STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES

Office of Pharmacy Services
Prior Authorization Criteria
Rinvoq® (upadacitinib)
Effective 9/28/2022

Prior Authorization Request Form

Rinvoq (upadacitinib) is a Janus kinase (JAK) inhibitor indicated for the treatment of:

Adults with moderately to severely active rheumatoid arthritis who have had an inadequate response or intolerance to one or more TNF blockers.
Limitations of Use: Use of RINVOQ in combination with other JAK inhibitors, biologic DMARDs, or with potent immunosuppressants such as azathioprine and cyclosporine is not recommended.

Adults with active psoriatic arthritis who have had an inadequate response or intolerance to one or more TNF blockers.
Limitations of Use: Use of RINVOQ in combination with other JAK inhibitors, biologic DMARDs, or with potent immunosuppressants such as azathioprine and cyclosporine is not recommended.

Adults and pediatric patients 12 years of age and older with refractory, moderate to severe atopic dermatitis whose disease is not adequately controlled with other systemic drug products, including biologics, or when use of those therapies are inadvisable.
Limitations of Use: RINVOQ is not recommended for use in combination with other JAK inhibitors, biologic immunomodulators, or with other immunosuppressants.

Adults with moderately to severely active ulcerative colitis who have had an inadequate response or intolerance to one or more TNF blockers.
Limitations of Use: RINVOQ is not recommended for use in combination with other JAK inhibitors, biological therapies for ulcerative colitis, or with other potent immunosuppressants such as azathioprine and cyclosporine.

Adults with active ankylosing spondylitis who have had an inadequate response or intolerance to one or more TNF blockers.
Limitations of Use: Use of RINVOQ in combination with other JAK inhibitors, biologic DMARDs, or with potent immunosuppressants such as azathioprine and cyclosporine is not recommended.

CRITERIA FOR APPROVAL for Atopic Dermatitis*:

1. Prescribed by or in consultation with an allergist, immunologist or dermatologist; **AND**

2. Documented diagnosis of moderate to severe Atopic Dermatitis (AD). Documentation must include the affected BSA, areas of involvement and severity of symptoms; **AND**

3. The patient must be within the age range as recommended by the FDA label and indication; **AND**

4. Affected body surface area is greater than or equal to 10%; **AND**

5. Patient has failed to find relief of symptoms after a minimum of 30-day trials of two agents from the following list in the last 12 months:

a. Medium to High potency topical corticosteroid**
b. Elidel
c. Eucrisa
d. Tacrolimus; **AND**

6. The patient has a had a documented intolerance, allergy, or treatment failure after ninety (90) days with Adbry or Dupixent (unless contraindicated).

*For other Rinvoq indications, refer to criteria for Cytokine and CAM Antagonists

**Trial of medium to high potency topical steroid is required unless the affected area involves sensitive areas such as the face, skin folds or genitals. However, a trial of two other agents among the list above, are still required prior to Rinvoq approval.

Approval Duration: Initial approval will be for 3 months.

Criteria for reauthorization:

1. Demonstrate continued documented compliance; **AND**
2. Documentation of satisfactory patient response (including current affected BSA and severity of symptoms) has been provided.

Continuation of therapy will be granted for 12 months.