Amerigroup

Medicaid

https://provider.amerigroup.com/TX

Rinvoq ER
Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-474-3341.

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician:_____
Patient ID #:_____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx:_____	Physician fax #:_____
Patient phone #: _____	Physician specialty: _____
Patient email address:_____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
Rinvoq ER			Specify:
7. Diagnosis:			

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

□ Yes	□ No	Does the client have a diagnosis of refractory, moderate to severe atopic dermatits (AD) in the last 730 days?
□ Yes	□ No	Does the client have a diagnosis of active ankylosing spondylitis, moderately to severely active rheumatoid arthritis (RA), active psoriatic arthritis (PsA), or ulcerative colitis in the last 730 days?
□ Yes	□ No	Has the client had 30 continuous days of therapy with at least one systemic agent for the treatment of atopic dermatitis in the last 90 days?
□ Yes	□ No	Has the client had inadequate response or intolerance to systemic agents for the treatment of atopic dermatitis?
□ Yes	□ No	Has the client had therapy with at least one TNF-blocker in the last 90 days?
□ Yes	□ No	Has the client had inadequate response or intolerance to TNF-blockers?
□ Yes	□ No	Does the client have 1 claim for a JAK Inhibitor, biologic DMARD, or potent immunosuppressant in the last 30 days?
□ Yes	□ No	Does the client have an inadequate response or intolerance to methotrexate?
□ Yes	□ No	Does the client have a diagnosis that indicates increased risk of GI perforation, thrombosis or malignancy in the last 180 days?
□ Yes	□ No	Does the client have a diagnosis of severe hepatic impairment in the last 365 days?
□ Yes	□ No	Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

Amerigroup members in the Medicaid Rural Service Area and the STAR Kids program are served by Amerigroup Insurance Company; all other Amerigroup members in Texas are served by Amerigroup Texas, Inc.

□ Yes □ No Patient has failed a 30-day treatment trial with at least one preferred agent(s) within the past 180 days.
□ Yes □ No Patient has a documented allergy or contraindication to preferred agents in this class.

For the *Texas Medicaid Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at **https://www.txvendordrug.com/formulary/formulary-search**

9. Physician signature

_____ _____

Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.