

Olumiant® Prior Authorization Request Form (Page 1 of 2)
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Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information <small>(required)</small>					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information <small>(required)</small>					
Select the diagnosis below: <input type="checkbox"/> Moderate to severe active rheumatoid arthritis <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Clinical Information: Is Olumiant prescribed by a rheumatologist? <input type="checkbox"/> Yes <input type="checkbox"/> No Select if the patient has tried and failed the following disease modifying antirheumatic drug (DMARD) for at least three (3) months: <input type="checkbox"/> Auranofin <input type="checkbox"/> Azathioprine <input type="checkbox"/> Hydroxychloroquine <input type="checkbox"/> Leflunomide <input type="checkbox"/> Methotrexate <input type="checkbox"/> Minocycline <input type="checkbox"/> Sulfasalazine Select if the patient has tried and failed the following: <input type="checkbox"/> Cimzia <input type="checkbox"/> Humira <input type="checkbox"/> Kevzara <input type="checkbox"/> Simponi <input type="checkbox"/> Xeljanz/Xeljanz XR					
Quantity Limit Requests: What is the quantity requested per DAY? _____ Previous therapies failed and/or therapies currently used in combination with the requested medication (<i>List ALL medications tried or authorization process will be delayed</i>): _____ _____ _____ Is the prescribed dose higher than the maximum dose recommendation in FDA-approved labeling (i.e., the package insert)? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , please provide documentation to support the safety and efficacy of the higher dose (such as evidence from practice guidelines or clinical trials from peer-reviewed medical literature). ** Please note: Chart documentation of the above is required to be submitted along with this fax _____ _____					
Medication being provided by: (Please check applicable box below) <input type="checkbox"/> PropriumRx <input type="checkbox"/> Specialty Pharmacy (specify name): _____					
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.*					
Prescriber Signature: _____			Date: _____		

Olumiant[®] Prior Authorization Request Form (Page 2 of 2)

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.