Drug Coverage Policy

Effective Date……02/15/2026
Coverage Policy Number…… DQM019
Policy Title…..Inflammatory Conditions – Olumiant Drug Quantity Management Policy – Per Days

Inflammatory Conditions – Olumiant Drug Quantity Management Policy – Per Days

- 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 where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. 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.

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).
- **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.

Dosing

Dosage recommendations for Olumiant are:[1]

- **Rheumatoid arthritis**: 2 mg once daily (QD).
- **COVID-19**: 4 mg QD for 14 days or until hospital discharge, whichever comes first. Of note, this policy does not target this indication.
- **Alopecia areata**: 2 mg QD. Increase to 4 mg QD if the response to treatment is not adequate. For patients with complete or nearly complete scalp hair loss, with or without substantial eyelash or eyebrow hair loss, consider 4 mg QD. Once patients achieve an adequate response to treatment with 4 mg, decrease the dose to 2 mg QD.

Availability

Olumiant is available as 1 mg, 2 mg, and 4 mg tablets supplied in bottles of 30 tablets each.[1]

Off-Label Use

Type 1 Interferonopathy

The European Alliance of Associations for Rheumatology (EULAR) and the ACR (2022) provide recommendations for the management of Type I interferonopathies, including chronic atypical neutrophilic dermatosis with lipodystrophy and elevated temperature/proteasome-associated autoinflammatory syndrome (CANDLE/PRAAS), stimulator of interferon genes associated vasculopathy with onset in infancy (SAVI), and Aicardi-Goutières syndrome (AGS).[4] Olumiant is generally considered a therapeutic option for symptom improvement in these conditions, with dosing strategies informed by small studies. Dosing is weight based and varies by condition.

Coverage Policy

POLICY STATEMENT

This Drug Quantity Management program has been developed to promote the safe, effective, and economic use of Olumiant. If the Drug Quantity Management rule is not met at the point of service, coverage will be determined by the Criteria below. All approvals are provided for 1 year in duration. Meeting Drug Quantity Management Program Criteria does not satisfy any other prior authorization or medical necessity criteria requirements.

Drug Quantity Limits

Product	Strength and Form	Retail Maximum Quantity Per 30 Days	Home Delivery Maximum Quantity Per 90 Days
Olumiant®	1 mg tablets	30 tablets	90 tablets
	2 mg tablets	30 tablets	90 tablets
(baricitinib tablets)	4 mg tablets	30 tablets	90 tablets

Exceptions to the quantity limits listed above are covered as medically necessary when the following criteria is met. Any other exception is considered not medically necessary.

CRITERIA

Olumiant 1 mg, 2 mg, and 4 mg tablets

1. If the patient has Aicardi-Goutières syndrome (AGS), chronic atypical neutrophilic dermatosis with lipodystrophy and elevated temperature/proteasome-associated autoinflammatory syndrome (CANDLE/PRAAS), or stimulator of interferon genes associated vasculopathy with onset in infancy (SAVI) approve the requested quantity for a 30-day supply at retail and a 90-day supply at home delivery.

References

1. Olumiant® tablets [prescribing information]. Indianapolis, IN: Lilly; June 2022.
2. Cetin Gedik K, Lamot L, Romano M, et al. The 2021 European Alliance of Associations for Rheumatology/American College of Rheumatology points to consider for diagnosis and management of autoinflammatory type I interferonopathies: CANDLE/PRAAS, SAVI and AGS. *Ann Rheum Dis*. 2022 May;81(5):601-613.

Revision Details

Type of Revision	Summary of Changes	Date
New	New Policy created to provide overrides to existing quantity limits.	02/15/2026

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