Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Rinvoq(Upadacitinib) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorization: 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Rinvoq(Upadacitinib).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at:** Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: ______________________________ Kaiser Medical ID#: _________________ Date of Birth: _____________

2 – Provider Information

Provider Name: ______________________________ Specialty: ____________________ Provider NPI: _________________

Provider Address: ____

Provider Phone #: _________________________Provider Fax #: __________________________

3 – Pharmacy Information

Pharmacy Name: ________________________________ Pharmacy NPI: ____

Pharmacy Phone #_______________________________ Pharmacy Fax #: ____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: ____

Sig: ____

Drug 2: Name/Strength/Formulation: ____

Sig: ____

5– Diagnosis/Clinical Criteria

1. Does the member have diagnosis of one of the following? **AND**
   □ Adult Rheumatoid Arthritis (RA)

   □ Psoriatic Arthritis (PA) (2 years of age and older)

   □ Atopic Dermatitis (AD) (12 years of age and older)

   □ Adult Ankylosing Spondylitis (AS)

   □ Adult Ulcerative Colitis (UC)

   □ Non-radiographic axial spondyloarthritis (nr-axSpA)

   □ Adult Moderate to severe Crohn's Disease (CD)

   □ Juvenile Polyarticular JIA (pJIA) (2 years of age and older)

   □ Other: ___________________

2. Indicate patient's age:____

3. Was there a therapeutic failure on oral methotrexate? **AND**
   □ No □ Yes
   If no, provide explanation: ____________________________________

4. Was there therapeutic failure to one of the preferred agents? (e.g. Enbrel, Humira) **AND**
   □ No □ Yes
   If No, provide explanation: _______________________________________

5. Is therapy being used in combination with other JAK inhibitors, biologic DMARDs , or potent immunosuppressants such as azathioprine or cyclosporine?

   □ No □ Yes; If yes, therapy will not be approved.

6 – Provider Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

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I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**
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