

# SENTARA COMMUNITY PLAN (MEDICAID)

## PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST\*

**Directions:** The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. If the information provided is not complete, correct, or legible, the authorization process can be delayed.

**Drug Requested:** Omvoh™ SQ & IV (mirikizumab-mrkz)

**MEMBER & PRESCRIBER INFORMATION:** Authorization may be delayed if incomplete.

Member Name: \_\_\_\_\_

Member Sentara #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

NPI #: \_\_\_\_\_

**DRUG INFORMATION:** Authorization may be delayed if incomplete.

Drug Name/Form/Strength: \_\_\_\_\_

Dosing Schedule: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code, if applicable: \_\_\_\_\_

Weight (if applicable): \_\_\_\_\_ Date weight obtained: \_\_\_\_\_

**ATTENTION:** Omvoh IV induction (loading dose) for treatment of Crohn's disease and ulcerative colitis can only be billed under the **MEDICAL BENEFIT.** NDC: 00002-7575-01; **J2267**

### **Adult Dosing:**

**Induction IV:** NDC: 00002-7575-01 – Omvoh IV 300 mg/15 mL vial – J2267

- UC: 300 mg administered by intravenous infusion over at least 30 minutes at Week 0, Week 4, and Week 8
- CD: 900 mg administered by intravenous infusion over at least 30 minutes at Week 0, Week 4, and Week 8

**Maintenance SubQ:**

- UC: 200 mg administered by subcutaneous injection at Week 12, and every 4 weeks thereafter
- CD: 300 mg administered by subcutaneous injection at Week 12, and every 4 weeks thereafter

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**CLINICAL CRITERIA:** Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

**Ulcerative Colitis**

**Maintenance Dose – 200 mg administered by subcutaneous injection (given as two consecutive injections of 100 mg each) at Week 12, and every 4 weeks thereafter**

**Authorization Criteria: To be reviewed for approval under the pharmacy benefit**

**Length of Approval: One-year**

- Member is 18 years or older
- Member has a diagnosis of **ulcerative colitis**
- Member tried and failed, has a contraindication, or intolerance to **BOTH** of the following **PREFERRED** biologics:
  - Humira®
  - infliximab (generic Remicade®)

**Crohn's Disease**

**Maintenance Dose – 300 mg administered by subcutaneous injection (given as two consecutive injections of 100 mg each and 200mg in any order) at Week 12, and every 4 weeks thereafter**

**Authorization Criteria: To be reviewed for approval under the pharmacy benefit**

**Length of Approval: One-year**

- Member is 18 years or older
- Member has a diagnosis of **Crohn's disease**
- Member tried and failed, has a contraindication, or intolerance to **BOTH** of the following **PREFERRED** biologics:
  - Humira®
  - infliximab (generic Remicade®)

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**Induction Dose (If required) – One time approval for duration of 2 months, member to receive up to three (3) IV infusion doses**

**Authorization Criteria: To be reviewed for one-time approval under the medical benefit**

- Member has **ONE** of the following diagnoses:
  - Crohn's disease
  - Ulcerative colitis
- Medication will be used as induction therapy
- Medication being provided by:
  - Location/site of drug administration:** \_\_\_\_\_
  - NPI or DEA # of administering location:** \_\_\_\_\_
- Member to receive FDA approved loading dose of 300 mg administered by intravenous infusion over at least 30 minutes at Week 0, Week 4, and Week 8 for ulcerative colitis diagnosis or 900 mg administered by intravenous infusion over at least 30 minutes at Week 0, Week 4, and Week 8 for Crohn's disease diagnosis

**Medication being provided by Specialty Pharmacy - PropriumRx**

***\*\*Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.\*\****

***\*Previous therapies will be verified through pharmacy paid claims or submitted chart notes.\****