

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.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: <input type="checkbox"/> Medicare	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	<b>Specialty/facility name (if applicable):</b>	

**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.**

<p>Q1. Is the drug prescribed by or in consultation with a gastroenterologist, rheumatologist or dermatologist?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p>Q2. Does recent tuberculin testing show that the patient is negative for latent tuberculosis infection?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p>Q3. Has the patient completed treatment (or is receiving treatment) for latent tuberculosis?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p>Q4. Does the patient have any other active, serious infection?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p>Q5. Is there confirmation that live vaccines will be avoided while on Rinvoq therapy?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p>Q6. Does monitoring of liver function tests show elevated liver enzymes (ALT or AST)?</p> <p><input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span></p>
<p>Q7. Does the patient have severe hepatic impairment?</p>

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<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Does a complete blood count with differential show any of the following: A. Absolute lymphocyte count is less than 500 cells/mm <sup>3</sup> , B. Absolute neutrophil count is less than 1000 cells/mm <sup>3</sup> , C. Hemoglobin level is less than 8 g/dL?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Does the patient have a documented diagnosis of moderately to severely active rheumatoid arthritis, active psoriatic arthritis, moderately to severely active ulcerative colitis, active ankylosing spondylitis, or non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. Is the patient 18 years of age or older?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q11. Is there a documented history of inadequate response or intolerance to at least one TNF blocker?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q12. Does the patient have a documented diagnosis of refractory, moderate to severe atopic dermatitis?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q13. Is the patient 12 years of age and older?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q14. Is there a documented history of inadequate control with at least one other systemic drug (including biologics) used to treat refractory, moderate to severe atopic dermatitis? (Please attach documentation).	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q15. Are other systemic drugs, including biologics, used to treat refractory, moderate to severe atopic dermatitis, inadvisable? (Please attach explanation).	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q16. Will the requested drug be used concomitantly with other JAK inhibitors, biologic disease modifying anti-rheumatic drugs (DMARDs for review of rheumatoid arthritis and psoriatic arthritis),	

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potent immunosuppressant drugs, strong cytochrome P450 4A4 (CYP3A4) inducers, or biologic immunomodulators, or biologic therapies (for ulcerative colitis)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q17. Additional Information:	

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

2023 Medicare Prior Authorization Request