South Dakota Department of Social Services

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Rinvoq® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Moderately to severely active rheumatoid arthritis (RA)
- ❑ Moderately to severely active ulcerative colitis
- ❑ Active psoriatic arthritis
- ❑ Active ankylosing spondylitis
- ❑ Active atopic dermatitis
- ❑ Moderately to severely active Crohn's disease
- ❑ Moderately to severely active polyarticular juvenile idiopathic arthritis (pJIA)
- ❑ Non-radiographic axial spondyloarthritis
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Select if the requested medication is prescribed by or in consultation with one of the following specialists:
❑ Dermatologist ❑ Gastroenterologist ❑ Rheumatologist ❑ Allergist/Immunologist ❑ Other _____

Will Rinvoq be used in combination with another biologic agent, Janus Kinus inhibitor e.g., Olumiant, Dupixent, Xeljanx/XR), or other potent immunsuppressants (e.g., azathioprine, cyclosporine, methotrexate, mycophenolate, etc)? ❑ **Yes** ❑ **No**

For rheumatoid arthritis, polyarticular juvenile idiopathic arthritis, psoriatic arthritis, ulcerative colitis, Crohn's disease, non-radiographic axial spondyloarthritis, and ankylosing spondylitis also answer the following:

Has the patient had an inadequate response to, intolerance to, or contraindication to one or more TNF blockers (e.g., Cimzia, Enbrel, Humira, Simponi, Remicade, etc)? _____

For atopic dermatitis also answer the following:

Has the patient had an inadequate response to, intolerance to, or contraindication to one or more topical corticosteroid, pimecrolimus cream, tacrolimus ointment, or Eucrisa (crisaborole) ointment; or systemic drug product for the treatment of atopic dermatitis (e.g., Adbry, Dupixent, etc)? _____

Quantity limit requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.