

# Rinvoq ER

## Prior Authorization of Benefits Form

**CONTAINS CONFIDENTIAL PATIENT INFORMATION**

**Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 844-474-3341.**

**1. Patient information**

**2. Physician information**

Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

**3. Medication**

**4. Strength**

**5. Directions**

**6. Quantity per 30 days**

Rinvoq ER			Specify:
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**7. Diagnosis:**

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**8. Approval criteria:** (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the client have a diagnosis of refractory, moderate to severe atopic dermatitis (AD) in the last 730 days?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the client have a diagnosis of active ankylosing spondylitis, moderately to severely active rheumatoid arthritis (RA), active psoriatic arthritis (PsA), or ulcerative colitis in the last 730 days?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has the client had 30 continuous days of therapy with at least one systemic agent for the treatment of atopic dermatitis in the last 90 days?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has the client had inadequate response or intolerance to systemic agents for the treatment of atopic dermatitis?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has the client had therapy with at least one TNF-blocker in the last 90 days?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has the client had inadequate response or intolerance to TNF-blockers?

[provider.wellpoint.com/tx/](https://provider.wellpoint.com/tx/)

Wellpoint members in the Medicaid Rural Service Area and the STAR Kids program are served by Wellpoint Insurance Company; all other Wellpoint members in Texas are served by Wellpoint Texas, Inc.

- Yes  No Does the client have 1 claim for a JAK Inhibitor, biologic DMARD, or potent immunosuppressant in the last 30 days?
- Yes  No Does the client have an inadequate response or intolerance to methotrexate?
- Yes  No Does the client have a diagnosis that indicates increased risk of GI perforation, thrombosis or malignancy in the last 180 days?
- Yes  No Does the client have a diagnosis of severe hepatic impairment in the last 365 days?
- Yes  No Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?
- Yes  No Patient has failed a 30-day treatment trial with at least one preferred agent(s) within the past 180 days.
- Yes  No Patient has a documented allergy or contraindication to preferred agents in this class.

For the *Texas Medicaid Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at <https://www.txvendordrug.com/formulary/formulary-search>

**9. Physician signature**

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Prescriber or authorized signature

\_\_\_\_\_

Date

*Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.*

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