



TEXAS MEDICAID Clinical Edit Prior Authorization upadacitinib (RINVOQ)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING

Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: MEDICATION INFORMATION

Medication Requested (Name):	Quantity Requested:
Dose Requested:	Dosing Instructions:

Patient's Primary Diagnosis: _____ ICD 10 Code: _____

Please indicate ONE (1) of the following:

STAR / STAR KIDS client (**Go to Step 3 - PDL PA Criteria Applies**)

OR CHIP / PERINATE client (**Go to Step 4**)

STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Has the client failed a 30-day treatment trial with at least one (1) preferred agent in the last 180 days?

Yes (Go to Step 4 Question 1)

No (Go to #2)

2. Is there a documented allergy or contraindication to preferred agents in this class?

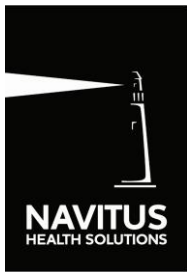
Yes (Go to Step 4 Question 1)

No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

Yes (Go to Step 4 Question 1)

No (Deny)



STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Is the client greater than or equal to (\geq) 18 years of age?

Yes (Go to #2)

No (Deny)

2. Does the client have a diagnosis of moderately to severely active Rheumatoid Arthritis (RA) in the last 730 days?

Yes (Go to #3)

No (Deny)

3. Does the client have a current claim for methotrexate?

Yes (Go to #5)

No (Go to #4)

4. Does the client have an inadequate response or intolerance to methotrexate? [Manual Step]

Yes (Go to #5)

No (Deny)

5. Does the client have one (1) claim for a Janus kinase (JAK) inhibitor, biologic disease-modifying antirheumatic drug (DMARD), or potent immunosuppressant in the last 30 days?

Examples of JAK inhibitors include JAKAFI and XELJANZ.

Examples of biologic DMARDs include ACTEMRA, CIMZIA, COSENTYX, ENBREL, HUMIRA, ILARIS, KEVZARA, KINERET, ORENCIA, OTEZLA, SILIQ, SIMPONI, STELARA, TALTZ, and TREMFYA.

Examples of potent immunosuppressants include azathioprine (IMURAN), cyclosporine (GENGRAF, NEORAL), mycophenolate (CELLCEPT), mycophenolic acid (MYFORTIC), and tacrolimus (ASTAGRAF XL, PROGRAF).

Yes (Deny)

No (Go to #6)

6. Does the client have one (1) claim for a strong CYP3A4 inducer in the last 90 days?

Examples include ATRIPLA, carbamazepine (CARBATROL, EQUETRO, TEGRETOL), modafinil (PROVIGIL), nevirapine (VIRAMUNE), phenobarbital, phenytoin (DILANTIN), pioglitazone (ACTOS), rifabutin, rifampin, SUSTIVA, XTANDI, and others.

Yes (Deny)

No (Go to #7)

7. Does the client have a diagnosis that indicates increased risk of gastrointestinal (GI) perforation, thrombosis or malignancy in the last 180 days?

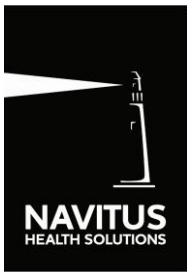
Yes (Deny)

No (Go to #8)

8. Does the client have a diagnosis of severe hepatic impairment in the last 365 days?

Yes (Deny)

No (Go to #9)



9. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

Yes (Deny)

No (Go to #10)

10. Is the requested dose less than or equal to (\leq) 1 tablet daily?

Yes (Approve – 365 days)

No (Deny)

STEP 5: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: 855-668-8553

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.