

## Sample Coverage Authorization Request Letter

Re:

To whom it may concern:

This letter serves as a coverage authorization request for Olumiant® (baricitinib) tablets for  
for the treatment of .

**Patient's diagnosis\*:**

Patient has been diagnosed with:

Please provide the following:

Primary ICD-10 diagnosis code \_\_\_\_\_ Other ICD-10 diagnosis code (if applicable) \_\_\_\_\_  
A \_\_\_\_\_ has either been consulted or is the prescribing physician for Olumiant

**Patient treatment history and comorbidities:**

Treatment	Dose	Start/stop dates	Reason(s) for discontinuation
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**Additional patient comorbidities or considerations:**

**Supporting references for the recommendation:**

**Physician contact information:**

The ordering physician is, . The coverage authorization decision may be  
faxed to \_\_\_\_\_ or mailed to \_\_\_\_\_ . Please send a  
copy of the coverage determination decision to \_\_\_\_\_

Sincerely,

\_\_\_\_\_  
**Patient's name and signature if required by payer**

Encl: Medical records, supporting documentation,  
photo(s), clinical trial information

Please click to access full [Prescribing Information](#), including [Boxed Warning](#), and [Medication Guide](#).

ICD, International Classification of Diseases; NPI, national provider identifier



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