Prior Authorization Request Form for
baricitinib (**Olumiant**)

USFHP Pharmacy Prior Authorization Form

JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

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:

Question	Yes	No
1. **Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?**	☐ Yes proceed to question **2**	☐ No proceed to question **4**
2. **Has the patient had an inadequate response to Humira?**	☐ Yes proceed to question **5**	☐ No 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 proceed to question **5**	☐ No **STOP Coverage not approved**
4. **Does the patient have a contraindication to Humira (adalimumab)?**	☐ Yes Proceed to question **5**	☐ No **STOP Coverage not approved**
5. **Is the patient 18 years of age or older?**	☐ Yes proceed to question **6**	☐ No **STOP Coverage not approved**
6. **Does the patient have a diagnosis of moderately to severely active rheumatoid arthritis?**	☐ Yes proceed to question **7**	☐ No **STOP Coverage not approved**
7. **Has the patient had an inadequate response to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [e.g. sulfasalazine, mesalamine], corticosteroids, immunosuppressants [e.g. azathioprine], etc.)?**	☐ Yes proceed to question **8**	☐ No **STOP 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 **STOP Coverage not approved**	☐ No proceed to question **9**

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Question	Yes	No
9. Does the patient have a history of thromboembolic disease?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **10**
10. Does the patient have a hemoglobin (Hgb) less than 8 g/dL?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **11**
11. Does the patient have an absolute neutrophil count (ANC) LESS THAN 1,000/mm3?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **12**
12. Does the patient have an absolute lymphocyte count (ALC) LESS THAN 500/mm3?	☐ Yes **STOP** **Coverage not approved**	☐ No proceed to question **13**
13. Does the patient have evidence of a negative TB test result in past 12 months (or TB is adequately managed)?	☐ Yes proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. 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

[08 April 2020]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: