	☐ No proceed to question **4**
2. Has the patient had an inadequate response to Humira?	☐ Yes proceed to question **5**	☐ No proceed to question **3**
3. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
4. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Has the patient experienced an inadequate response or adverse reaction to Xeljanz OR Xeljanz XR OR Olumiant?	☐ Yes proceed to question **7**	☐ No proceed to question **6**
6. Does the patient have a contraindication to Xeljanz OR Xeljanz XR OR Olumiant?	☐ Yes proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Is the patient 18 years of age or older?	☐ Yes proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Does the patient have a hemoglobin level LESS THAN 8 g/dL?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **9**
9. Does the patient have an absolute neutrophil count (ANC) LESS THAN 1,000/mm^3?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **10**

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10. Does the patient have an absolute lymphocyte count (ALC) LESS THAN 500/mm^3?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **11**
11. What is the indication or diagnosis?	☐ Moderate to severe active **rheumatoid arthritis** – proceed to question **12** ☐ Other indication or diagnosis – STOP: **Coverage not approved.**	
12. Has the patient had an inadequate response or an intolerance to methotrexate or other nonbiologic disease-modifying antirheumatic drugs (DMARDs)?	☐ Yes proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Will the patient be receiving other biologic DMARDs or potent immunosuppressants (for example, azathioprine and cyclosporine) at the same time (concomitantly)?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **14**
14. Does the patient have a history of thromboembolic disease?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **15**
15. Does the patient has evidence of a negative TB test result in the past 12 months (or TB is adequately managed)?	☐ Yes proceed to question **16**	☐ No **STOP** **Coverage not approved**
16. Will the patient be receiving other targeted immunomodulatory biologics with Rinvoq ER, including but not limited to the following: Actemra, Cimzia, Cosentyx, Enbrel, Humira, Ilumya, Kevzara, Kineret, Olumiant, Orencia, Remicade, Rituxan, Siliq, Simponi, Stelara, Taltz, Xeljanz or Xeljanz XR, or Tremfya?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[24 February 2024]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: