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Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

## Olumiant® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
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 (required)					
Medication Name:			Strength:	Dosage Form:	
<input type="checkbox"/> Check if requesting <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
Clinical Information (required)					
<b>Select the diagnosis below:</b>					
<input type="checkbox"/> Moderately to severely active rheumatoid arthritis (RA)					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
<b>Clinical Information:</b>					
Is Olumiant prescribed by or in consultation with a rheumatologist? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has the patient had a trial and failure, contraindication, or intolerance to one non-biologic disease modifying anti-rheumatic drug (DMARD) (e.g., Rheumatrex/Trexall [methotrexate], Arava [leflunomide], Azulfidine [sulfasalazine])? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is this request for continuation of prior Olumiant therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Select if the patient has had a trial and failure, contraindication, or intolerance to the following, or attestation demonstrating a trial may be inappropriate:					
<input type="checkbox"/> Cimzia (certolizumab pegol)					
<input type="checkbox"/> Humira (adalimumab)					
<input type="checkbox"/> Simponi (golimumab) or Simponi Aria (golimumab IV)					
Select if the patient has had a trial and failure, contraindication, or intolerance to the following:					
<input type="checkbox"/> Kevzara (sarilumab)					
<input type="checkbox"/> Xeljanz (tofacitinib) or Xeljanz XR (tofacitinib ER)					
Will Olumiant be used in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Will Olumiant be used in combination with other janus kinase (JAK) inhibitors (e.g., azathioprine or cyclosporine)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Reauthorization:</b>					
Is there documentation the patient has had a positive clinical response to Olumiant therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Will Olumiant be used in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Will Olumiant be used in combination with other janus kinase (JAK) inhibitors (e.g., azathioprine or cyclosporine)? <input type="checkbox"/> Yes <input type="checkbox"/> No					

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

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**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.

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