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 moderate to severe **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 moderate to severe **Crohn's disease**
- ❑ Member tried and failed, has a contraindication, or intolerance to **BOTH** of the following **PREFERRED** biologics:
  - ❑ Humira®
  - ❑ infliximab (generic Remicade®)

❑ **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

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- ❑ 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.