Prior Authorization Criteria

MISSISSIPPI DIVISION OF MEDICAID

RINVOQ® (upadacitinib) PA CRITERIA for Atopic Dermatitis:

RINVOQ® (upadacitinib) is a Janus kinase (JAK) inhibitor that is 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
- the treatment of adults and pediatric patients 2 years of age and older with active psoriatic arthritis who have had an inadequate response or intolerance to one or more TNF blockers
- the treatment of 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
- the treatment of adults with moderately to severely active ulcerative colitis (UC) who have had an inadequate response or intolerance to one or more TNF blockers, or if TNF blockers are clinically inadvisable, patients should have received at least one approved systemic therapy prior to RINVOQ® use
- the treatment of adults with moderately to severely active Crohn's disease (CD) who have had an inadequate response or intolerance to one or more TNF blockers, or if TNF blockers are clinically inadvisable, patients should have received at least one approved systemic therapy prior to RINVOQ® use
- the treatment of adults with active ankylosing spondylitis who have had an inadequate response or intolerance to one or more TNF blockers
- the treatment of adults with active non-radiographic axial spondyloarthritis with objective signs of inflammation who have had an inadequate response or intolerance to TNF blocker therapy
- the treatment of patients 2 years of age and older with active polyarticular juvenile idiopathic arthritis who have had an inadequate response or intolerance to one or more TNF blockers
- the treatment of adults with giant cell arteritis

Prior authorization is required for RINVOQ® (upadacitinib) for atopic dermatitis. Prior authorization approval will be considered when the following criteria are met. Along with the Universal PA Form, please submit any supporting clinical documentation.

Initial Authorization: 6 Months

1. Patient must meet the minimum age and weight requirements recommended by the package insert for this FDA approved indication; **AND**

2. The patient has a diagnosis of moderate to severe chronic atopic dermatitis (AD) with at least 10% of body surface area (BSA) affected; **AND**

3. Prescribed by, or in consultation with, a dermatologist, allergist/immunologist, or other specialist in the treatment of atopic dermatitis; **AND**

4. The patient meets the prior therapy requirement based on the diagnosis unless documented contraindication or intolerance:
    a. For moderate atopic dermatitis: BOTH of the following:
        i. At least two weeks trial with an inadequate response to one preferred medium to very-high potency topical corticosteroid within the past 90 days; AND
        ii. At least four weeks trial with an inadequate response to one preferred topical calcineurin inhibitor or EUCRISA (crisaborole) within the past 90 days
    b. For severe atopic dermatitis: BOTH of the following:
        i. At least two weeks trial with an inadequate response to one preferred medium to very-high potency topical corticosteroid within the past 90 days; AND
        ii. At least four weeks trial with an inadequate response to one preferred topical calcineurin inhibitor within the past 90 days; **AND**

5. Prescribed RINVOQ® dose does not exceed 30mg once daily.

Re-Authorization: 1 Year

1. Patient continues to meet initial authorization criteria; **AND**

2. Prescribed dose does not exceed 30mg once daily; **AND**

3. Positive clinical response to RINVOQ® therapy.

RINVOQ® (upadacitinib) Dosing in Atopic Dermatitis: 15 mg once daily; may increase to 30 mg once daily if inadequate response.

Formulation: RINVOQ® is available as 15mg, 30mg, or 45mg oral extended-release tablets.