Olumiant (baricitinib)
Effective 01/01/2022

Plan	☐ MassHealth ☒ MassHealth (PUF) ☐Commercial/Exchange	**Program Type**	☒ Prior Authorization ☒ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit (NLX)		
Specialty Limitations	This medication has been designated a specialty medication and must be filled at a contracted specialty pharmacy.		
Contact Information	**Specialty Medications**		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	Non-Specialty Medications		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	Medical Specialty Medications (NLX)		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
Exceptions	N/A		

Overview

Olumiant is a Janus kinase (JAK) inhibitor indicated for:

- Treatment of adult patients with moderately to severely active rheumatoid arthritis who have had an inadequate response to one or more TNF antagonist therapies.

Coverage Guidelines

Authorization may be reviewed on a case by case basis for members new to AllWays Health Partners who are currently receiving treatment with Olumiant excluding when the product is obtained as samples or via manufacturer's patient assistance programs.

OR

Authorization may be granted for members when ALL the following criteria are met, and documentation is provided:

1. Member has a diagnosis of moderate to severe rheumatoid arthritis (RA)
2. Paid claims or physician documented inadequate response or adverse reaction to ONE traditional DMARD or contraindication to ALL traditional DMARDs (see Appendix A)
3. **ONE** of the following:
    a. Paid claims or physician documented inadequate response or adverse reaction to ONE biologic DMARD that is FDA-approved for RA
    b. Contraindication to ALL biologic DMARDs FDA-approved for RA
4. Paid claims or physician documented inadequate response, adverse reaction or contraindication to Xeljanz® (tofacitinib) or Xeljanz XR® (tofacitinib extended-release)
5. Quantity requested is ≤1 tablet/day

Continuation of Therapy

Reauthorization requires physician documentation of continuation of therapy, positive response to therapy, FDA approved indication and appropriate dosing.

Limitations

1. Initial approvals will be granted for 6 months
2. Reauthorizations will be granted for 12 months
3. The following quantity limits apply:

Olumiant 1mg and 2mg	30 tablets per 30 days

Appendices

Appendix A: Traditional DMARDS

Traditional DMARDS*	
azathioprine	methotrexate*
cyclosporine	sulfasalazine*
hydroxychloroquine*	thalidomide
leflunomide	
If a member has a contraindication to **ALL** of the most commonly used traditional DMARDs* (methotrexate, sulfasalazine, and hydroxychloroquine), a trial with a traditional DMARD may be bypassed.	

Appendix B. Conventional Therapies for Plaque Psoriasis

Conventional Treatment Lines	Agents Used
Topical Agents	emollients, keratolytics, corticosteroids, coal tar, anthralin, calcipotriene, tazarotene, calcitriol, calcineurin inhibitors
Systemic Agents	Traditional DMARDs: methotrexate, apremilast, acitretin,
Phototherapy	ultraviolet A and topical psoralens (topical PUVA), ultraviolet A and oral psoralens (systemic PUVA), narrow band UV-B (NUVB)

Appendix C: Off-Label Indications

More frequent/Higher doses

Requests more frequent or higher doses of injectable biologics, may be approved if ALL of the following is provided:

1. Documentation of severe disease
2. **ONE** of the following:
    a. Inadequate response or adverse reaction to **ONE** other injectable biologic which is FDA-approved for the requested indication*
    b. Contraindication to **ALL** other injectable biologics which are FDA-approved for the requested indication
3. Documented partial response to FDA-approved dosing of current biologic therapy
4. Documentation of specialist consult for the requested indication

Atopic Dermatitis (moderate-to-severe)

Prescriber documents ALL of the following:

1. Paid claim or physician attestation of inadequate response, adverse reaction or contraindication to phototherapy

2. Paid claim or physician attestation of response, adverse reaction or contraindication to **TWO** traditional DMARDs (cyclosporine, methotrexate, mycophenolate, azathioprine) or a contraindication to all traditional DMARDs

References

1. Olumiant (baricitinib) [prescribing information]. Indianapolis, IN: Lilly USA LLC; October 2019
2. Taylor PC, Keystone EC, van der Heijde D, et al. Baricitinib versus placebo or adalimumab in rheumatoid arthritis. N Engl J Med. 2017;376(7):652-662
3. Westhovens R, Taylor PC, Alten R, et al. Filgotinib (GLPG0634/GS-6034), an oral JAK1 selective inhibitor, is effective in combination with methotrexate (MTX) in patients with active rheumatoid arthritis and insufficient response to MTX: results from a randomised, dose-finding study (DARWIN 1). Ann Rheum Dis 2017; 76:998
4. Humira (adalimumab) [prescribing information]. North Chicago, IL: AbbVie Inc; March 2020.
5. Enbrel (etanercept) [prescribing information]. Thousand Oaks, CA: Immunex Corporation; March 2020

Review History

05/20/2020 – Created and Reviewed May P&T. Effective 8/1/20.
10/21/2020 – Reviewed and Updated; separated out Comm/Exch vs. MassHealth. Matched MassHealth Preferred Unified Formulary for implementation 1/1/2021
11/17/2021 –Reviewed and Updated for Nov P&T; matched MH UPPL for 1/1/2022 implementation; added appendix with higher dose/more frequent dosing and off label indication. Effective 01/01/2022

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