USFHP 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

https://www.usfamilyhealth.org/for-providers/pharmacy-information/

Prior authorization does not expire. Clinical documentation may be required.

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. 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. 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 **9**	☐ No **STOP** **Coverage not approved**
9. Will the patient be receiving any other targeted immunomodulatory biologics concurrently, including but not limited to the following: TNF inhibitors, IL-1, IL-6, IL-17, IL-23, IL-36, S1p, or JAK inhibitor?	☐ 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 _____