HEALTHY U MEDICAID

PRIOR AUTHORIZATION REQUEST FORM

GIANT CELL ARTERITIS

Rinvoq®, Tyenne®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to: 801-213-1547
- For **Retail Pharmacy** please fax requests to: 385-425-4052

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for Pharmacy Customer Service for assistance at 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-formulary drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred/Non-Formulary:

1. 1st Line Preferred Agents:
   A. Tyenne® (tocilizumab-aazg)
2. Non-Preferred agents with single step; after trial and failure of a tocilizumab product:
   A. Rinvoq (upadacitinib)

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the request being made by a rheumatologist?	☐	☐	
2. Does the member has a diagnosis of giant cell arteritis confirmed by biopsy or imaging?	☐	☐	**Please provide documentation**
3. Does the member has elevated levels of C-reactive protein (CRP) AND erythrocyte sedimentation rate (ESR)?	☐	☐	**Please provide documentation**
4. Is the member currently taking prednisone (or equivalent) ≥ 20mg once daily?	☐	☐	**Please provide documentation**
5. Is the member taking JAK inhibitors, biologic DMARDS, or potent immunosuppressants such as azathioprine and cyclosporine?	☐	☐	**Please provide documentation**

REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the therapy been tolerable?	☐	☐	**Please provide documentation**
3. Has the member had improvement in at least one symptom (e.g. headache, scalp or jaw pain, fatigue, vision)?	☐	☐	**Please provide documentation**
4. Has the member had improvement in CRP and/or ESR levels?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

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Policy: PHARM-HU-165
Origination Date: 06/11/2025
Reviewed/Revised Date: 06/11/2025
Next Review Date: 06/11/2026
Current Effective Date: 07/01/2025