BlueCross BlueShield Federal Employee Program

OLUMIANT
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

For Standard and Basic Option patients Humira including preferred Humira biosimilars, Actemra SC including preferred Actemra SC biosimilars, Enbrel, Rinvoq, and Xeljanz/Xeljanz XR are preferred products. Patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year.

Olumiant (baricitinib)

NOTE: Form must be completed in its **entirety** for processing

Please select strength: ❑**1mg tablet** ❑**2mg tablet** ❑**4mg tablet**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Is this medication being used to treat COVID-19? ❑Yes ❑No
   The FDA approved emergency use for Olumiant, in combination with remdesivir, for the treatment of COVID-19 in hospitalized patients. This should be billed under the medical benefit

2. Is this request for brand or generic? ❑Brand ❑Generic

3. Will the patient need more than 90 tablets every 90 days? ❑Yes* ❑No
   If YES, please specify the requested quantity: _____ tablets per 90 days

4. **Standard/Basic Option:** Has the patient tried and failed Humira or a Humira biosimilar, Enbrel, Rinvoq, or Xeljanz/Xeljanz XR?
   ❑**Yes:** Would you like to participate in this program and switch the patient to one of the preferred medications? ❑Yes* ❑No
   If YES, select the preferred product: ❑Humira/preferred biosimilar ❑Actemra SC/preferred biosimilar ❑Enbrel ❑Rinvoq ❑Xeljanz/Xeljanz XR
   ❑**No**: Would you like to participate in this program and switch the patient to one of the preferred medications? ❑Yes* ❑No
   If YES, select the preferred product: ❑Humira/preferred biosimilar ❑Enbrel ❑Rinvoq ❑Xeljanz/Xeljanz XR

5. Does the patient have a diagnosis of rheumatoid arthritis (RA)? ❑Yes ❑No

6. Has the prescriber considered the risks for malignancy and major adverse cardiovascular events (MACE) (such as advanced age, smoking history, cardiovascular risk factors etc.) and determined that Olumiant therapy is appropriate? ❑Yes ❑No

7. Does the patient have any active bacterial, invasive fungal, viral, or other opportunistic infections present? ❑Yes ❑No

8. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No

9. Will Olumiant be used in combination with potent immunosuppressants such as azathioprine or cyclosporine? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL QUESTIONS

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

10. Will Olumiant be used in combination with another biologic *DMARD or targeted synthetic DMARD? ❑Yes* ❑No

If YES, please specify the medication: _____

DMARDs: Actemra or an Actemra biosimilar, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.

11. Has the patient been on Olumiant continuously for the last **6 months** excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

a. Does the patient have moderate to severely active rheumatoid arthritis? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3-month trial of at least one conventional disease modifying antirheumatic drug (DMARD)? ❑Yes ❑No

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one TNF blocker such as Humira or a Humira biosimilar, Cimzia, Enbrel, Remicade, or Simponi/Simponi Aria? ❑Yes ❑No

d. Has the patient been tested for latent tuberculosis (TB)? ❑Yes* ❑No

If YES, was the result of the test positive or negative for TB infection? ❑Positive* ❑Negative

If Positive, has the patient completed treatment or is the patient currently receiving treatment for latent TB? ❑Yes ❑No

e. Does the patient have a history of thrombotic events including deep vein thrombosis (DVT) or pulmonary embolism (PE)? ❑Yes ❑No

f. Does the patient have severe hepatic impairment (Child-Pugh Class C)? ❑Yes ❑No

g. Does the patient have a lymphocyte count less than 500 cells per cubic millimeter (cells/mm3)? ❑Yes ❑No

h. Does the patient have an absolute neutrophil count (ANC) less than 1000 cells per cubic millimeter (cells/mm3)? ❑Yes ❑No

i. Does the patient have a hemoglobin less than 8 grams per deciliter? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

a. Has the patient's condition improved or stabilized with therapy? ❑Yes ❑No

b. Has the patient developed thrombotic events (including DVTs or PEs) while on this therapy? ❑Yes ❑No

12. **Standard/Basic Option Patient:** Does the patient have an intolerance or contraindication** or have they had an inadequate treatment response to TWO of the following preferred medications: Humira or a Humira biosimilar, Actemra SC or an Actemra SC biosimilar, Enbrel, Rinvoq, or Xeljanz/Xeljanz XR? ❑Yes ❑No*

If NO, is there a clinical reason for not trying TWO of the preferred medications? ❑Yes ❑No

****Contraindications include (not all inclusive): allergy, autoantibody formation/lupus-like syndrome, or a history of congestive heart failure, hepatitis B virus infection, malignancy, or demyelinating disorder such as multiple sclerosis, Guillain-Barre syndrome, or optic neuritis.***