Rinvoq ER

Express Scripts
Prior Authorization
Phone 1-844-424-8886
Fax 1-877-251-5896

To start your Part D Coverage Determination request, you (or your representative or your doctor or other prescriber) should contact Express Scripts, Inc (ESI):

- You may Call ESI at 1-844-424-8886, 24 hours a day, 7 days a week,
  TTY users: 1-800-716-3231
- You may Fax your request to: 1-877-251-5896 (Attention: Medicare Reviews)
- You may also send your request via email to: medicarepartdparequests@express-scripts.com

Member's Last Name:	Member's First Name:
SCAN ID number:	Date of Birth:
Prescriber's Name:	Contact Person:
Office phone:	Office Fax:

Medication:	Diagnosis:

SECTION A Please answer the following questions

1. θ Yes θ No Is the diagnosis or indication for the treatment of moderately to severely active rheumatoid arthritis? ***If yes, proceed to question 9.***

2. θ Yes θ No Is the diagnosis or indication for the treatment of refractory, moderate to severe atopic dermatitis? ***If yes, proceed to question 11.***

3. θ Yes θ No Is the diagnosis or indication for the treatment of psoriatic arthritis? ***If yes, proceed to question 9.***

4. θ Yes θ No Is the diagnosis or indication for the treatment of adults with active ankylosing spondylitis? ***If yes, proceed to question 9.***

5. θ Yes θ No Is the diagnosis or indication for the treatment of moderate to severe ulcerative colitis? ***If yes, proceed to question 9.***

6. θ Yes θ No Is the diagnosis or indication for the treatment of adults with non-radiographic axial spondyloarthritis? ***If yes, proceed to 9.***

7. θ Yes θ No Is the diagnosis or indication for the treatment of moderately to severely active Crohn's disease? ***Proceed to 9.***

8. θ Yes θ No Is the diagnosis or indication for the treatment of active polyarticular juvenile idiopathic arthritis? ***Proceed to 9.***

9. θ Yes θ No Has the member previously used at least one TNF-blocker prior to the initiation of Rinvoq ER? ***If yes, proceed to 13.***

10. θ Yes θ No Is the member unable to tolerate at least one TNF-blocker? ***If yes, proceed to 13.***

11. θ Yes θ No Has the member previously used at least one other systemic drug therapy (e.g., an oral corticosteroid, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, etc.), including a biologic? ***If yes, proceed to 13.***

12. θ Yes θ No Is the member unable to tolerate systemic drug therapy, including a biologic?

13. θ Yes θ No Is the prescription written or recommended by a rheumatologist, gastroenterologist, or dermatologist?

14. θ Yes θ No Will the requested medication be used concomitantly with other JAK inhibitors, biologic immunomodulators or with biologic DMARDs (e.g., TNF Antagonists), or with biologic immunomodulators, or with other biological therapies, or with potent immunosuppressants, such as azathioprine or cyclosporine?

Please document the symptoms and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-877-251-5896

Our response time for prescription drug coverage standard requests is 72 hours. If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescriber's support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received. View our formulary and Prior Authorization criteria online at http://www.scanhealthplan.com