Prescriber Criteria Form

Upadacitinib 2025 PA Fax 3186-A v6 020125.docx
Rinvoq (upadacitinib), Rinvoq LQ (upadacitinib oral solution)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Upadacitinib.

Drug Name (select from list of drugs shown):

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Has the patient previously received the requested drug for one of the following conditions: A) rheumatoid arthritis, B) psoriatic arthritis, C) ulcerative colitis, D) Crohn's disease, E) ankylosing spondylitis, F) non-radiographic axial spondyloarthritis, G) polyarticular juvenile idiopathic arthritis? [If yes, then no further questions.]	Yes ◯	No ◯
2	Does the patient have a diagnosis of moderately to severely active rheumatoid arthritis? [If no, then skip to question 4.]	Yes ◯	No ◯
3	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab-aacf, Enbrel [etanercept], Humira [adalimumab], Idacio [adalimumab-aacf])? [No further questions.]	Yes ◯	No ◯
4	Does the patient have a diagnosis of active psoriatic arthritis? [If no, then skip to question 6.]	Yes ◯	No ◯
5	Has the patient experienced inadequate treatment response, intolerance, or does the patient have a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab-aacf, Enbrel [etanercept], Humira [adalimumab], Idacio [adalimumab-aacf])? [No further questions.]	Yes ◯	No ◯

6	Has the patient been diagnosed with refractory, moderate to severe atopic dermatitis? [If no, then skip to question 12.]	Yes ◯	No ◯
7	Is the patient currently receiving therapy with the requested drug? [If no, then skip to question 10.]	Yes ◯	No ◯
8	Has the patient achieved or maintained a positive clinical response? [If no, then no further questions.]	Yes ◯	No ◯
9	Is the patient 12 years of age or older? [No further questions.]	Yes ◯	No ◯
10	Does the patient meet any of the following: A) patient has had an inadequate response to treatment with at least one other systemic drug product, including biologics, B) use of at least one other systemic drug product, including biologics, is not advisable? [If no, then no further questions.]	Yes ◯	No ◯
11	Is the patient 12 years of age or older? [No further questions.]	Yes ◯	No ◯
12	Does the patient have a diagnosis of moderately to severely active ulcerative colitis? [If no, then skip to question 14.]	Yes ◯	No ◯
13	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab-aacf, Humira [adalimumab], Idacio [adalimumab-aacf])? [No further questions.]	Yes ◯	No ◯
14	Does the patient have a diagnosis of active ankylosing spondylitis? [If no, then skip to question 16.]	Yes ◯	No ◯
15	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab-aacf, Enbrel [etanercept], Humira [adalimumab], Idacio [adalimumab-aacf])? [No further questions.]	Yes ◯	No ◯
16	Does the patient have a diagnosis of active non-radiographic axial spondyloarthritis? [If no, then skip to question 18.]	Yes ◯	No ◯
17	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to at least one tumor necrosis factor (TNF) inhibitor? [No further questions.]	Yes ◯	No ◯
18	Does the patient have a diagnosis of moderately to severely active Crohn’s disease? [If no, then skip to question 20.]	Yes ◯	No ◯
19	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab-aacf, Humira [adalimumab], Idacio [adalimumab-aacf])? [No further questions.]	Yes ◯	No ◯

20	Does the patient have a diagnosis of active polyarticular juvenile idiopathic arthritis? [If no, then no further questions.]	Yes ◯	No ◯
21	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab-aacf, Enbrel [etanercept], Humira [adalimumab], Idacio [adalimumab-aacf])?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____