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 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**
  - 300 mg administered by intravenous infusion over at least 30 minutes at Week 0, Week 4, and Week 8
- ❑ **Maintenance SubQ:**
  - 200 mg administered by subcutaneous injection (given as two consecutive injections of 100 mg each) at Week 12, and every 4 weeks thereafter
    - **NDC: 00002-8011-01/27 – Omvoh 100 mg/mL prefilled pen**
    - **NDC: 00002-8870-01/27 – Omvoh 100 mg/mL prefilled syringe**

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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.

❑ **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 has a diagnosis of **ulcerative colitis**
- ❑ Medication has been prescribed by a **Gastroenterologist**
- ❑ Member meets **ONE** of the following:
  - ❑ Member tried and failed, has a contraindication, or intolerance to **BOTH** of the following **PREFERRED** biologics:
    - ❑ Humira®
    - ❑ infliximab (generic Remicade®)
  - ❑ Member has been established on Omvoh™ prefilled pen for at least 90 days **AND** prescription claims history indicates **at least a 90-day supply of Omvoh was dispensed within the past 130 days (verified by chart notes or pharmacy paid claims)**

❑ **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

- ❑ 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

Medication being provided by a Specialty Pharmacy – Proprium Rx

*****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.****

***Approved by Pharmacy and Therapeutics Committee:** ~~1/18/2024~~; **7/26/2024**
REVISED/UPDATED/REFORMATTED: ~~6/10/2024;~~ **8/12/2024**