

Documentation Checklist for Patients With Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, or Non-Radiographic Axial Spondyloarthritis

This checklist is a guide provided by AbbVie that can help you complete the patient's required prior authorization (PA) form. It (1) may include certain PA criteria which are not necessary for a specific payer and (2) may not include all necessary PA requirements for a specific payer.

Patient Information

First name: _____ Middle name: _____ Last name: _____ DOB: _____

Initial Authorization Request Reauthorization Request Patient 18 years of age or older

Physician name: _____ Date: _____
 Specialty: Rheumatology Dermatology Immunology Other: _____

Diagnosis: ICD-10-CM codes¹ (select one and provide additional information as necessary)

<input type="checkbox"/> M05.60 – M05.9 Rheumatoid arthritis <i>Please specify: M05.</i> _____	<input type="checkbox"/> M06.0 – M06.0A Other rheumatoid arthritis without rheumatoid factor <i>Please specify: M06.</i> _____
<input type="checkbox"/> L40.50 Arthropathic psoriasis, unspecified	<input type="checkbox"/> M45.0-M45.9 Ankylosing spondylitis <i>Please specify: M45.</i> _____
<input type="checkbox"/> M45.A (M45.A0-AB) Non-radiographic axial spondyloarthritis <i>Please specify: M45.A</i> _____	

Medical History

Elevated inflammation markers (that support active or erosive disease, or as applicable based on indication): Erythrocyte sedimentation rate (ESR)
 C-reactive protein (CRP) Other: _____
 Applicable documentation supporting inflammation included with submission (eg, MRI scans)
 Psoriatic arthritis: Patient has long-term damage that interferes with function (eg, joint deformities) and disease is rapidly progressive. Please provide example(s): _____
 When did symptoms first begin? _____
 Most recent test results, with supporting documentation, included with submission: Tuberculosis test Liver enzymes Complete blood count (CBC)
 Other: _____

Treatment History Drug Class	Drug Name	Dose	Duration (start and end date)	Outcome
<input type="checkbox"/> Biologic (IL antagonist, selective T-cell costimulation modulator, TNF inhibitor) <input type="checkbox"/> CD20 antibody <input type="checkbox"/> Immunosuppressant <input type="checkbox"/> JAK inhibitor <input type="checkbox"/> NSAID <input type="checkbox"/> PDE4 inhibitor				<input type="checkbox"/> Effective <input type="checkbox"/> Failed <input type="checkbox"/> Intolerant <input type="checkbox"/> Contraindicated
<input type="checkbox"/> Biologic (IL antagonist, selective T-cell costimulation modulator, TNF inhibitor) <input type="checkbox"/> CD20 antibody <input type="checkbox"/> Immunosuppressant <input type="checkbox"/> JAK inhibitor <input type="checkbox"/> NSAID <input type="checkbox"/> PDE4 inhibitor				<input type="checkbox"/> Effective <input type="checkbox"/> Failed <input type="checkbox"/> Intolerant <input type="checkbox"/> Contraindicated
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<input type="checkbox"/> Biologic (IL antagonist, selective T-cell costimulation modulator, TNF inhibitor) <input type="checkbox"/> CD20 antibody <input type="checkbox"/> Immunosuppressant <input type="checkbox"/> JAK inhibitor <input type="checkbox"/> NSAID <input type="checkbox"/> PDE4 inhibitor				<input type="checkbox"/> Effective <input type="checkbox"/> Failed <input type="checkbox"/> Intolerant <input type="checkbox"/> Contraindicated

Will any of the above therapies continue to be used by the patient? No Yes If yes, list drug name(s) that will be continued: _____

Important Reminders: Certain drugs cannot be used in combination with other drugs. Clearly document what drug(s), if any, will be continued with the drug being requested.

Treatment Reauthorization

How long has the patient been on the requested therapy? List full duration (start date): _____
 Has the patient experienced an improvement in disease severity/activity (ie, with CRP, ESR)? _____
 Will any other therapies for the above indications be used in combination with/continued by the patient? No Yes If yes, list drug name(s) that will be used: _____

This information is presented for informational purposes only and is not intended to provide reimbursement or legal advice. The information presented here does not guarantee payment or coverage. Providers are encouraged to contact third-party payers for specific information about their coverage policies.

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Documentation Checklist for Patients With Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, or Non-Radiographic Axial Spondyloarthritis (cont'd)

Listed below are examples of the drug classes used for the treatment of rheumatoid arthritis (RA), psoriatic arthritis (PsA), ankylosing spondylitis (AS), or non-radiographic axial spondyloarthritis (nr-axSpA). This is not a comprehensive list. Some medications listed below are not approved for the treatment of the respective condition.

Biologic		RA	PsA	AS	nr-axSpA
<i>CD20 antibody</i>	rituximab (Rituxan [®])	✓			
<i>Interleukin (IL) antagonist</i>	anakinra (Kineret [®])	✓			
	guselkumab (Tremfya [®])		✓		
	ixekizumab (Taltz [®])		✓	✓	✓
	risankizumab-rzaa (Skyrizi [®])		✓		
	sarilumab (Kevzara [®])	✓			
	secukinumab (Cosentyx [®])		✓	✓	✓
	tocilizumab (Actemra [®])	✓			
	ustekinumab (Stelara [®])		✓		
<i>Selective T-cell costimulation modulator</i>	abatacept (Orencia [®])	✓	✓		
<i>Tumor necrosis factor (TNF) inhibitor</i>	adalimumab and biosimilars (Humira [®] , Amjevita [™] , Cyltezo [®] , Hadlima [™] , Hulio [®] , Hyrimoz [®] , Idacio [®] , Yuflyma [®] , Yusimry [™])	✓	✓	✓	
	certolizumab pegol (Cimzia [®])	✓	✓	✓	✓
	etanercept (Enbrel [®])	✓	✓	✓	
	golimumab (Simponi [®] , Simponi Aria [®])	✓	✓	✓	
	infliximab and biosimilars (Remicade [®] , Avsola [®] , Inflectra [®] , Renflexis [®])	✓	✓	✓	
Immunosuppressant					
	azathioprine (Azasan [®] , Imuran [®])	✓			
	cyclophosphamide (Cytoxan [®])	✓			
	cyclosporine (Gengraf [®] , Neoral [®])	✓	✓		
	hydroxychloroquine (Plaquenil [®])	✓			
	leflunomide (Arava [®])	✓	✓		
	methotrexate (Trexall [®] , Rheumatrex [®])	✓	✓		
	sulfasalazine (Azulfidine [®])	✓			
Janus kinase (JAK) inhibitor					
	baricitinib (Olumiant [®])	✓			
	tofacitinib (Xeljanz [®])	✓	✓	✓	
	upadacitinib (Rinvoq [®])	✓	✓	✓	✓
Nonsteroidal anti-inflammatory drug (NSAID)					
	ibuprofen			✓	✓
	naproxen			✓	✓
Phosphodiesterase-4 (PDE4) inhibitor					
	apremilast (Otezla [®])		✓		

✓ Used in treatment of respective condition.

The listed drugs are for example purposes only and do not include all potential options; specific required drugs or drug classes will vary based upon the payer's formulary.

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Reference: 1. Centers for Medicare & Medicaid Services. 2024 ICD-10-CM. 2024 Code Tables, Tabular and Index. Updated June 29, 2023. Accessed December 11, 2023. <https://www.cms.gov/files/zip/2024-code-tables-tabular-and-index-updated-06/29/2023.zip>

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