OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
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)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Moderately to severely active rheumatoid arthritis (RA)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is Olumiant prescribed by or in consultation with a rheumatologist? ❑ **Yes** ❑ **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])? ❑ **Yes** ❑ **No**

Is this request for continuation of prior Olumiant therapy? ❑ **Yes** ❑ **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:

- ❑ Cimzia (certolizumab pegol)
- ❑ Humira (adalimumab)
- ❑ Simponi (golimumab) or Simponi Aria (golimumab IV)

Select if the patient has had a trial and failure, contraindication, or intolerance to the following:

- ❑ Kevzara (sarilumab)
- ❑ Xeljanz (tofacitinib) or Xeljanz XR (tofacitinib ER)

Will Olumiant be used in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine)? ❑ **Yes** ❑ **No**

Will Olumiant be used in combination with other janus kinase (JAK) inhibitors (e.g., azathioprine or cyclosporine)? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation the patient has had a positive clinical response to Olumiant therapy? ❑ **Yes** ❑ **No**

Will Olumiant be used in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine)? ❑ **Yes** ❑ **No**

Will Olumiant be used in combination with other janus kinase (JAK) inhibitors (e.g., azathioprine or cyclosporine)? ❑ **Yes** ❑ **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?

_____

_____

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.