

PHARMACY POLICY STATEMENT

Marketplace

DRUG NAME	Rinvoq (upadacitinib)
BENEFIT TYPE	Pharmacy
STATUS	Prior Authorization Required

Rinvoq was initially approved by the FDA in 2019 for rheumatoid arthritis. Since then, it has also been granted approvals for the treatment of moderate to severe atopic dermatitis, psoriatic arthritis, ulcerative colitis, ankylosing spondylitis and non-radiographic axial spondyloarthritis. Rinvoq is a Janus kinase (JAK) inhibitor. It works by inhibiting the activity of one or more of the Janus kinase family of enzymes, thereby interfering with the JAK-STAT signaling pathway.

Rinvoq (upadacitinib) will be considered for coverage when the following criteria are met:

Rheumatoid Arthritis (RA)

For **initial** authorization:

1. Member is at least at least 18 years of age; AND
2. Rinvoq must be prescribed by or in consultation with a rheumatologist; AND
3. Member has a documented diagnosis of moderately to severely active RA; AND
4. Member must have a trial and failure of, or intolerance to methotrexate for at least 3 months;
Note: If methotrexate is contraindicated, one of the following conventional DMARDs must be trialed instead: leflunomide, sulfasalazine, or hydroxychloroquine; AND
5. Member must have a documented history of inadequate response or intolerance to a tumor necrosis factor (TNF) blocker (e.g., Remicade, Humira, Enbrel); AND
6. Member does not have any laboratory abnormalities indicating neutropenia (ANC <1000 cells/mm³), lymphopenia (ALC <500 cells/mm³), or anemia (hemoglobin < 8 g/dL); AND
7. Member has had a negative tuberculosis test within the past 12 months.
8. **Dosage allowed/Quantity limit:** 15 mg once daily. (Quantity Limit: 30 tablets per 30 days).

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes demonstrate improvement of RA signs and symptoms (e.g. fewer number of painful and swollen joints, achievement of remission, slowed progression of joint damage, etc.).

If all the above requirements are met, the medication will be approved for an additional 12 months.

Psoriatic Arthritis (PsA)

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a rheumatologist or a dermatologist; AND
3. Member has a documented diagnosis of active psoriatic arthritis (PsA); AND

4. Member has met a 4-week trial of an NSAID taken at maximally tolerated dose AND a 3-month trial of a non-biologic DMARD agent (e.g., methotrexate, sulfasalazine, cyclosporine, etc.) unless one of the following situations is met:
 - a) Non-biologic DMARD is not required for:
 - i) Concomitant axial disease (i.e., involving sacroiliac joint and spine) or enthesitis; OR
 - b) NSAID and non-biologic DMARD are not required for:
 - i) Severe PsA (defined as having at least one of the following: erosive disease, active PsA at many sites including dactylitis or enthesitis, elevated levels of ESR or CRP, joint deformities, or major impairment in quality of life); AND
5. Member must have a documented history of inadequate response or intolerance to a tumor necrosis factor (TNF) blocker (e.g., Remicade, Humira, Enbrel); AND
6. Member has had a negative tuberculosis test within the past 12 months.
7. Member does not have any laboratory abnormalities indicating neutropenia ($ANC < 1000$ cells/mm³), lymphopenia ($ALC < 500$ cells/mm³), or anemia (hemoglobin < 8 g/dL);
8. **Dosage allowed/Quantity limit:** 15 mg once daily. (Quantity Limit: 30 tablets per 30 days).

If all the above requirements are met, the medication will be approved for 6 months.

For reauthorization:

1. Chart notes have been provided showing improvement of signs and symptoms of disease.

If all the above requirements are met, the medication will be approved for an additional 12 months.

Atopic Dermatitis (AD)

For initial authorization:

1. Member must be 12 years of age or older; AND
2. Medication must be prescribed by a dermatologist, allergist, or immunologist; AND
3. Member has a documented diagnosis of moderate-to-severe atopic dermatitis; AND
4. Member's atopic dermatitis involves 10% or more of the body surface area (BSA) OR involves highly visible or functional areas (e.g., neck, face, genitals, palms) and is significantly impairing quality of life; AND
5. Member has a documented trial and failure of, intolerance, or contraindication to at least one of the following:
 - a) Medium to high potency topical corticosteroid for at least 4 weeks;
 - b) Topical calcineurin inhibitor (e.g., tacrolimus, pimecrolimus) or Eucrisa for at least 4 weeks; AND
6. Member has documented trial and failure of, intolerance, or contraindication to one of the following:
 - a) At least 8 weeks of phototherapy treatment (i.e., UV-A, UV-B, a combination of both, psoralen plus UV-A (PUVA), or UV-B1 (narrow-band UV-B));
 - b) At least 12 weeks of one oral immunomodulatory agent (e.g., cyclosporine, methotrexate, azathioprine).
7. Member does not have any laboratory abnormalities indicating neutropenia ($ANC < 1000$ cells/mm³), lymphopenia ($ALC < 500$ cells/mm³), or anemia (hemoglobin < 8 g/dL);
8. **Dosage allowed/Quantity limit:** Initiate treatment with 15 mg orally once daily. If an adequate response is not achieved, the dosage may be increased to 30 mg orally once daily. (Quantity Limit: 30 tablets per 30 days).

If all the above requirements are met, the medication will be approved for 6 months.

For reauthorization:

1. Chart notes demonstrate improvement of signs and symptoms such as fewer flares, less itching/erythema, improved quality of life, etc.

If all the above requirements are met, the medication will be approved for an additional 12 months.

Ulcerative Colitis (UC)

For **initial** authorization:

1. Member is 18 years of age or older with moderately to severely active UC; AND
2. Medication must be prescribed by or in consultation with a gastroenterologist; AND
3. Member has had a negative tuberculosis test within the past 12 months; AND
4. Member must have a documented history of inadequate response or intolerance to a tumor necrosis factor (TNF) blocker (e.g., Remicade, Humira, Simponi); AND
5. Member does not have any laboratory abnormalities indicating neutropenia (ANC <1000 cells/mm³), lymphopenia (ALC <500 cells/mm³), or anemia (Hg < 8 g/dL).
6. **Dosage allowed/Quantity limit:**
 - a) Induction: 45 mg once daily for 8 weeks.
 - b) Maintenance: 15 mg once daily. A dosage of 30 mg once daily may be considered for patients with refractory, severe or extensive disease. (Quantity Limit: 30 tablets per 30 days).

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes have been provided showing improvement in signs and symptoms of UC (defined as clinical remission, decrease in rectal bleeding, decreased improved Mayo score, improved endoscopic healing, etc.).

If all the above requirements are met, the medication will be approved for an additional 12 months.

Ankylosing Spondylitis (AS) or Non-radiographic Axial Spondyloarthritis (nr-AxSpA)

Note: Diagnosis of axial spondyloarthritis (axSpA) is also accepted. AxSpA consists of 2 subtypes - ankylosing spondylitis (AS) and non-radiographic axial spondyloarthritis (nr-axSpA).

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a rheumatologist; AND
3. Member has a documented diagnosis of active AS, nr-axSpA or axSpA; AND
4. Member shows at least one of the following signs or symptoms of inflammation:
 - a) Elevated serum C-reactive protein (CRP);
 - b) Sacroiliitis on magnetic resonance imaging (MRI); AND
5. Member has tried and failed to respond to treatment with at least two NSAIDs taken at the maximum recommended dosages. Treatment failure requires at least 4 weeks of therapy with each NSAID without an adequate response; AND
6. Member has tried and failed one preferred TNF inhibitor (e.g. Remicade, Humira, Amjevita, Enbrel) for at least 3 months; AND
7. Member has had or will have completed a tuberculosis test within the past 12 months; AND
8. Member does not have any laboratory abnormalities indicating neutropenia (ANC <1000 cells/mm³), lymphopenia (ALC <500 cells/mm³), or anemia (Hg < 8 g/dL).
9. **Dosage allowed/Quantity limit:** 15 mg once daily. (Quantity Limit: 30 tablets per 30 days).

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes have been provided showing improvement of signs and symptoms of disease (ie. improvement of back pain, function, morning stiffness, etc).

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Rinvoq (upadacitinib) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
09/26/2019	New policy for Rinvoq created.
11/19/2020	Changed the trials to require methotrexate as one of the non-biologic DMARD trials; only one trial is needed if member has poor prognostic factors. Removed repeated TB test in reauth. Replaced the list of excluded diagnoses with the generic statement. Updated references.
12/30/2021	Transferred to new template. RA: Updated references. Changed initial approval duration to 6 months (was 12 months). Edited the terminology “non-biologic” DMARD to “conventional” DMARD. Changed from requiring 2 csDMARD to just 1. Added trial and failure of TNF blocker; now 2 nd line per label change. Added criteria for new indication of PsA. Added criteria for new indication of AD.
05/24/2022	Added criteria for new indication of UC. Added criteria for new indication of AS.
02/23/2022	Updated references. Added criteria for new indication of nr-AxSpA. Added trial duration for biologics in AD. Simplified AD header to exclude moderate to severe.

References:

1. Rinvoq [prescribing information]. North Chicago, IL: AbbVie Inc.; October 2022.
2. Singh JA, Saag KG, Bridges SL Jr, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Rheumatol*. 2016;68(1):1-26.
3. Smolen JS, Landewé RBM, Bijlsma JWW, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2019 update. *Ann Rheum Dis*. 2020;79(6):685-699.
4. ClinicalTrials.gov. Identifier: NCT02706951. A Study Comparing Upadacitinib (ABT-494) Monotherapy to Methotrexate (MTX) Monotherapy in Subjects With Rheumatoid Arthritis (RA) Who Have an Inadequate Response to MTX (SELECT-MONOTHERAPY). Available at: <https://clinicaltrials.gov/ct2/show/NCT02706951?term=NCT02706951&rank=1>.
5. ClinicalTrials.gov. Identifier: NCT02675426. A Study Comparing Upadacitinib (ABT-494) to Placebo in Subjects With Rheumatoid Arthritis on a Stable Dose of Conventional Synthetic Disease-Modifying Antirheumatic Drugs (csDMARDs) Who Have an Inadequate Response to csDMARDs Alone (SELECT-NEXT). Available at: <https://clinicaltrials.gov/ct2/show/NCT02675426?term=NCT02675426&rank=1>.
6. ClinicalTrials.gov. Identifier: NCT02706847. A Study to Compare Upadacitinib (ABT-494) to Placebo in Subjects With Rheumatoid Arthritis on Stable Dose of Conventional Synthetic Disease-Modifying Antirheumatic Drugs (csDMARDs) Who Have an Inadequate Response or Intolerance to Biologic DMARDs (SELECT-BEYOND). Available at: <https://clinicaltrials.gov/ct2/show/NCT02706847?term=NCT02706847&rank=1>.
7. Van Vollenhoven R, Takeuchi T, Pangan AL, et al. Efficacy and Safety of Upadacitinib Monotherapy in Methotrexate-Naive Patients With Moderately-to-Severely Active Rheumatoid Arthritis (SELECT-EARLY): A Multicenter, Multi-Country, Randomized, Double-Blind, Active Comparator-Controlled Trial. *Arthritis Rheumatol*. 2020;72(10):1607-1620. doi:10.1002/art.41384.
8. Fleischmann RM, Genovese MC, Enejosa JV, et al. Safety and effectiveness of upadacitinib or adalimumab plus methotrexate in patients with rheumatoid arthritis over 48 weeks with switch to alternate therapy in patients with insufficient response. *Ann Rheum Dis*. 2019;78(11):1454-1462. doi:10.1136/annrheumdis-2019-215764
9. Fraenkel L, Bathon JM, England BR, et al. 2021 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Rheumatol*. 2021;73(7):1108-1123. doi:10.1002/art.41752

10. Coates LC, Kavanaugh A, Mease PJ, et al. Group for Research and Assessment of Psoriasis and Psoriatic Arthritis 2015 Treatment Recommendations for Psoriatic Arthritis. *Arthritis Rheumatol*. 2016 May;68(5):1060-71.
11. Atopic dermatitis clinical guideline (2021). In American Academy of Dermatology. Retrieved from Atopic dermatitis clinical guideline (aad.org).
12. Eichenfield LF, Tom WL, Berger TG, et al. Guidelines of care for the management of atopic dermatitis: section 2. Management and treatment of atopic dermatitis with topical therapies. *J Am Acad Dermatol*. 2014;71(1):116-132.
13. Sidbury R, Davis DM, Cohen DE, et al. Guidelines of care for the management of atopic dermatitis: Section 3. Management and treatment with phototherapy and systemic agents. *J Am Acad Dermatol*. 2014 Aug;71(2):327-49.
14. Deleanu D, Nedelea I. Biological therapies for atopic dermatitis: An update. *Exp Ther Med*. 2019;17(2):1061-1067.
15. Ward MM, Deodhar A, Gensler LS, et al. 2019 Update of the American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network Recommendations for the Treatment of Ankylosing Spondylitis and Nonradiographic Axial Spondyloarthritis. *Arthritis Care Res (Hoboken)*. 2019;71(10):1285-1299. doi:10.1002/acr.24025
16. Akgul O, Ozgocmen S. Classification criteria for spondyloarthropathies. *World J Orthop*. 2011;2(12):107-115. doi:10.5312/wjo.v2.i12.07.
17. Yu DT, Tubergen AV. Treatment of axial spondyloarthritis (ankylosing spondylitis and nonradiographic axial spondyloarthritis) in adults. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc.
18. Ramiro S, Nikiphorou E, Sepriano A, et al. ASAS-EULAR recommendations for the management of axial spondyloarthritis: 2022 update. *Ann Rheum Dis*. 2023;82(1):19-34. doi:10.1136/ard-2022-223296
19. Boguniewicz M, Alexis AF, Beck LA, et al. Expert Perspectives on Management of Moderate-to-Severe Atopic Dermatitis: A Multidisciplinary Consensus Addressing Current and Emerging Therapies. *J Allergy Clin Immunol Pract*. 2017;5(6):1519-1531. doi:10.1016/j.jaip.2017.08.005

Effective date: 07/01/2023

Revised date: 02/23/2023

Appendix: Preferred Biologic Products	
Approved for Rheumatoid Arthritis	- Actemra (<i>requires step through Humira</i>) - Enbrel - Humira - Amjevita
Approved for Juvenile Idiopathic Arthritis	- Actemra (<i>requires step through Humira</i>) - Enbrel - Humira - Amjevita
Approved for Ankylosing Spondylitis	- Cosentyx - Enbrel - Humira - Rinvoq - Amjevita
Approved for Non-radiographic Axial	- Cimzia - Cosentyx
Approved for Atopic Dermatitis	Rinvoq
Approved for Psoriatic Arthritis	- Cosentyx - Enbrel - Humira - Otezla - Skyrizi - Stelara - Tremfya - Amjevita

Approved for Psoriasis	• Cosentyx • Enbrel • Amjevita • Humira • Otezla • Skyrizi • Stelara • Tremfya
Approved for Crohn's Disease	• Amjevita • Humira • Stelara
Approved for Ulcerative Colitis	• Amjevita • Humira • Stelara • Rinvoq