PRIOR AUTHORIZATION REQUEST
Olumiant

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. Will the requested medication be given in combination with a BIOLOGIC disease-modifying antirheumatic drug (DMARD) or in combination with a targeted synthetic DMARD or with another potent immunosuppressant (for example, azathioprine, cyclosporine)?
   - ☐ Biologic DMARD
   - ☐ Targeted synthetic DMARD
   - ☐ Conventional synthetic DMARD – Please Proceed to question 2
   - ☐ No, the requested medication will NOT be used in combination with another BIOLOGIC, targeted Synthetic disease-modifying antirheumatic drug (DMARD), or potent immunosuppressant – **Please Proceed to question 2**
2. ☐ Yes ☐ No Is the patient currently receiving the requested medication?
3. What is the indication or diagnosis?
   - ☐ Rheumatoid arthritis – **Please answer question 4 – 6**
   - ☐ COVID-19 (Coronavirus Disease 2019) Note: This includes requests for cytokine release syndrome associated with COVID-19 – **Please answer question 7**
   - ☐ All other indications or diagnoses - Please Specify _____
4. ☐ Yes ☐ No Has the patient had a 3-month trial of at least ONE tumor necrosis factor inhibitor (TNFi) for this condition, unless intolerant?
5. ☐ Yes ☐ No Is the requested medication being prescribed by or in consultation with a rheumatologist?
6. ☐ Yes ☐ No Has the patient had a response, as determined by the prescriber?
7. Please provide the patient's diagnosis or indication, prescribed dose, frequency and route of administration, any other medications previously tried with duration of trial, and prescriber's or consultant's specialty. If the patient is already on this medication, when was it started?

_____

If you have any questions, call: 800-753-2851

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Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

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