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**

Patient Name: Physician Name:

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

Address: _____ Address: _____

Sponsor ID # _____ Phone #: _____

Date of Birth: _____ Secure Fax #: _____

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)).	☐ Acknowledge Proceed to question **2**	
2. What is the indication for Olumiant?	☐ Rheumatoid arthritis (RA) - Proceed to question **3** ☐ Alopecia – **STOP Coverage not approved** ☐ Other – **STOP Coverage not approved**	
3. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	☐ Yes proceed to question **4**	☐ No proceed to question **6**
4. Has the patient had an inadequate response to Humira?	☐ Yes proceed to question **7**	☐ 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?	☐ Yes proceed to question **7**	☐ No **STOP** **Coverage not approved**
6. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Is the patient 18 years of age or older?	☐ Yes proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Does the patient have a diagnosis of moderately to severely active rheumatoid arthritis?	☐ Yes proceed to question **9**	☐ No **STOP** **Coverage not approved**

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9. 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 proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Will the patient be receiving other biologic DMARDs or potent immunosuppressants (for example, azathioprine and cyclosporine) at the same time (concomitantly)?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **11**
11. Does the patient have a history of thromboembolic disease?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **12**
12. Is the provider aware of the FDA safety alerts AND Boxed Warnings?	☐ Yes proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Does the patient have a hemoglobin (Hgb) less than 8 g/dL?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **14**
14. Does the patient have an absolute neutrophil count (ANC) LESS THAN 1,000/mm3?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **15**
15. Does the patient have an absolute lymphocyte count (ALC) LESS THAN 500/mm3?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **16**
16. Does the patient have evidence of a negative TB test result in past 12 months (or TB is adequately managed)?	☐ Yes proceed to question **17**	☐ No **STOP** **Coverage not approved**
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)	☐ Yes **STOP** **Coverage not approved**	☐ No **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