Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Cytokine and CAM Antagonists – Olumiant (Baricitinib) (Medicaid)

This fax machine is located in a secure location as required by HIPAA Regulations. Complete / Review information, sign, and date. Fax signed forms to Molina Pharmacy Prior Authorization Department at **1-888-487-9251**. Please contact Molina Pharmacy Prior Authorization Department at **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Olumiant (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)	
OLUMIANT 1 MG TABLET	OLUMIANT 2 MG TABLET

Patient Information	
Patient Name:	
Patient ID:	
Patient DOB:	

Prescribing Physician	
Physician Name:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State, Zip:	

Diagnosis:	ICD Code:
Directions for administration:	

*****Please include all relevant clinical notes, lab work, medication history and any other applicable documentation.**

Please circle the appropriate answer for each question.

1. Is the requested drug required per court order? (court order required) Y N
   If the answer to this question is yes, approved for 365 days.
   If the answer to this question is no, go to question 2.

2. Is the patient greater than or equal to 18 years of age? Y N
   If the answer to this question is yes, go to question 3.
   If the answer to this question is no, denied.

3. Does the patient have a diagnosis of rheumatoid arthritis (RA) in the last 730 days? Y N
   If the answer to this question is yes, go to question 4.
   If the answer to this question is no, denied.

4. Has the patient had 1 claim for a tumor necrosis factor (TNF) blocker in the last 180 days? Y N

TNF Blocker
CIMZIA
ENBREL

HUMIRA
SIMPONI
SIMPONI ARIA

If the answer to this question is yes, go to question 5.
If the answer to this question is no, denied.

5. Does the patient have 1 claim for a JAK inhibitor, biologic DMARD or potent immunosuppressant in the last 30 days? Y N

JAK inhibitors
JAKAFI
OLUMIANT
RINVOQ ER
XELJANZ
XELJANZ XR

Biologic DMARDs
ACTEMRA
CIMZIA
COSENTYX
ENBREL
HUMIRA
HUMIRA PEDI CROHN
ILARIS
KEVZARA
KINERET
ORENCIA
ORENCIA CLICKJECT
OTEZLA
SILIQ
SIMPONI
STELARA
TALTZ

Potent Immunosuppressants
ASTAGRAF XL
AZATHIOPRINE
CELLCEPT
CYCLOSPORINE
CYCLOSPORINE MODIFIED
GENGRAF
IMURAN
MYCOPHENOLATE
MYCOPHENOLIC ACID
NEORAL
SANDIMMUNE
TACROLIMUS

If the answer to this question is yes, denied.
If the answer to this question is no, go to question 6.

6. Does the patient have 1 claim for a strong organic anion transporter 3 (OAT3) inhibitor in the last 90 days? Y N

Strong OAT3 Inhibitors
ARAVA

AUBAGIO
JYNARQUE
LEFLUNOMIDE
PROBENECID
PROBENECID-COLCHICINE
SAMSCA

If the answer to this question is yes, denied.
If the answer to this question is no, go to question 7.

7. Does the patient have a diagnosis that indicates increased risk of GI perforation, thrombosis or malignancy in the last 180 days? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 8.

8. Does the patient have a diagnosis of severe renal (eGFR < 60mL/min/1.73m2) or severe hepatic impairment in the last 365 days? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 9.

9. Does the patient have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 10.

10. Is the requested dose less than or equal to 1 tablet daily? Y N
    If the answer to this question is yes, go to question 11.
    If the answer to this question is no, denied.

11. Is the request for a non-preferred drug? Y N
    If the answer to this question is yes, go to question 12.
    If the answer to this question is no, approved for 365 days.

12. Has the patient failed a 30-day treatment with at least 1 preferred agent within the last 180 days? Y N
    If the answer to this question is yes, approved for 365 days.
    If the answer to this question is no, go to question 13.

13. Is there a documented allergy or contraindication to preferred agents in this class? Y N
    If the answer to this question is yes, approved for 365 days.
    If the answer to this question is no, go to question 14.

14. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? Y N
    If the answer to this question is yes, approved for 365 days.
    If the answer to this question is no, denied.

Comments:

I affirm that the information given on this form is true and accurate as of this date.

_____ _____

Prescriber (or Authorized) Signature Date