

# 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.

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**

Clinical documentation may be required for approval.

**Step 1** Please complete patient and physician information (please print):

Patient Name: _____ Address: _____ Sponsor ID #: _____ Date of Birth: _____	Physician Name: _____ Address: _____ Phone #: _____ Secure Fax #: _____
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**Step 2** Please complete clinical assessment:

1. Provider acknowledges that use of Olumiant for alopecia areata is excluded by federal regulation (32 CFR 199.4(g)(41)(ii)(A)).	<input type="checkbox"/> Acknowledge Proceed to question 2	
2. What is the indication for Olumiant?	<input type="checkbox"/> Rheumatoid arthritis (RA) - Proceed to question 3 <input type="checkbox"/> Alopecia – <b>STOP Coverage not approved</b> <input type="checkbox"/> Other – <b>STOP Coverage not approved</b>	
3. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	<input type="checkbox"/> Yes proceed to question 4	<input type="checkbox"/> No proceed to question 6
4. Has the patient had an inadequate response to Humira?	<input type="checkbox"/> Yes proceed to question 7	<input type="checkbox"/> No proceed to question 5
5. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	<input type="checkbox"/> Yes proceed to question 7	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
6. Does the patient have a contraindication to Humira (adalimumab)?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
7. Is the patient 18 years of age or older?	<input type="checkbox"/> Yes proceed to question 8	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
8. Does the patient have a diagnosis of moderately to severely active rheumatoid arthritis?	<input type="checkbox"/> Yes proceed to question 9	<input type="checkbox"/> No <b>STOP</b> Coverage not approved

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<p>9. Has the patient had an inadequate response to non-biologic systemic therapy? (For example: methotrexate, aminosaliclates [for example, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [for example, azathioprine], etc.)?</p>	<p><input type="checkbox"/> Yes proceed to question 10</p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p>10. Will the patient be receiving other biologic DMARDs or potent immunosuppressants (for example, azathioprine and cyclosporine) at the same time (concomitantly)?</p>	<p><input type="checkbox"/> Yes <b>STOP</b> Coverage not approved</p>	<p><input type="checkbox"/> No proceed to question 11</p>
<p>11. Does the patient have a history of thromboembolic disease?</p>	<p><input type="checkbox"/> Yes <b>STOP</b> Coverage not approved</p>	<p><input type="checkbox"/> No proceed to question 12</p>
<p>12. Is the provider aware of the FDA safety alerts AND Boxed Warnings?</p>	<p><input type="checkbox"/> Yes proceed to question 13</p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p>13. Does the patient have a hemoglobin (Hgb) less than 8 g/dL?</p>	<p><input type="checkbox"/> Yes <b>STOP</b> Coverage not approved</p>	<p><input type="checkbox"/> No proceed to question 14</p>
<p>14. Does the patient have an absolute neutrophil count (ANC) LESS THAN 1,000/mm<sup>3</sup>?</p>	<p><input type="checkbox"/> Yes <b>STOP</b> Coverage not approved</p>	<p><input type="checkbox"/> No proceed to question 15</p>
<p>15. Does the patient have an absolute lymphocyte count (ALC) LESS THAN 500/mm<sup>3</sup>?</p>	<p><input type="checkbox"/> Yes <b>STOP</b> Coverage not approved</p>	<p><input type="checkbox"/> No proceed to question 16</p>
<p>16. Does the patient have evidence of a negative TB test result in past 12 months (or TB is adequately managed)?</p>	<p><input type="checkbox"/> Yes proceed to question 17</p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p>17. 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)</p>	<p><input type="checkbox"/> Yes <b>STOP</b> Coverage not approved</p>	<p><input type="checkbox"/> No Sign and date below</p>

**Step**

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

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date