Drug Coverage Policy

Effective Date.....11/01/2024
Coverage Policy Number.....IP0681
Policy Title.....Olumiant Prior Authorization Policy

Inflammatory Conditions – Olumiant Prior Authorization Policy

- Olumiant® (baricitinib tablets – Lilly)

INSTRUCTIONS FOR USE
The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment and have discretion in making individual coverage determinations. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Cigna Healthcare Coverage Policy

Overview
Olumiant, an inhibitor of the Janus kinases (JAK) pathways, is indicated for the following uses:[1]

- **Alopecia Areata,** in adults with severe disease.
- **Coronavirus Disease 2019 (COVID-19)**, for hospitalized adults requiring supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane

oxygenation (ECMO). For COVID-19, the dose is 4 mg once daily for 14 days or until hospital discharge, whichever comes first.
- **Rheumatoid Arthritis**, in adults with moderate to severe active disease who have had an inadequate response to one or more tumor necrosis factor inhibitors. Olumiant is not recommended for use in combination with other JAK inhibitors, or in combination with biologics or potent immunosuppressants such as azathioprine or cyclosporine.

Guidelines
Olumiant is addressed in the following guidelines:
- **Alopecia Areata:** An international expert opinion on treatments for alopecia areata (2020) lists JAK inhibitors among the therapies for treatment of extensive hair loss. First-line treatments for adults include high- or super-high potency topical corticosteroids and/or systemic corticosteroids. Steroid-sparing therapies to mitigate the risk associated with prolonged use of corticosteroids include cyclosporine, methotrexate, and azathioprine.
- **COVID-19:** The Infectious Diseases Society of America (IDSA) and the National Institutes of Health (NIH) have developed treatment guidelines for the management of COVID-19; both guidelines address the use of Olumiant.[3,4] Both the IDSA and NIH guidelines recommend Olumiant for hospitalized patients with COVID-19 for a duration of 14 days or until discharge from the hospital.
- **Rheumatoid Arthritis:** Guidelines from the American College of Rheumatology (2021) recommend addition of a biologic or a targeted synthetic disease-modifying antirheumatic drug (DMARD) for a patient taking the maximum tolerated dose of methotrexate who is not at target.[2]

Medical Necessity Criteria

Policy Statement
Prior Authorization is recommended for benefit coverage of Olumiant. All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days. Because of the specialized skills required for evaluation and diagnosis of patients treated with Olumiant as well as the monitoring required for adverse events and long-term efficacy, initial approval for certain indications requires Olumiant to be prescribed by or in consultation with a physician who specializes in the condition being treated.

NOTE: This product also requires the use of preferred products before approval of the requested product. Refer to the respective *Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans (PSM001) or Individual and Family Plans (PSM002)* for additional preferred product criteria requirements and exceptions.

Olumiant is considered medically necessary when ONE of the following is met (1, 2 or 3):

FDA-Approved Indications

1. **Alopecia Areata.** Approve for the duration noted if the patient meets one of the following (A or B):
   Note: Alopecia universalis and alopecia totalis are subtypes of alopecia areata.
   A) Initial Therapy. Approve for 6 months if the patient meets all of the following (i, ii, iii, iv, and v):
      i. Patient is ≥ 18 years of age; AND
      ii. Patient has a current episode of alopecia areata lasting for ≥ 6 months; AND
      iii. Patient has ≥ 50% scalp hair loss; AND

iv. Patient has tried at least one of the following for alopecia areata (a or b):
a) Conventional systemic therapy; OR
Note: Examples of conventional systemic therapies include corticosteroids, methotrexate, and cyclosporine. An exception to the requirement for a trial of one conventional systemic agent can be made if the patient has already tried Leqselvi (deuruxolitinib tablets) or Litfulo (ritlecitinib capsules).
b) High- or super-high potency topical corticosteroid; AND

v. The medication is prescribed by or in consultation with a dermatologist.

B) Patient is Currently Receiving Olumiant. Approve for 1 year if the patient meets all of the following (i, ii, iii, and iv):

i. Patient is ≥ 18 years of age; AND

ii. Patient has been established on the requested drug for at least 6 months; AND
Note: A patient who has received < 6 months of therapy or who is restarting therapy with the requested drug is reviewed under criterion A (Initial Therapy).

iii. Patient experienced a beneficial clinical response, defined as improvement from baseline (prior to initiating Olumiant) in extent and density of scalp hair loss; AND

iv. According to the prescriber, the patient continues to require systemic therapy for treatment of alopecia areata.
Note: International consensus states that systemic treatment is best discontinued once complete regrowth has been achieved and maintained for 6 months or when regrowth is sufficient to be managed topically.

2. COVID-19 (Coronavirus Disease 2019) – Hospitalized Patient. For a patient who is hospitalized, forward all requests to the Medical Director. For a non-hospitalized patient, do not approve (refer to Conditions Not Recommended for Approval – COVID-19 – Non-Hospitalized Patient). Olumiant is indicated for COVID-19 only in hospitalized adults requiring supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO).[1] For COVID-19, the dose is 4 mg once daily for 14 days or until hospital discharge, whichever comes first.
Note: This includes requests for cytokine release syndrome in a patient hospitalized with COVID-19.[3,4]

3. Rheumatoid Arthritis. Approve for the duration noted if the patient meets ONE of the following (A or B):

A) Initial Therapy. Approve for 6 months if the patient meets all of the following (i, ii, and iii):

i. Patient is ≥ 18 years of age; AND

ii. Patient meets ONE of the following (a or b):
a) Patient has had a 3-month trial of at least ONE tumor necrosis factor inhibitor; OR
b) Patient has tried at least one tumor necrosis factor inhibitor but was unable to tolerate a 3-month trial; AND
Note: Refer to Appendix for examples of tumor necrosis factor inhibitors used for rheumatoid arthritis. Conventional synthetic disease-modifying antirheumatic drugs (DMARDs) such as methotrexate, leflunomide, hydroxychloroquine, and sulfasalazine do not count.

iii. The medication is prescribed by or in consultation with a rheumatologist.

B) Patient is Currently Receiving Olumiant. Approve for 1 year if the patient meets BOTH of the following (i and ii):

i. Patient has been established on the requested drug for at least 6 months; AND
Note: A patient who has received < 6 months of therapy or who is restarting therapy with the requested drug is reviewed under criterion A (Initial Therapy).

ii. Patient meets ONE of the following (a or b):
a) Patient experienced a beneficial clinical response when assessed by at least one objective measure; OR

Note: Examples of standardized and validated objective measures of disease activity include Clinical Disease Activity Index (CDAI), Disease Activity Score (DAS) 28 using erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP), Patient Activity Scale (PAS)-II, Rapid Assessment of Patient Index Data 3 (RAPID-3), and/or Simplified Disease Activity Index (SDAI).

b) Patient experienced an improvement in at least one symptom, such as decreased joint pain, morning stiffness, or fatigue; improved function or activities of daily living; decreased soft tissue swelling in joints or tendon sheaths.

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Receipt of sample product does not satisfy any criteria requirements for coverage.

Conditions Not Covered

Any other use is considered experimental, investigational, or unproven, including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

1. **Concurrent Use with a Biologic or with a Targeted Synthetic Oral Small Molecule Drug.** This medication should not be administered in combination with another biologic or with a targeted synthetic oral small molecule drug used for an inflammatory condition (see Appendix for examples). Combination therapy is generally not recommended due to a potentially higher rate of adverse events and lack of controlled clinical data supporting additive efficacy.
   Note: This does NOT exclude the use of conventional synthetic DMARDs (e.g., methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine) in combination with this medication.

2. **Concurrent Use with a Biologic Immunomodulator.** Olumiant is not recommended in combination with biologic immunomodulators.[1]
   Note: Examples include Adbry (tralokinumab-ldrm subcutaneous injection), Cinqair (reslizumab intravenous), Dupixent (dupilumab subcutaneous injection), Fasenra (benralizumab subcutaneous injection), Nucala (mepolizumab subcutaneous injection), Tezspire (tezepelumab-ekko subcutaneous injection), and Xolair (omalizumab subcutaneous injection).

3. **Concurrent Use with Topical Janus Kinase Inhibitors (JAKis).** Olumiant should not be administered in combination with a topical JAKi [e.g. Opzelura (ruxolitinib) cream)] used for Atopic Dermatitis. Combination therapy is generally not recommended due to a potential for a higher rate of adverse effects and lack of evidence for additive efficacy.

4. **Concurrent use with Other Potent Immunosuppressants** (e.g., azathioprine, cyclosporine).[1] Co-administration with other potent immunosuppressive drugs has the risk of added immunosuppression and has not been evaluated in rheumatoid arthritis.
   Note: This does NOT exclude use of Olumiant with methotrexate; Olumiant has been evaluated with background methotrexate or in combinations with conventional synthetic DMARDs containing methotrexate.

5. **COVID-19 (Coronavirus Disease 2019) – Non-Hospitalized Patient.** Olumiant is only indicated in hospitalized adults with COVID requiring supplemental oxygen, non-

invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO).[1] For COVID-19, the dose is 4 mg once daily for 14 days or until hospital discharge, whichever comes first.

References

1. Olumiant® tablets [prescribing information]. Indianapolis, IN: Lilly; June 2022.
2. Fraenkel L, Bathon JM, England BR, et al. 2021 American College of Rheumatology guideline for the treatment of rheumatoid arthritis. *Arthritis Rheumatol*. 2021;73(7):1108-1123.
3. COVID-19 Treatment Guidelines Panel. Coronavirus disease 2019 (COVID-19) treatment guidelines. National Institutes of Health. Updated February 29, 2024. Available at: https://www.covid19treatmentguidelines.nih.gov/. Accessed on July 22, 2024.
4. Bhimraj A, Morgan RL, Shumaker AH, et al. Infectious Diseases Society of America Guidelines on the treatment and management of patients with COVID-19. Updated June 26, 2023. Available at: https://www.idsociety.org/COVID19guidelines. Accessed July 22, 2024.

APPENDIX

	Mechanism of Action	Examples of Indications*
Biologics		
Adalimumab SC Products (Humira®, biosimilars)	Inhibition of TNF	AS, CD, JIA, PsO, PsA, RA, UC
Cimzia® (certolizumab pegol SC injection)	Inhibition of TNF	AS, CD, nr-axSpA, PsO, PsA, RA
Etanercept SC Products (Enbrel®, biosimilars)	Inhibition of TNF	AS, JIA, PsO, PsA, RA
Infliximab IV Products (Remicade®, biosimilars)	Inhibition of TNF	AS, CD, PsO, PsA, RA, UC
Zymfentra® (infliximab-dyyb SC injection)	Inhibition of TNF	CD, UC
Simponi®, Simponi Aria® (golimumab SC injection, golimumab IV infusion)	Inhibition of TNF	SC formulation: AS, PsA, RA, UC
		IV formulation: AS, PJIA, PsA, RA
Tocilizumab Products (Actemra® IV, biosimilar; Actemra SC, biosimilar)	Inhibition of IL-6	SC formulation: PJIA, RA, SJIA
		IV formulation: PJIA, RA, SJIA
Kevzara® (sarilumab SC injection)	Inhibition of IL-6	RA
Orencia® (abatacept IV infusion, abatacept SC injection)	T-cell costimulation modulator	SC formulation: JIA, PSA, RA
		IV formulation: JIA, PsA, RA
Rituximab IV Products (Rituxan®, biosimilars)	CD20-directed cytolytic antibody	RA
Kineret® (anakinra SC injection)	Inhibition of IL-1	JIA^, RA
Omvoh® (mirikizumab IV infusion, SC injection)	Inhibition of IL-23	UC
Stelara® (ustekinumab SC injection, ustekinumab IV infusion)	Inhibition of IL-12/23	SC formulation: CD, PsO, PsA, UC
		IV formulation: CD, UC
Siliq® (brodalumab SC injection)	Inhibition of IL-17	PsO
Cosentyx® (secukinumab SC injection; secukinumab IV infusion)	Inhibition of IL-17A	SC formulation: AS, ERA, nr-axSpA, PsO, PsA
		IV formulation: AS, nr-axSpA, PsA
Taltz® (ixekizumab SC injection)	Inhibition of IL-17A	AS, nr-axSpA, PsO, PsA
Bimzelx® (bimekizumab-bkzx SC injection)	Inhibition of IL-17A/17F	PsO
Ilumya® (tildrakizumab-asmn SC injection)	Inhibition of IL-23	PsO

Skyrizi® (risankizumab-rzaa SC injection, risankizumab-rzaa IV infusion)	Inhibition of IL-23	SC formulation: CD, PSA, PsO, UC IV formulation: CD, UC
Tremfya® (guselkumab SC injection, guselkumab IV infusion)	Inhibition of IL-23	SC formulation: PsA, PsO, UC IV formulation: UC
Entyvio® (vedolizumab IV infusion, vedolizumab SC injection)	Integrin receptor antagonist	CD, UC
Oral Therapies/Targeted Synthetic Oral Small Molecule Drugs		
Otezla® (apremilast tablets)	Inhibition of PDE4	PsO, PsA
Cibinqo™ (abrocitinib tablets)	Inhibition of JAK pathways	AD
Olumiant® (baricitinib tablets)	Inhibition of JAK pathways	RA, AA
Litfulo® (ritlecitinib capsules)	Inhibition of JAK pathways	AA
Leqselvi® (deuruxolitinib tablets)	Inhibition of JAK pathways	AA
Rinvoq® (upadacitinib extended-release tablets)	Inhibition of JAK pathways	AD, AS, nr-axSpA, RA, PsA, UC
Rinvoq® LQ (upadacitinib oral solution)	Inhibition of JAK pathways	PsA, PJIA
Sotyktu® (deucravacitinib tablets)	Inhibition of TYK2	PsO
Xeljanz® (tofacitinib tablets/oral solution)	Inhibition of JAK pathways	RA, PJIA, PsA, UC
Xeljanz® XR (tofacitinib extended-release tablets)	Inhibition of JAK pathways	RA, PsA, UC
Zeposia® (ozanimod tablets)	Sphingosine 1 phosphate receptor modulator	UC
Velsipity® (etrasimod tablets)	Sphingosine 1 phosphate receptor modulator	UC

* Not an all-inclusive list of indications. Refer to the prescribing information for the respective agent for FDA-approved indications; SC – Subcutaneous; TNF – Tumor necrosis factor; AS – Ankylosing spondylitis; CD – Crohn's disease; JIA – Juvenile idiopathic arthritis; PsO – Plaque psoriasis; PsA – Psoriatic arthritis; RA – Rheumatoid arthritis; UC – Ulcerative colitis; nr-axSpA – Non-radiographic axial spondyloarthritis; IV – Intravenous, PJIA – Polyarticular juvenile idiopathic arthritis; IL – Interleukin; SJIA – Systemic juvenile idiopathic arthritis; ^ Off-label use of Kineret in JIA supported in guidelines; ERA – Enthesitis-related arthritis; DMARD – Disease-modifying antirheumatic drug; PDE4 – Phosphodiesterase 4; JAK – Janus kinase; AD – Atopic dermatitis; AA – Alopecia areata; TYK2 – Tyrosine kinase 2.

Revision Details

Type of Revision	Summary of Changes	Date
New	New policy	11/01/2024

The policy effective date is in force until updated or retired.