Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Omvoh vial
(mirikizumab-mrkz intravenous)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:

☐ Omvoh 300mg/15ml vial
☐ other (please specify):

Dose Quantity: Duration of therapy:

Frequency of Administration: J-Code: ICD10:

Is this a new start or continuation of therapy with the requested medication? If patient has been taking samples, please pick "new start."
☐ New start of therapy
☐ Continuation of therapy

Besides the medication being requested, other biologics and tsDMARDs (targeted synthetic disease-modifying antirheumatic drugs) include Actemra, adalimumab (Humira and all biosimilars), Adbry, Bimzelx, Cibinqo, Cimzia, Cosentyx, Enbrel, Entyvio, Ilumya, infliximab (Remicade and all biosimilars), Kevzara, Kineret, Litfulo, Olumiant, Orencia, Otezla, Rinvoq, rituximab (Rituxan and all biosimilars), Siliq, Simponi Aria, Simponi, Skyrizi, Sotyktu, Stelara, Taltz, Tremfya, Tysabri, Velsipity, Xeljanz, Zeposia. Which of the following best describes your patient's situation?

☐ The patient is NOT taking any other biologic or tsDMARD at this time, nor will they in the future. The requested drug is the only biologic or tsDMARD the patient is/will be using.
☐ The patient is currently on another biologic or tsDMARD, but this drug will be stopped and the requested drug will be started.
☐ The patient is currently on another biologic or tsDMARD, and the requested drug will be added. The patient may continue to take both drugs together.
☐ The patient is currently on BOTH the requested drug AND another biologic or tsDMARD.
☐ other/unknown

Please provide the rationale for concurrent use.

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

*****Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

NOTE: *Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:

☐ Ulcerative colitis (UC)
☐ Other (please specify):

Clinical Information:

Is this medication to be used as induction therapy? ☐ Yes ☐ No

Has the patient had a trial of one OTHER biologic for ulcerative colitis (not including the requested one OR a biosimilar of the requested one) such as adalimumab SC products (Humira and biosimilars), infliximab IV products (Remicade, biosimilars), Zymfentra, Simponi, Stelara IV, Entyvio? ☐ Yes ☐ No

(if yes) Please provide the name/names of the biologic(s) used.

(if no) The covered alternatives are systemic therapy for ulcerative colitis (examples include 6-mercaptopurine, azathioprine, cyclosporine, tacrolimus, or a corticosteroid such as prednisone or methylprednisolone). Note that a trial of a mesalamine product does not count as a systemic therapy for ulcerative colitis. If your patient has tried this drug, please provide drug name/strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried these drugs, please provide details why your patient can't try this alternative.

(if no trial of other biologic for UC) Per the information provided above, which of the following is true for your patient in regard to the covered alternative?
☐ The patient tried the alternative, but it didn't work.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

(if other) Does the patient have pouchitis? ☐ Yes ☐ No

(if pouchitis) Has the patient tried any of the following: an antibiotic (examples include metronidazole and ciprofloxacin), a probiotic, corticosteroid enema (an example is hydrocortisone enema), or mesalamine enema? ☐ Yes ☐ No

Is the requested medication prescribed by (or in consultation with) a gastroenterologist? ☐ Yes ☐ No

Has the patient already been started on therapy with the requested medication and requires 1 or 2 more doses to complete induction? ☐ Yes ☐ No

The covered alternatives are: 1) An adalimumab product (adalimumab-adaz/Hyrimoz [by Sandoz/Novartis], adalimumab-adbm/Cyltezo, Adalimumab-ryvk/Simlandi, or Humira [by AbbVie]); 2) Entyvio; 3) Stelara (all of which may require prior authorization). For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try that drug.

Per the information given above, is there documentation that your patient has had contraindication to any of the following? (check all that apply)
☐ Adalimumab-adaz/Hyrimoz [by Sandoz/Novartis]
☐ Adalimumab–adbm/Cyltezo
☐ Adalimumab-ryvk/Simlandi
☐ Entyvio
☐ Humira [by AbbVie]
☐ Stelara
☐ Other:

Per the information given above, is there documentation that your patient has had failure or intolerance to any of the following? (check all that apply)
☐ Adalimumab-adaz/Hyrimoz [by Sandoz/Novartis]
☐ Adalimumab–adbm/Cyltezo
☐ Adalimumab-ryvk/Simlandi
☐ Entyvio
☐ Humira [by AbbVie]
☐ Stelara
☐ Other:

Additional Pertinent Information: (*Please provide clinical rationale for the use of this drug for your patient (pertinent patient history, alternatives tried, any inability to use alternatives above or standard therapy, etc.). Please include drug name(s), date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced.)*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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