



PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Rinvoq

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health 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.

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

☐ **REQUEST FOR EXPEDITED REVIEW:** By checking this box and signing below, I certify that the 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.

Q1. Will the patient be taking this drug concomitantly with another biologic Disease Modifying Anti-Rheumatic Drug (DMARD), a targeted synthetic DMARD, JAK inhibitors, or with potent immunosuppressants such as azathioprine and cyclosporine?

☐ Yes

☐ No

Q2. Is the patient within the appropriate age group listed in the FDA labeling for the indication which this drug is being prescribed?

☐ Yes

☐ No

Q3. Is this a reauthorization request?

☐ Yes - Go to 4

☐ No - Go to 5

Q4. Is there confirmation of continued positive clinical response since starting Rinvoq / Rinvoq LQ?

☐ Yes

☐ No



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Patient Name:	Prescriber Name:
Q5. Is the drug prescribed by or in consultation with an appropriate specialist per diagnosis: gastroenterologist, rheumatologist, or dermatologist?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q6. Are chart notes attached documenting a diagnosis of rheumatoid arthritis (RA), psoriatic arthritis (PsA), active ankylosing spondylitis (AS), non-radiographic axial spondyloarthritis (nr-axSpA), or polyarticular juvenile idiopathic arthritis (pJIA)?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. Is there a documentation of inadequate response, intolerance, or contraindication to at least one TNF blocker?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. Are chart notes attached documenting a diagnosis of atopic dermatitis?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Is there a documentation of inadequate response, intolerance, or contraindication to 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	
Q10. Are chart notes attached documenting a diagnosis of giant cell arteritis (GCA)?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q11. Is there documentation of inadequate response, intolerance, or contraindication to at least one systemic corticosteroid?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q12. Are chart notes attached documenting a diagnosis of moderately to severely active ulcerative colitis (UC) or moderately to severely active Crohn's disease (CD)?	



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Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q13. Does the patient have documentation of inadequate response, intolerance, or contraindication to at least one TNF blocker OR documentation of inadequate response or intolerance to at least one approved systemic therapy if TNF blockers are not clinically appropriate?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q14. Additional Information:	

Prescriber Signature

Date

v2026