Fax completed form to Navitus at: 855-668-8553
For questions, please call: 877-908-6023

TEXAS MEDICAID

Drug Prior Authorization
Cytokine & CAM Antagonists: upadacitinib (RINVOQ)

Request Information (required)
This request is: ☐ **Expedited* (Urgent)** ☐ **Standard (Non-Urgent)** *Expedited means the standard review time may seriously harm the member's life, health, or ability to regain maximum function.

Member Information (required)			Prescriber Information (required)		
Member Name:			Prescriber Name:		
Member Insurance ID #:			NPI # :	Specialty:	
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:

Please fill out the following information:

1. Medication Requested (Name):
(Go to #2)

2. Quantity Requested:
(Go to #3)

3. Dose Requested (Strength):
(Go to #4)

4. Dosing Instructions:
(Go to #5)

Required Criteria

5. Provide primary diagnosis including ICD-10 code(s):
(Go to #6)

6. Please indicate the requested drug's formulary status: *(Formulary available at www.txvendordrug.com)

- ◯ Non-Preferred Drug (NPD or NAP)
  (Go to #7)
- ◯ Preferred Drug (PDL)
  (Go to #13)
- ◯ No Status, Drug is not in a Market Basket
  (Go to #13)
- ◯ N/A as this request is for a CHIP/PERINATE member
  (Go to #13)

Preferred Drug List (PDL) Criteria (required for non-preferred products)

7. Does the member have a diagnosis of atopic dermatitis in the last 365 days?

- ◯ Yes
  (Go to #8)
- ◯ No
  (Go to #9)

8. Has the member failed a 30-day treatment trial with at least one (1) preferred agent from the atopic dermatitis (AD), immunomodulators class in the last 180 days?

- ◯ Yes
  (Go to #13)
- ◯ No
  (Go to #9)

9. Does the member have a diagnosis of ankylosing spondylitis (AS), rheumatoid arthritis (RA), psoriatic arthritis (PsA), or ulcerative colitis (UC) in the last 365 days?

- ◯ Yes
  (Go to #10)
- ◯ No
  (Go to #11)

10. Has the member failed a 30-day treatment trial with at least one (1) preferred agent from the cytokine and CAM antagonist class in the last 60 days?

- ◯ Yes
  (Go to #13)
- ◯ No
  (Go to #11)

11. Is there a documented allergy or contraindication to preferred agents in the appropriate class based on the member's diagnosis?

- ◯ Yes
  (Go to #13)
- ◯ No
  (Go to #12)

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

- ◯ Yes
  (Go to #13)
- ◯ No (Deny)
  (Go to #13)

Clinical Criteria (required)

13. Does the member have a diagnosis of refractory, moderate to severe atopic dermatitis (AD) in the last 730 days?

- ◯ Yes
  (Go to #14)
- ◯ No
  (Go to #15)

14. Is the member greater than or equal to (≥) 12 years of age?

- ◯ Yes
  (Go to #17)
- ◯ No (Deny)
  (Go to #17)

15. Does the member have a diagnosis of active ankylosing spondylitis, moderately to severely active Crohn's disease (CD), active non-radiographic axial spondyloarthritis (nr-axSpA), moderately to severely active rheumatoid arthritis (RA), active psoriatic arthritis (PsA) or ulcerative colitis in the last 730 days?

- ◯ Yes
  (Go to #16)
- ◯ No (Deny)
  (Go to #16)

16. Is the member greater than or equal to (≥) 18 years of age?

- ◯ Yes
  (Go to #19)
- ◯ No (Deny)
  (Go to #19)

17. Has the member had 30 continuous days of therapy with at least one (1) systemic agent for the treatment of atopic dermatitis (AD) in the last 90 days?

    Examples of systemic agents include: azathioprine (IMURAN), cyclosporine (GENGRAF, NEORAL, SANDIMUNE), dexamethasone, DUPIXENT, hydrocortisone (CORTEF), methotrexate (OTREXUP, TREXALL, XATMEP), methylprednisolone (MEDROL), mycophenolate (CELLCEPT), mycophenolate acid (MYFORTIC), prednisolone (MILLIPRED, VERIPRED), and prednisone.

- ◯ Yes
  (Go to #21)
- ◯ No, and this is a renewal request.
  (Go to #21)
- ◯ No, and this is an initial request.
  (Go to #18)

18. Has the member had an inadequate response or intolerance to systemic agents for the treatment of atopic dermatitis (AD)? [Manual]

Examples of systemic agents include: azathioprine (IMURAN), cyclosporine (GENGRAF, NEORAL, SANDIMUNE), dexamethasone, DUPIXENT, hydrocortisone (CORTEF), methotrexate (OTREXUP, TREXALL, XATMEP), methylprednisolone (MEDROL), mycophenolate (CELLCEPT), mycophenolate acid (MYFORTIC), prednisolone (MILLIPRED, VERIPRED), and prednisone.

- ◯ Yes
  (Go to #21)
- ◯ No (Deny)
  (Go to #21)

19. Has the member had therapy with at least one (1) tumor necrosis factor (TNF) blocker in the last 90 days?

Examples of TNF-blockers include: CIMZIA, ENBREL, HUMIRA, and SIMPONI.

- ◯ Yes
  (Go to #21)
- ◯ No
  (Go to #20)

20. Has the member had inadequate response or intolerance to tumor necrosis factor (TNF) blockers? [Manual]

- ◯ Yes
  (Go to #21)
- ◯ No (Deny)
  (Go to #21)

21. Will the member have concurrent therapy with a Janus kinase (JAK) inhibitor, biologic disease-modifying anti-rheumatic drug (DMARD), or potent immunosuppressant?

Examples of JAK inhibitors include: JAKAFI, OLUMIANT, 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, SANDIMMUNE), mycophenolate (CELLCEPT), mycophenolic acid (MYFORTIC), and tacrolimus (ASTAGRAF XL, PROGRAF).

◯ Yes (Deny)
(Go to #22)

◯ No
(Go to #22)

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

Examples of strong CYP3A4 inducers include: ATRIPLA, APTIOM, bexarotene (TARGRETIN), carbamazepine (CARBATROL, EQUETRO, EPITOL, TEGRETOL), INTELENCE, LYSODREN, modafinil (PROVIGIL), nevirapine (VIRAMUNE), ORKAMBI, phenobarbital, phenytoin (DILANTIN, PHENYTEK), pioglitazone (ACTOS), pioglitazone-metformin (ACTOPLUS MET), pioglitazone-alogliptin (OSENI), primidone, rifabutin, rifampin, SUSTIVA, TAFINLAR, TRACLEER, XTANDI, and others.

◯ Yes (Deny)
(Go to #23)

◯ No
(Go to #23)

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

◯ Yes (Deny)
(Go to #24)

◯ No
(Go to #24)

24. Does the member have a diagnosis of severe hepatic impairment in the last 365 days?

◯ Yes (Deny)
(Go to #25)

◯ No
(Go to #25)

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

- ◯ Yes (Deny)
  (Go to #26)
- ◯ No
  (Go to #26)

26. Is the requested dose less than or equal to (≤) one (1) tablet daily?

- ◯ Yes (Approve - 365 days)
  (Go to #27)
- ◯ No (Deny)
  (Go to #27)

Additional Information

27. Please provide any additional information we should consider (or attach any supporting documents):
(END)

Submission Information (required)

Prescriber Signature: _____ **Date:** _____

**** PLEASE FAX COMPLETED FORM TO: 855-668-8553 ****

If criteria not met, submit chart documentation with form citing complex medical circumstances.
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