UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2021 P 1249-4
Program	Prior Authorization/Notification
Medication	Olumiant® (baricitinib)
P&T Approval Date	7/1/2108, 7/2019, 7/2020, 7/2021
Effective Date	10/1/2021; Oxford only: N/A

1. Background:

Olumiant (baricitinib) is a Janus Kinase (JAK) inhibitor indicated for the treatment of adult patients with moderately to severely active rheumatoid arthritis who have had an inadequate response to one or more tumor necrosis factor (TNF) antagonist therapies. Use of Olumiant in combination with other JAK inhibitors, biologic DMARDs, or with potent immunosuppressants such as azathioprine and cyclosporine is not recommended.[1]

2. Coverage Criteria:

A. Rheumatoid Arthritis (RA)

1. Initial Authorization

a. Olumiant will be approved based on **all** of the following criteria:

(1) Diagnosis of moderately to severely active RA

-AND-

(2) History of failure, contraindication, or intolerance to at least **one** TNF antagonist therapy [e.g., Cimzia (certolizumab), Humira (adalimumab), Simponi (golimumab)]

-AND-

(3) Patient is not receiving Olumiant in combination with **any** of the following:
- (a) Biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]
- (b) Potent immunosuppressant (e.g., azathioprine or cyclosporine)[1]
- (c) Janus kinase inhibitor [e.g., Xeljanz/Xeljanz XR (tofacitinib)]

Authorization will be issued for 12 months.

2. Reauthorization

a. Olumiant will be approved based on **both** of the following criteria:

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(1) Documentation of positive clinical response to Olumiant therapy

-AND-

(2) Patient is not receiving Olumiant in combination with **any** of the following:
   (a) Biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]
   (b) Potent immunosuppressant (e.g., azathioprine or cyclosporine)[1]
   (c) Janus kinase inhibitor [e.g., Xeljanz/Xeljanz XR (tofacitinib)]

Authorization will be issued for 12 months.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits, Step Therapy, and/or Medical Necessity may be in place.

4. References:

1. Olumiant [package insert]. Indianapolis, IN: Lilly USA, LLC; July 2020.
2. Pavy S. Constantin A, Pham T, et al. Methotrexate therapy for rheumatoid arthritis: clinical practice guidelines based on published evidence and expert opinions. Joint Bone Spine 2006;73(4):388-95.
3. Singh JA, Saag KG, Bridges SL, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. Arthritis Care & Research. Arthritis Rheum. 2016;68(1):1-26.

Program	Prior Authorization/Notification – Olumiant (baricitinib)
Change Control	
7/2018	New program.
7/2019	Annual review. No changes to the program.
7/2020	Annual review. Updated reauthorization issue duration.
7/2021	Annual review. No changes to coverage criteria.

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