# US Family Health Plan
# Prior Authorization Request Form for
# baricitinib (**Olumiant**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD. Humira is the Department of Defense's preferred targeted biologic agent for FDA approved indications.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
**Attn: Pharmacy, 77 Warren St, Brighton, MA 02135**

QUESTIONS? **Call 1-877-880-7007**

## Step 1

**Please complete patient and physician information** (please print):

| | | | |
|---|---|---|---|
| Patient Name: | | Physician Name: | |
| Address: | | Address: | |
| | | | |
| Sponsor ID # | | Phone #: | |
| Date of Birth: | | Secure Fax #: | |

## Step 2

**Please complete clinical assessment:**

| | | |
|---|---|---|
| **1. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?** | ☐ Yes<br>proceed to question **2** | ☐ No<br>proceed to question **4** |
| **2. Has the patient had an inadequate response to Humira?** | ☐ Yes<br>proceed to question **5** | ☐ No<br>proceed to question **3** |
| **3. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?** | ☐ Yes<br>proceed to question **5** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **4. Does the patient have a contraindication to Humira (adalimumab)?** | ☐ Yes<br>Proceed to question **5** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **5. Is the patient 18 years of age or older?** | ☐ Yes<br>proceed to question **6** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **6. Does the patient have a diagnosis of moderately to severely active rheumatoid arthritis?** | ☐ Yes<br>proceed to question **7** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **7. Has the patient had an inadequate response to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [for example, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [for example, azathioprine], etc.)?** | ☐ Yes<br>proceed to question **8** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **8. Will the patient be receiving other biologic DMARDs or potent immunosuppressants (for example, azathioprine and cyclosporine) at the same time (concomitantly)?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>proceed to question **9** |

| | | |
|---|---|---|
| **9. Does the patient have a history of thromboembolic disease?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>proceed to question **10** |
| **10. Is the provider aware of the FDA safety alerts AND Boxed Warnings?** | ☐ Yes<br>proceed to question **11** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **11. Does the patient have a hemoglobin (Hgb) less than 8 g/dL?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>proceed to question **12** |
| **12. Does the patient have an absolute neutrophil count (ANC) LESS THAN 1,000/mm3?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>proceed to question **13** |
| **13. Does the patient have an absolute lymphocyte count (ALC) LESS THAN 500/mm3?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>proceed to question **14** |
| **14. Does the patient have evidence of a negative TB test result in past 12 months (or TB is adequately managed)?** | ☐ Yes<br>proceed to question **15** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **15. Will the patient be receiving other targeted immunomodulatory biologics, with Olumiant, including but not limited to the following: Actemra, Cimzia, Cosentyx, Enbrel, Humira, Ilumya, Kevzara, Kineret, Orencia, Remicade, Rituxan, Siliq, Simponi, Stelara, Taltz, Tremfya, Skyrizi, Rinvoq, or Xeljanz/Xeljanz XR? (Note: does not apply to Otezla)** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>**Sign and date below** |

**Step 3** **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date