Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Rinvoq - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the drug prescribed by or in consultation with a gastroenterologist, rheumatologist or dermatologist?

☐ Yes ☐ No

Q2. Does recent tuberculin testing show that the patient is negative for latent tuberculosis infection?

☐ Yes ☐ No

Q3. Has the patient completed treatment (or is receiving treatment) for latent tuberculosis?

☐ Yes ☐ No

Q4. Does the patient have any other active, serious infection?

☐ Yes ☐ No

Q5. Is there confirmation that live vaccines will be avoided while on Rinvoq therapy?

☐ Yes ☐ No

Q6. Does monitoring of liver function tests show elevated liver enzymes (ALT or AST)?

☐ Yes ☐ No

Q7. Does the patient have severe hepatic impairment?

☐ Yes ☐ No

Q8. Does a complete blood count with differential show any of the following: A. Absolute lymphocyte count is less than 500 cells/mm3, B. Absolute neutrophil count is less than 1000 cells/mm3 , C. Hemoglobin level is less than 8 g/dL?

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Patient Name:	**Prescriber Name:**

☐ Yes ☐ No

Q9. Does the patient have a documented diagnosis of moderately to severely active rheumatoid arthritis, active psoriatic arthritis, moderately to severely active ulcerative colitis, active ankylosing spondylitis, non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation, or moderately to severely active Crohn's disease?

☐ Yes ☐ No

Q10. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q11. Is there a documented history of inadequate response or intolerance to at least one TNF blocker?

☐ Yes ☐ No

Q12. Does the patient have a documented diagnosis of refractory, moderate to severe atopic dermatitis?

☐ Yes ☐ No

Q13. Is the patient 12 years of age and older?

☐ Yes ☐ No

Q14. Is there a documented history of inadequate control with at least one other systemic drug (including biologics) used to treat refractory, moderate to severe atopic dermatitis? (Please attach documentation).

☐ Yes ☐ No

Q15. Are other systemic drugs, including biologics, used to treat refractory, moderate to severe treat atopic dermatitis, inadvisable? (Please attach explanation).

☐ Yes ☐ No

Q16. Will the requested drug be used concomitantly with other JAK inhibitors, biologic disease modifying anti-rheumatic drugs (DMARDs for review of rheumatoid arthritis and psoriatic arthritis), potent immunopsuppressant drugs, strong cytochrome P450 4A4 (CYP3A4) inducers, or biologic immunomodulators, or biologic therapies (for ulcerative colitis)?

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

2023 Medicare Prior Authorization Request