Prior Authorization Form

Note: Please provide as much information as possible on this form. Missing data may cause processing delays for requested authorization(s). Attach additional sheets to this form if necessary.

Please fax the completed PA form and any additional informational sheets to Nirvanahealth at the following fax number: +1(866) 871-8565

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
Health Plan Name:		Prescriber Address:	
Patient Insurance Id:			
Patient Date of Birth:		Prescriber Phone:	( )
Patient Phone:		Prescriber Fax:	( )
		Prescriber Specialty:	
		Prescriber DEA:	
		Prescriber NPI:	

Medication & Medical Information	
Requested Drug(s) & Strength(s):	[ ] Rinvoq 15 mg tablet,extended release [ ] Rinvoq 30 mg tablet,extended release [ ] Rinvoq 45 mg tablet,extended release
Requested Daily Quantity Limit – Amount:	
Requested Daily Quantity Limit – Days:	
Expected Length of Therapy:	
Directions:	
Diagnosis and Diagnosis Codes (ICD-10 Standard Codes):	
List drugs used previously to treat the same condition:	
Additional clinical information or history. Please include any relevant test results and/or medical record notes:	

Questionnaire

Q1: I, as the provider or designated representative of the provider, certify and attest that the information provided is complete and accurate and that, upon request, I shall provide any information to RxAdvance that RxAdvance determines is reasonably necessary to verify my responses. (Check only one that apply)

[ ] Yes

[ ] No

Q2: Is the member currently treated with this medication? (Check only one that apply)

[ ] Yes (please list start date of therapy (month/day/year)) _____ (*Required)

[ ] No

Q3: What is the member's diagnosis? (Check only one that apply)

[ ] Moderately to severely active Rheumatoid arthritis (RA)

[ ] Psoriatic arthritis (PsA)

[ ] Moderate to severe Atopic dermatitis (AD)

[ ] Moderately to severely active Ulcerative colitis (UC)

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request)
_____(*Required)

[ ] Non-radiographic axial spondyloarthritis (NRAS)

[ ] Ankylosing spondylitis (AS)

Q4: Does the member have a positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline or improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline? (Check only one that apply)

[ ] Yes (please specify and attach supporting documentation) _____ (*Required)

[ ] No (please provide medical justification for continuation of therapy)
_____(*Required)

Q5: Does the member have a positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (e.g., pain, stiffness, pruritus, inflammation) from baseline, or reduction in the body surface area involvement from baseline? (Check only one that apply)

[ ] Yes (please specify and attach supporting documentation) _____ (*Required)

[ ] No (please provide medical justification for continuation of therapy)
_____(*Required)

Q6: Is Rinvoq being prescribed in combination with other Janus kinase (JAK) inhibitors, biologic disease-modifying antirheumatic drugs (DMARDs), or potent immunosuppressants (e.g., azathioprine, cyclosporine)? (Check only one that apply)

[ ] Yes (please specify drug name) _____(*Required)

[ ] No

Q7: Does the member have a positive clinical response to therapy as evidenced by at least one of the following: reduction in body surface area involvement from baseline, or reduction in SCORAD index value from baseline? (Check only one that apply)

[ ] Yes (please specify and attach supporting documentation) _____ (*Required)

[ ] No (please provide medical justification for continuation of therapy)
_____(*Required)

Q8: Is Rinvoq being prescribed in combination with other Janus kinase (JAK) inhibitors, biologic immunomodulators, or other immunosuppressants (e.g., azathioprine, cyclosporine)? (Check only one that apply)

[ ] Yes (please specify drug name) _____(*Required)

[ ] No

Q9: Does the member have a positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline or reversal of high fecal output state? (Check only one that apply)

[ ] Yes (please specify and attach supporting documentation) _____ (*Required)

[ ] No (please provide medical justification for continuation of therapy) _____(*Required)

Q10: Is Rinvoq used in combination with other Janus kinase (JAK) inhibitors, biological therapies for UC, or potent immunosuppressants (e.g., azathioprine, cyclosporine)? (Check only one that apply)

[ ] Yes (please specify drug name) _____(*Required)

[ ] No

Q11: Is Rinvoq being prescribed in combination with other Janus kinase (JAK) inhibitors, biologic disease-modifying antirheumatic drugs (DMARDs), or potent immunosuppressants (e.g., azathioprine, cyclosporine)? (Check only one that apply)

[ ] Yes (please specify drug name) _____(*Required)

[ ] No

Q12: Does the member have a positive clinical response to therapy as evidenced by at least one of the following: disease activity (e.g., pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (e.g., lumbar spine motion, chest expansion), or total active (swollen and tender) joint count? (Check only one that apply)

[ ] Yes (please specify and attach supporting documentation) _____ (*Required)

[ ] No (please provide medical justification for continuation of therapy) _____(*Required)

Q13: What is the member's diagnosis? (Check only one that apply)

[ ] Moderately to severely active Rheumatoid arthritis (RA)

[ ] Psoriatic arthritis (PsA)

[ ] Moderate to severe Atopic dermatitis (AD)

[ ] Moderately to severely active Ulcerative colitis (UC)

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request) _____(*Required)

[ ] Non-radiographic axial spondyloarthritis (NRAS)

[ ] Ankylosing spondylitis (AS)

Q14: Has the member had 3-month trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine? (Check only one that apply)

[ ] Yes (please specify drug name/strength/duration of therapy, or, please explain if member is unable to take these drugs) _____(*Required)

[ ] No (please explain) _____(*Required)

Q15: Is the medication prescribed by or in consultation with a rheumatologist? (Check only one that apply)

[ ] Yes

[ ] No (please provide prescriber specialty) _____(*Required)

Q16: Does the member have actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement? (Check only one that apply)

[ ] Yes (please specify) _____(*Required)

[ ] No (please explain) _____(*Required)

Q17: Is the medication prescribed by or in consultation with a dermatologist or rheumatologist? (Check only one that apply)

[ ] Yes (please specify prescriber specialty) _____(*Required)

[ ] No (please specify prescriber specialty) _____(*Required)

Q18: Has the member had an inadequate response or intolerance to one or more TNF inhibitors (e.g., Enbrel, Humira)? (Check only one that apply)

[ ] Yes (please specify drug name/strength/duration of therapy, or, please explain if member is unable to take these drugs) _____(*Required)

[ ] No (please explain) _____(*Required)

Q19: Is Rinvoq being prescribed in combination with other Janus kinase (JAK) inhibitors, biologic disease-modifying antirheumatic drugs (DMARDs), or potent immunosuppressants (e.g., azathioprine, cyclosporine)? (Check only one that apply)

[ ] Yes (please specify drug name) _____(*Required)

[ ] No

Q20: The member's diagnosis is supported by: (Check only one that apply)

[ ] Involvement of at least 10% body surface area (BSA)

[ ] Scoring Atopic Dermatitis (SCORAD) index value of at least 25

[ ] Other (please explain) _____(*Required)

Q21: Has the member had a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication or intolerance to at least one of the following: a) Medium or higher potency topical corticosteroid, b) Pimecrolimus cream, c) Tacrolimus ointment, or d) Eucrisa ointment? (Check only one that apply)

[ ] Yes (please specify drug name/strength/duration of therapy, or, please explain if member is unable to take these drugs) _____(*Required)

[ ] No (please explain) _____(*Required)

Q22: Has the member had a minimum 12-week supply of at least one systemic drug product for the treatment of AD (examples include, but are not limited to, Adbry, Dupixent, etc.)? (Check only one that apply)

[ ] Yes (please specify drug name and duration of therapy) _____ (*Required)

[ ] No

Q23: Does the member have any contraindication, intolerance, or treatment is inadvisable with both of the following FDA-approved AD therapies: Adbry and Dupixent? (Check only one that apply)

[ ] Yes (please explain) _____(*Required)

[ ] No (please explain) _____(*Required)

Q24: Is Rinvoq used in combination with other Janus kinase (JAK) inhibitors, biologic immunomodulators, or other immunosuppressants (e.g., azathioprine, cyclosporine)? (Check only one that apply)

[ ] Yes (please specify drug name) _____(*Required)

[ ] No

Q25: Is the member at least 12 years old? (Check only one that apply)

[ ] Yes

[ ] No (please provide supporting clinical rationale for the request)
_____(*Required)

Q26: Is the medication prescribed by or in consultation with a dermatologist, allergist, or immunologist? (Check only one that apply)

[ ] Yes (please specify prescriber specialty) _____(*Required)

[ ] No (please specify prescriber specialty) _____(*Required)

Q27: Does the member have greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (e.g., hemoglobin, ESR, CRP), or is dependent on, or refractory to, corticosteroids? (Check only one that apply)

[ ] Yes (please explain) _____(*Required)

[ ] No (please explain) _____(*Required)

Q28: Has the member had a trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: 6-mercaptopurine, aminosalicylate (e.g., mesalamine, olsalazine, sulfasalazine), azathioprine, or corticosteroids (e.g., prednisone)? (Check only one that apply)

[ ] Yes (please specify drug name/strength/duration of therapy, or, please explain if member is unable to take these drugs)
_____(*Required)

[ ] No (please explain) _____(*Required)

Q29: Has the member had an inadequate response or intolerance to one or more TNF inhibitors (e.g., Humira)? (Check only one that apply)

[ ] Yes (please specify drug name and duration of therapy) _____
(*Required)

[ ] No (please explain) _____(*Required)

Q30: Is Rinvoq being prescribed in combination with a potent immunosuppressant (e.g., azathioprine, cyclosporine)? (Check only one that apply)

[ ] Yes (please specify drug name) _____(*Required)

[ ] No

Q31: Is the medication prescribed by or in consultation with a gastroenterologist? (Check only one that apply)

[ ] Yes

[ ] No (please provide prescriber specialty) _____(*Required)

Q32: Does the member have signs of inflammation? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Q33: Has the member had an inadequate response or intolerance to one or more TNF inhibitors (e.g., Cimzia)? (Check only one that apply)

[ ] Yes (please specify duration of therapy) _____(*Required)

[ ] No (please explain) _____(*Required)

Q34: Has the member had an inadequate response or intolerance to one or more TNF inhibitors (e.g., Enbrel, Humira)? (Check only one that apply)

[ ] Yes (please specify drug name and duration of therapy) _____ (*Required)

[ ] No (please explain) _____(*Required)

Q35: Has the member had an inadequate response, contraindication or intolerance to one nonsteroidal anti-inflammatory drug (NSAID) (e.g., ibuprofen, naproxen) for a minimum duration of a one-month? (Check only one that apply)

[ ] Yes (please specify drug name(s) and the contraindication(s) or type of adverse effect(s) experienced and duration of therapy) _____(*Required)

[ ] No (please explain) _____(*Required)

Q36: Is the medication prescribed by or in consultation with a rheumatologist? (Check only one that apply)

[ ] Yes

[ ] No (please provide prescriber specialty) _____(*Required)

Q37: Is Rinvoq being prescribed in combination with other Janus kinase (JAK) inhibitors, biologic disease-modifying antirheumatic drugs (DMARDs), or potent immunosuppressants (e.g., azathioprine, cyclosporine)? (Check only one that apply)

[ ] Yes (please specify drug name) _____(*Required)

[ ] No

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, Insurer, Medical Group or its designated representatives may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.	
Signature of Prescriber or Authorized Representative:	Date:
Print Authorized Representative Name:	