AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Olumiant	Page:	1 of 4
Effective Date:	2/25/2026	Last Review Date:	2/2026
Applies to:	☐Illinois ☒New Jersey ☐Pennsylvania Kids	☐Florida ☐Maryland ☐Virginia	☐Florida Kids ☐Michigan ☐Kentucky PRMD

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Olumiant under the patient's prescription drug benefit.

Description:

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met, and the member has no exclusions to the prescribed therapy.

FDA-approved Indications[1]

- Treatment of adult patients with moderately to severely active rheumatoid arthritis who have had an inadequate response to one or more tumor necrosis factor (TNF) blockers.
- Treatment of coronavirus disease 2019 (COVID-19) in hospitalized adults requiring supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO).
- Treatment of adult patients with severe alopecia areata. – *Reference Alopecia Areata Products C29268-A Aetna NJ Medicaid for this indication.*

Note: The criteria outlined in this policy is only applicable to coverage in the outpatient setting. Hospitalized members receiving Olumiant for the treatment of COVID-19 will be managed according to the member's inpatient benefit.

All other indications are considered experimental/investigational and not medically necessary.

Applicable Drug List:

Non-preferred: Olumiant

Policy/Guideline:

Documentation for all indications:
The patient is unable to take Rinvoq and ONE additional preferred product (a preferred adalimumab product, tocilizumab product, Enbrel or Kevzara), where indicated, for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication. Documentation is required for approval.

Documentation

Submission of the following information is necessary to initiate the prior authorization review:

Rheumatoid arthritis (RA)

Initial requests

Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.

Continuation requests

Chart notes or medical record documentation supporting positive clinical response.

Prescriber Specialties

This medication must be prescribed by or in consultation with one of the following:

- Rheumatoid arthritis: rheumatologist

Coverage Criteria

Rheumatoid arthritis (RA)[1,3,4]

Authorization of 12 months may be granted for adult members for treatment of moderately to severely active rheumatoid arthritis (RA) when the member has experienced an inadequate response, intolerance, or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor.

Continuation of Therapy

Rheumatoid arthritis (RA)[1,3,4]

Authorization of 12 months may be granted for all adult members (including new members) who are using the requested medication for moderately to severely active RA and who achieve or maintain a positive clinical response as evidenced by disease activity improvement of at least 20% from baseline in tender joint count, swollen joint count, pain, or disability.

Other[1,2]

For all indications: Member has had a documented negative tuberculosis (TB) test (which can include a tuberculosis skin test [TST] or an interferon-release assay [IGRA]) within 12 months of initiating therapy for persons who are naïve to biologic drugs or targeted synthetic drugs associated with an increased risk of TB.

If the screening testing for TB is positive, there must be further testing to confirm there is no active disease (e.g., chest x-ray). Do not administer the requested medication to members with active TB infection. If there is latent disease, TB treatment must be started before initiation of the requested medication.

For all indications: Member cannot use the requested medication concomitantly with any other biologic drug, targeted synthetic drug, or potent immunosuppressant such as azathioprine or cyclosporine.

Dosage and Administration

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Approval Duration and Quantity Restrictions:

Approval:
Initial Approval: 12 months
Renewal Approval: 12 months

Quantity Level Limit:
- Olumiant (baricitinib) 1 mg tablet: 30 per 30 days
- Olumiant (baricitinib) 2 mg tablet: 30 per 30 days
- Olumiant (baricitinib) 4 mg tablet: 30 per 30 days

References:

1. Olumiant [package insert]. Indianapolis, IN: Lilly USA, LLC; June 2022.
2. Testing for TB Infection. Centers for Disease Control and Prevention. Retrieved on November 11, 2025 from: https://www.cdc.gov/tb/testing/index.html.
3. Smolen JS, Landewé RBM, Bergstra SA, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2022 update. Ann Rheum Dis. 2023;82:3-18.
4. Fraenkel L, Bathon JM, England BR, et al. 2021 American College of Rheumatology guideline for the treatment of rheumatoid arthritis. Arthrit Care Res. 2021;0:1-16.

5. King B, Ohyama M, Kwon O, et al. Two phase 3 trials of baricitinib for alopecia areata. NEJM. 2022;386(18):1687-1699.
6. King B, Ohyama M, Kwon O, et al. Two phase 3 trials of baricitinib for alopecia areata. NEJM. 2022;386(18)(suppl):1-77.