aetna®

Olumiant® (baricitinib) Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	E-mail:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider E-mail:		Office Contact Name:		Phone:	

Specialty *(Check one)*: ☐ **Rheumatologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Olumiant (baricitinib): Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For initiation requests (clinical documentation required):

☐ Yes ☐ No Will Olumiant (baricitinib) be used concomitantly with apremilast, tofacitinib, biologic DMARDs (e.g., adalimumab, infliximab), or potent immunosuppressants (i.e., azathioprine, cyclosporine)?

☐ Yes ☐ No Has the patient been tested for TB with a PPD test, interferon-release assay (IGRA) or chest x-ray within 6 months of initiating a biologic therapy?
→ (check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray
Please enter the results of the TB test: ☐ Positive ☐ Negative ☐ Unknown
If positive, Does the patient have latent or active TB? ☐ Latent ☐ Active
If latent TB, ☐ Yes ☐ No Will TB treatment be started before initiation of therapy with Olumiant (baricitinib)?

Rheumatoid Arthritis

Please indicate the severity of the patient's rheumatoid arthritis: ☐ Mild ☐ Moderate ☐ Severe

☐ Yes ☐ No Is there evidence that the disease is active?

☐ Yes ☐ No Was treatment with methotrexate ineffective?
→ ☐ Yes ☐ No Was treatment with methotrexate not tolerated or contraindicated?
→ Please select: ☐ not tolerated ☐ contraindicated
☐ Yes ☐ No Was treatment with another conventional DMARD ineffective?
→ Please select: ☐ azathioprine ☐ hydroxychloroquine ☐ leflunomide ☐ sulfasalazine
Please indicate the length of the DMARD treatment: ☐ Less than 30 days ☐ 30-60 days ☐ 60-90 days ☐ 90 days or more

→ Please indicate the length of treatment: ☐ Less than 30 days ☐ 30-60 days ☐ 60-90 days ☐ 90 days or more

Continued on next page

aetna®

Olumiant® (baricitinib) Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

Please select which of the following TNFs the patient has tried:

☐ Cimzia (certolizumab)
Was treatment ineffective, not tolerated, or contraindicated? ☐ ineffective ☐ not tolerated ☐ contraindicated
Please indicate how long the medication trial was: ☐ Less than 30 days ☐ 30-60 days ☐ 60-90 days ☐ 90 days or more

☐ Enbrel (etanercept)
Was treatment ineffective, not tolerated, or contraindicated? ☐ ineffective ☐ not tolerated ☐ contraindicated
Please indicate how long the medication trial was: ☐ Less than 30 days ☐ 30-60 days ☐ 60-90 days ☐ 90 days or more

☐ Humira (adalimumab)
Was treatment ineffective, not tolerated, or contraindicated? ☐ ineffective ☐ not tolerated ☐ contraindicated
Please indicate how long the medication trial was: ☐ Less than 30 days ☐ 30-60 days ☐ 60-90 days ☐ 90 days or more

☐ Inflectra (infliximab-dyyb)
Was treatment ineffective, not tolerated, or contraindicated? ☐ ineffective ☐ not tolerated ☐ contraindicated
Please indicate how long the medication trial was: ☐ Less than 30 days ☐ 30-60 days ☐ 60-90 days ☐ 90 days or more

☐ Remicade (infliximab)
Was treatment ineffective, not tolerated, or contraindicated? ☐ ineffective ☐ not tolerated ☐ contraindicated
Please indicate how long the medication trial was: ☐ Less than 30 days ☐ 30-60 days ☐ 60-90 days ☐ 90 days or more

☐ Renflexis (infliximab-abda)
Was treatment ineffective, not tolerated, or contraindicated? ☐ ineffective ☐ not tolerated ☐ contraindicated
Please indicate how long the medication trial was: ☐ Less than 30 days ☐ 30-60 days ☐ 60-90 days ☐ 90 days or more

☐ Simponi/Simponi Aria (golimumab)
Was treatment ineffective, not tolerated, or contraindicated? ☐ ineffective ☐ not tolerated ☐ contraindicated
Please indicate how long the medication trial was: ☐ Less than 30 days ☐ 30-60 days ☐ 60-90 days ☐ 90 days or more

For continuation of therapy (clinical documentation required for all requests):

Please indicate the length of time on Olumiant (baricitinib) therapy: _____

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of Olumiant (baricitinib)? (Sampling of Olumiant (baricitinib) does not guarantee coverage under the provisions of the pharmacy benefit).

☐ Yes ☐ No Will Olumiant (baricitinib) be used concomitantly with apremilast, tofacitinib, biologic DMARDs (e.g., adalimumab, infliximab), or potent immunosuppressants (i.e., azathioprine, cyclosporine)?

Please indicate the severity of the patient's rheumatoid arthritis at baseline (pretreatment with Olumiant (baricitinib)): ☐ Mild ☐ Moderate ☐ Severe

☐ Yes ☐ No Is there clinical documentation supporting disease stability?

☐ Yes ☐ No Is there clinical documentation supporting disease improvement?

☐ Yes ☐ No Does the patient have any risk factors for TB?

→ ☐ Yes ☐ No Has the patient had a TB test within the past year?
(check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray
Please enter the results of the TB test: ☐ Positive ☐ Negative ☐ Unknown

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.