Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Rinvoq - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

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.

Member Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare Advantage	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 applying the 72 hour 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 this a reauthorization request? If YES, go to 3. If NO, go to 4.

☐ Yes ☐ No

Q3. Is there confirmation of continued positive clinical response since starting Rinvoq / Rinvoq LQ?

☐ Yes ☐ No

Q4. Is the drug prescribed by or in consultation with an appropriate specialist such as gastroenterologist, rheumatologist, or dermatologist?

☐ Yes ☐ No

Q5. Are chart notes attached documenting a diagnosis of rheumatoid arthritis (RA), psoriatic arthritis (PsA), moderately to severely active ulcerative colitis (UC), active ankylosing spondylitis

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(AS), active non-radiographic axial spondyloarthritis (nr-axSpA), moderately to severely active Crohn's disease (CD), or polyarticular juvenile idiopathic arthritis (pJIA)?

☐ Yes ☐ No

Q6. Is there a documentation of inadequate response, intolerance, or contraindication to at least 1 TNF blocker?

☐ Yes ☐ No

Q7. Are chart notes attached documenting a diagnosis of atopic dermatitis?

☐ Yes ☐ No

Q8. Is there a documentation of inadequate response, intolerance, or contraindication to at least 1 other systemic drug (including biologics) used to treat refractory, moderate to severe atopic dermatitis?

☐ Yes ☐ No

Q9. Are chart notes attached documenting a diagnosis of giant cell arteritis (GCA)?

☐ Yes ☐ No

Q10. Requested Duration:

☐ 12 Months ☐ Other:

Q11. Additional Information:

_____ _____

Prescriber Signature Date

v2026