Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Rinvoq - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the drug prescribed by, or in consultation with, a rheumatologist?
☐ Yes ☐ No

Q2. Is the patient 18 years of age or older?
☐ Yes ☐ No

Q3. Does the patient have a confirmed diagnosis of moderately to severely active rheumatoid arthritis?
☐ Yes ☐ No

Q4. Does recent tuberculin testing show that the patient is negative for latent tuberculosis infection?
☐ Yes ☐ No

Q5. Has the patient completed treatment (or is receiving treatment) for latent tuberculosis?
☐ Yes ☐ No

Q6. Does the patient have any other active, serious infection?
☐ Yes ☐ No

Q7. Will live vaccines will be avoided while on Rinvoq therapy?
☐ Yes ☐ No

Q8. Does monitoring of liver function tests show elevated liver enzymes (ALT or AST)?
☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q9. Does the patient have severe hepatic impairment?

☐ Yes ☐ No

Q10. Does a complete blood count with differential show any of the following:

A) Absolute lymphocyte count is less than 500 cells/mm3;
B) Absolute neutrophil count is less than 1000 cells/mm3;
C) Hemoglobin level is less than 8 g/dL?

☐ Yes ☐ No

Q11. Is methotrexate contraindicated?
Attach documentation of contraindication.

☐ Yes ☐ No

Q12. Is there a documented history of inadequate response or intolerance to methotrexate?
Attach documentation to support methotrexate history.

☐ Yes ☐ No

Q13. Is there a documented history of an inadequate response or intolerance to other non-biologic disease modifying anti-rheumatic drugs (non-biologic DMARDs like azathioprine, hydroxychloroquine, leflunomide, or sulfasalazine)?
Attach documentation to support response to non-biologic DMARDs.

☐ Yes ☐ No

Q14. Is the patient currently taking or will be taking Rinvoq in combination with any of the following: another Janus kinase (JAK) inhibitor, a biologic disease modifying anti-rheumatic drugs (biologic DMARD), a potent immunosuppressant drugs (like azathioprine and cyclosporine) or a strong Cytochrome P450 3A4 (CYP3A4) inducers (like rifampin)?

☐ Yes ☐ No

Q15. Additional Information:

Q16. Duration:

☐ 12 months

Prescriber Signature

Date

2022 Medicare Prior Authorization Request