Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Rinvoq
(upadacitinib)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
Rinvoq 15mg: ☐

Dose and Quantity: Duration of therapy:

Frequency of administration: ICD10:

Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples of **Rinvoq**, please choose "new start of therapy". ☐ new start of therapy ☐ continued therapy

If continued therapy:
Has your patient had a good response to therapy with this drug (such as improvement or remission)? ☐ Yes ☐ No
(if no) Please provide clinical support for the continued use of **Rinvoq**:

Which applies to your patient?
☐ patient is established on this drug with previous approval by Cigna
☐ patient is established on this drug with previous approval by another health plan
☐ patient is established on this drug with regular use for more than 1 year
☐ patient was previously established on this drug, and is restarting after a break in therapy
Please provide the dates your patient has received **Rinvoq**:

(Please note: there are different preferred products depending on your patient's plan. Please refer to the applicable Cigna health care professional resource [e.g. cignaforhcp.com] to determine benefit availability and the terms and conditions of coverage)

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:
☐ rheumatoid arthritis (RA) ☐ other (please specify):

Clinical Information:

Besides the drug being requested, other biological drugs include Actemra, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Rituxan, Siliq, Simponi/Simponi Aria, Skyrizi, Stelara, Tremfya, Tysabri, and Xeljanz/Xeljanz XR. Which of the following best describes your patient's situation?

☐ The patient is NOT taking any other biological at this time, nor will they in the future. The requested drug is the only biological the patient is/will be using.
☐ The patient is currently on another biological, but this drug will be stopped and the requested drug will be started.
☐ The patient is currently on another biological, and the requested drug will be added. The patient may continue to take both drugs together.
☐ The patient is currently on BOTH the requested drug AND another biological.
☐ other/unknown

(if other/more than the requested drug) Please provide name of drug, dates taken and, if applicable, the clinical rationale for the combined use of the requested drug and another biologic to treat your patient's diagnosis.

Is there documentation that your patient either has had failure, inadequate response or intolerance to any of the following? (check all that apply):

☐ Actemra	☐ Cimzia	☐ Cosentyx	☐ Enbrel	☐ Entyvio	☐ Humira	☐ Ilumya
☐ Inflectra	☐ Kevzara	☐ Kineret	☐ Olumiant	☐ Orencia	☐ Otezla	☐ Remicade
☐ Renflexis	☐ Rituxan	☐ Siliq	☐ Simponi (Aria)	☐ Skyrizi	☐ Stelara	☐ Tremfya
☐ Xeljanz (XR)	☐ Other: _____					

Please provide drug name(s), date(s) taken and what the documented results were for each drug tried:

Is there documentation that your patient has a contraindication per FDA label or is not a candidate for any of the following? (check all that apply):

☐ Actemra	☐ Cimzia	☐ Cosentyx	☐ Enbrel	☐ Entyvio	☐ Humira	☐ Ilumya
☐ Inflectra	☐ Kevzara	☐ Kineret	☐ Olumiant	☐ Orencia	☐ Otezla	☐ Remicade
☐ Renflexis	☐ Rituxan	☐ Siliq	☐ Simponi (Aria)	☐ Skyrizi	☐ Stelara	☐ Tremfya
☐ Xeljanz (XR)	☐ Other: _____					

Please explain any contraindication OR reason why your patient is not a candidate for each drug checked above:

Is there documentation that your patient either has had failure, inadequate response or intolerance OR has a contraindication per FDA label OR is not a candidate for one disease-modifying anti-rheumatic drug (DMARD) (for example, methotrexate, leflunomide, sulfasalazine)? ☐ Yes ☐ No

Additional Pertinent Information: *Please include alternatives tried, with drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced.*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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