



Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Rinvoq (Upadacitinib)**. Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: [1-866-331-2104](tel:1-866-331-2104)]. If you have any questions or concerns, please call [1-866-331-2103](tel:1-866-331-2103). **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: [Pharmacy | Community Provider Portal | Kaiser Permanente](#)**

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Provider Name: _____ Specialty: _____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____ Provider Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone # _____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Drug 2: Name/Strength/Formulation: _____

Sig: _____

5– Diagnosis/Clinical Criteria

1. Does the member have diagnosis of one of the following? **AND**

- Rheumatoid Arthritis (RA)
- Psoriatic Arthritis (PA)
- Atopic Dermatitis (AD)
- Ankylosing Spondylitis (AS)
- Ulcerative Colitis (UC)
- Non-radiographic axial spondyloarthritis (nr-axSpA)
- Moderate to severe Crohn’s Disease (CD)
- Other: _____

2. Was there a therapeutic failure on oral methotrexate? **AND**

No Yes

If no, provide explanation: _____

3. Was there therapeutic failure to one of the preferred agents? (e.g. Enbrel, Humira) **AND**

No Yes

If No, provide explanation: _____

4. Is Rinvoq being used in combination with other JAK inhibitors, biologic DMARDs , or potent immunosuppressants such as azathioprine or cyclosporine?

No Yes; If yes, therapy will not be approved.

6 – Provider Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	Date:
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