

Pharmacy Policy

Olumiant

Policy Number: 9.132

Revision Number: R0

Version Effective Date: 1/1/2021

<p>Product Applicability <input type="checkbox"/> All Plan+ Products</p>	
<p>Well Sense Health Plan</p> <p><input checked="" type="checkbox"/> New Hampshire Medicaid</p>	<p>Boston Medical Center HealthNet Plan</p> <p><input type="checkbox"/> MassHealth - MCO</p> <p><input type="checkbox"/> MassHealth - ACO</p> <p><input type="checkbox"/> Qualified Health Plans/ConnectorCare/Employer Choice Direct</p> <p><input type="checkbox"/> Senior Care Options</p>

Note: Disclaimer and audit information is located at the end of this document.

Prior Authorization Policy

Products Affected:

- Olumiant (baricitinib)

The Plan may authorize coverage of the above products for members meeting the following criteria:

Covered Use	All FDA approved indications not otherwise excluded
Exclusion Criteria	Use in combination with biologics or potent immunosuppressants
Required Medical Information	<p>Diagnosis of one of the following:</p> <ol style="list-style-type: none"> 1. Moderate to severely active Rheumatoid Arthritis (RA); AND <ol style="list-style-type: none"> a. An inadequate response or intolerance to at least one formulary non-biologic DMARD, or is currently on methotrexate; AND b. One of the following: <ol style="list-style-type: none"> i. An inadequate response, intolerance, or contraindication to Enbrel or Humira or a clinical rationale for use of the requested agent instead of Enbrel or Humira; OR ii. Patient has documented needle-phobia to the degree that the patient has

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	previously refused any injectable therapy or medical procedure (refer to DSM-IV-TR 300.29 for specific phobia diagnostic criteria)
Age Restrictions	18 years of age or older
Prescriber Restriction	RA: Prescribed by or in consultation with a rheumatologist
Coverage Duration	12 months
Other criteria	Reauthorization: 1. Currently receiving medication via Well Sense benefit or member has previously met initial approval criteria; AND 2. Patient's clinical condition has improved or stabilized

Applicable Coding:

None

Clinical Background Information and References

1. Olumiant (baricitinib) [prescribing information]. Indianapolis, IN: Lilly USA LLC; June 2018.
2. Singh, Jasvinder A., et al. "2015 American College of Rheumatology guideline for the treatment of rheumatoid arthritis." Arthritis & rheumatology 68.1 (2016): 1-26.
3. Cohen, Stanley, and A. Cannella. "Treatment of rheumatoid arthritis in adults resistant to initial nonbiologic DMARD therapy." UpToDate, Waltham, MA: Walters Kluwer Health (2016).

Original Approval Date	Original Effective Date	Policy Owner	Approved by
12/1/2020	1/1/2021	Pharmacy Services	Pharmacy & Therapeutics (P&T) Committee, NH DHHS

Policy Revisions History			
Review Date	Summary of Revisions	Revision Effective Date	Approved by
12/1/2020	9.196 Olumiant Policy retired, new policy created. No criteria changes.	1/1/2021	P&T Committee, NH DHHS

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Next Review Date

2021

Other Applicable Policies

Reference to Applicable Laws and Regulations, If Any

Disclaimer Information

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

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