PRIOR AUTHORIZATION REQUEST

OLUMIANT

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the request for an INITIAL therapy or a CONTINUATION of therapy? [] Initial (If checked, go to 8) [] Continuation (If checked, go to 2)		
2	Will the requested medication be used in combination with a Biologic or a Targeted Synthetic Disease-Modifying Antirheumatic Drug (DMARD)? Examples of Biologics include but not limited to adalimumab SC products (Humira,	Yes	No

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	biosimilars), Actemra (IV or SC), Cimzia, Cosentyx, Kevzara, Kineret, Orencia (IV or SC), an infliximab product (for example, Remicade, biosimilars), rituximab IV products (Rituxan, biosimilars), Siliq, Stelara (IV or SC), Taltz, Ilumya, Skyrizi, Tremfya, Entyvio, or Simponi (Aria or SC). Examples of Targeted Synthetic DMARD include but not limited to Cibinqo, Rinvoq, Xeljanz/XR, Otezla. [If yes, no further questions.]		
3	Is the patient currently receiving the requested medication? [If no, skip to question 8.]	Yes	No
4	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 8.]	Yes	No
5	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 8.]	Yes	No
6	Will the requested medication be used in combination with other potent immunosuppressants (for example, azathioprine, cyclosporine)? [Note: This does NOT include the use of methotrexate in combination with the requested medication.] [If yes, no further questions.]	Yes	No
7	Has the patient been taking the requested medication for at least 3 months and has experienced a clinically significant benefit from the medication, as documented by the prescriber? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
8	Will the requested medication be used in combination with a Biologic or a Targeted Synthetic Disease-Modifying Antirheumatic Drug (DMARD)? Examples of Biologics include but not limited to adalimumab SC products (Humira, biosimilars), Actemra (IV or SC), Cimzia, Cosentyx, Kevzara, Kineret, Orencia (IV or SC), an infliximab product (for example, Remicade, biosimilars), rituximab IV products (Rituxan, biosimilars), Siliq, Stelara (IV or SC), Taltz, Ilumya, Skyrizi, Tremfya, Entyvio, or Simponi (Aria or SC). Examples of Targeted Synthetic DMARD include but not limited to Cibinqo, Rinvoq, Xeljanz/XR, Otezla. [If yes, no further questions.]	Yes	No
9	What is the indication or diagnosis? [] Rheumatoid arthritis (If checked, go to 10) [] Severe alopecia areata (If checked, go to 19) [] COVID-19 (Coronavirus disease 2019) [Note: This includes requests for		

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	cytokine release syndrome associated with COVID-19.] (If checked, no further questions) [] All other indications or diagnoses (If checked, no further questions)		
10	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
11	Does the patient have a documented diagnosis of moderately to severely active rheumatoid arthritis? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
12	Has documentation been submitted to confirm that the patient has tried at least TWO conventional synthetic disease-modifying antirheumatic drugs (DMARDs) for at least 3 months? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of conventional synthetic DMARDs include, methotrexate, sulfasalazine, hydroxychloroquine, or leflunomide.] [If yes, skip to question 14.]	Yes	No
13	Has documentation been submitted to confirm that the patient has an intolerance to at least TWO conventional synthetic disease-modifying antirheumatic drugs (DMARDs) (such as, methotrexate, sulfasalazine, hydroxychloroquine, or leflunomide)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
14	Has documentation been submitted to confirm that the patient has had an intolerance, contraindication to, or failed treatment for at least 3 months with at least one tumor necrosis factor inhibitors, an adalimumab product (Hadlima, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
15	Has documentation been submitted to confirm that the patient has had an intolerance, contraindication to, or failed treatment for at least 3 months with Xeljanz (tofacitinib)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
16	Will the patient be using the requested medication in combination with other Janus kinase inhibitors [such as, Xeljanz (tofacitinib), Rinvoq (upadacitinib)]? [If yes, no further questions.]	Yes	No
17	Is the requested medication being prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
18	Does the prescribed dosing exceed Food and Drug Administration (FDA) approved indication? [Dosing: 2 mg once daily.]	Yes	No

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	[No further questions.]		
19	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
20	Does the patient have a documented diagnosis of severe alopecia areata? [If no, no further questions.]	Yes	No
21	Has the patient had a current episode of alopecia areata lasting 6 months or greater? [If no, no further questions.]	Yes	No
22	Does the patient have a scalp hair loss of 50% or greater as measured by the Severity of Alopecia Tool (SALT)? [Note: Mild hair loss is 20% or less scalp hair loss, Moderate is 21 to 49% scalp hair loss and Severe is 50 to 100% scalp hair loss.] [If no, no further questions.]	Yes	No
23	Has the patient tried at least TWO systemic therapies for at least 3 months? [Note: Examples of systemic therapies include corticosteroids, methotrexate, and cyclosporine.] [If no, no further questions.]	Yes	No
24	Has the patient tried TWO topical therapies for at least 6 months for alopecia areata? [Note: Examples of topical therapies include fluocinolone acetonide, betamethasone dipropionate, clobetasol propionate, anthralin.] [If no, no further questions.]	Yes	No
25	Has documentation been provided to confirm that the patient does NOT have hair loss due to androgenetic alopecia, chemotherapy-induced hair loss, or other causes of hair loss other than alopecia areata? ACTION REQUIRED: Submit supporting documentation. [Note: Androgenetic alopecia includes male and female pattern hair loss; other causes of hair loss include trichotillomania, telogen effluvium, and systemic lupus erythematosus.] [If no, no further questions.]	Yes	No
26	Will the patient be using the requested medication in combination with other Janus kinase inhibitors [such as, Xeljanz (tofacitinib), Rinvoq (upadacitinib)]? [If yes, no further questions.]	Yes	No
27	Is the requested medication being prescribed by or in consultation with a rheumatologist or a dermatologist? [If no, no further questions.]	Yes	No
28	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Dosing: 2 mg - 4 mg once daily.]	Yes	No

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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: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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If you have any questions, call: 1-888-258-8250