SENTARA HEALTH PLANS

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Olumiant® (baricitinib)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

NOTE: The Health Plan considers the use of concomitant therapy with more than one biologic immunomodulator (e.g., Dupixent, Entyvio, Humira, Rinvoq, Stelara) prescribed for the same or different indications to be experimental and investigational. Safety and efficacy of these combinations has **NOT** been established and will **NOT** be permitted.

- Will the member be discontinuing a previously prescribed biologic if approved for requested medication?

  ❑ Yes **OR** ❑ No

- If yes, please list the medication that will be discontinued and the medication that will be initiated upon approval along with the corresponding effective date.

  Medication to be discontinued: _____ **Effective date:** _____

  Medication to be initiated: _____ **Effective date:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

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❑ Diagnosis: Moderate-to-Severe Active Rheumatoid Arthritis

Recommended Dose: 2 mg by mouth once daily

- ❑ Member has a diagnosis of moderate- to-severe active **rheumatoid arthritis**
- ❑ Prescribed by a **Rheumatologist**
- ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**
  - ❑ hydroxychloroquine
  - ❑ leflunomide
  - ❑ methotrexate
  - ❑ sulfasalazine
- ❑ Member meets **ONE** of the following:
  - ❑ Member tried and failed, has a contraindication, or intolerance to **TWO** of the **PREFERRED** biologics below **(verified by chart notes or pharmacy paid claims)**:

❑ Preferred adalimumab product	❑ Enbrel®
❑ Rinvoq®/Rinvoq® LQ	❑ Preferred tocilizumab product: Actemra® SC or Tyenne® SC
❑ Xeljanz®/XR®	

  - ❑ Member has been established on Olumiant® for at least 90 days **AND** prescription claims history indicates **at least a 90-day supply of Olumiant was dispensed within the past 130 days (verified by chart notes or pharmacy paid claims)**

❑ Diagnosis: Alopecia Areata

Recommended Dose: 2 mg by mouth once daily; if response is inadequate may increase to 4 mg once daily. In patients receiving 4 mg once daily (as initial therapy or after a dose increase), reduce dose to 2 mg once daily once an adequate response is achieved.

- ❑ Member is 18 years of age or older
- ❑ Prescribed by or in consultation with a **Dermatologist**
- ❑ Member has a diagnosis of **alopecia areata**
- ❑ Member has ≥ 50% of scalp hair loss measured by the Severity of Alopecia Tool (SALT) for more than 6 months **(chart notes with documentation of SALT score must be submitted)**
- ❑ Member does **NOT** have hair loss due to other forms of alopecia (i.e., androgenetic alopecia, chemotherapy induced, trichotillomania, telogen effluviums, and systemic lupus erythematosus)

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- ❑ Member has experienced treatment failure, has a contraindication or intolerance to **ONE** of the following therapies used for at least **three (3) months (chart notes documenting treatment failure must be submitted)**:
  - ❑ Oral corticosteroids (e.g., prednisone)
  - ❑ Oral immunosuppressants (e.g., azathioprine, cyclosporine, methotrexate)
  - ❑ Intralesional corticosteroids (e.g., triamcinolone acetonide 5-10 mg/mL)
  - ❑ Topical immunotherapy treatment (e.g., Squaric Acid Dibutyl Ester – SADBE; Diphenylcyclopropenone – DPCP)
- ❑ Member is **NOT** receiving Olumiant® in combination with other JAK inhibitors, biologic immunomodulators, or with other potent immunosuppressants

Medication being provided by Specialty Pharmacy – Proprium Rx

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee:** ~~10/18/2018; 2/16/2023; 8/17/2023; 1/18/2024;~~ **11/21/2024**
REVISED/UPDATED/REFORMATTED: ~~12/30/2018; 11/20/2019; 12/21/2022; 3/9/2023;8/13/2023; 10/31/2023 2/9/2024; 3/27/2024; 12/17/2024;~~ **7/7/2025**