Cigna®

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

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

What is the indication or diagnosis?

☐ Crohn's disease
☐ Ulcerative colitis (UC)
☐ Other (please specify):

Clinical Information:

Will the requested medication be used in combination with a BIOLOGIC or with a targeted synthetic oral small molecule drug?
☐ Biologic (an adalimumab product [Humira, biosimilar], Bimzelx, Cimzia, Cosentyx (IV or SC), etanercept SC product [Enbrel, biosimilar], Entyvio (IV or SC), Ilumya, infliximab IV products [Remicade, biosimilar], Kevzara, Kineret, Omvoh (SC), Orencia [IV or SC], a rituximab IV product [Rituxan, biosimilar], Skyrizi (IV or SC), Siliq, Simponi [Aria or SC]), an ustekinumab product (Stelara [SC or IV], biosimilar), Taltz, a tocilizumab product (Actemra [IV or SC], biosimilar), Tremfya (IV or SC), or Zymfentra.
☐ Targeted synthetic oral small molecule drug (such as Cibinqo, Leqselvi, Litfulo, Sotyktu, Olumiant, Otezla, Rinvoq, Rinvoq LQ, Xeljanz, Xeljanz XR, Velsipity, or Zeposia.)
☐ Conventional synthetic DMARD (such as methotrexate, leflunomide, sulfasalazine, hydroxychloroquine)
☐ No, the requested medication will NOT be used in combination with another BIOLOGIC or Targeted Synthetic oral small molecule drug

(if UC) Will the medication be used as induction therapy? ☐ Yes ☐ No

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

(if UC) Has the patient had a trial of one systemic agent for ulcerative colitis other than the requested drug? Please Note: A biosimilar of the requested biologic does not count. A trial of a mesalamine product does not count as a systemic therapy for ulcerative colitis. Examples include 6-mercaptopurine, azathioprine, cyclosporine, tacrolimus; or a corticosteroid such as prednisone, methylprednisolone; or a biologic such as an adalimumab product (Humira, biosimilars), Entyvio (vedolizumab injection), an infliximab product (Remicade, biosimilars), Simponi (golimumab for SC injection), Skyrizi IV/SC, Tremfya IV/SC, an ustekinumab product (Stelara, biosimilars [IV/SC]), or Zymfentra. ☐ Yes ☐ No

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

(if yes) Has the patient tried an antibiotic, probiotic, corticosteroid enema, or mesalamine enema? Please Note: Examples of antibiotics include metronidazole and ciprofloxacin. Examples of corticosteroid enemas include hydrocortisone enema. ☐ Yes ☐ No

(if Crohn's) Will the medication be used as induction therapy? ☐ Yes ☐ No

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

(if Crohn's) Has the patient tried or is currently taking a systemic corticosteroid, or are systemic corticosteroids contraindicated in this patient? Please Note: Examples of corticosteroids are prednisone or methylprednisolone. ☐ Yes ☐ No

(if no) Has the patient tried one other conventional systemic therapy for Crohn's disease? Please Note: Examples of conventional systemic therapy for Crohn's disease include azathioprine, 6-mercaptopurine, or methotrexate. A trial of a mesalamine product does not count as a systemic therapy for Crohn's disease. ☐ Yes ☐ No

(if no) Has the patient already tried at least one biologic other than the requested drug? Please Note: A biosimilar of the requested biologic does not count. Examples of biologics used for Crohn's disease are an adalimumab product (Humira, biosimilars), Cimzia, an infliximab IV product (Remicade, biosimilars), Zymfentra, a ustekinumab product (Stelara [SC or IV], biosimilar), Skyrizi (SC or IV), or Entyvio (SC or IV). ☐ Yes ☐ No

(if no) Does the patient have enterocutaneous (perianal or abdominal) or rectovaginal fistulas? ☐ Yes ☐ No

(if no) Has the patient had an ileocolonic resection (to reduce the chance of Crohn's disease recurrence)? ☐ Yes ☐ No

(if UC) Is the dose prescribed 300 mg as an intravenous infusion administered at Weeks 0, 4, and 8? ☐ Yes ☐ No

(if Crohn's) Is the dose prescribed 900 mg as an intravenous infusion administered at Weeks 0, 4, and 8? ☐ Yes ☐ No

(if UC) Has the patient tried one the following: an adalimumab product, Skyrizi intravenous, a ustekinumab intravenous product, Tremfya intravenous, Entyvio intravenous, an infliximab IV product, Simponi subcutaneous, Entyvio subcutaneous, Skyrizi subcutaneous, ustekinumab subcutaneous, Tremfya subcutaneous, or Zymfentra? Please Note: Examples of adalimumab products include Humira, Abrilada, adalimumab-aacf, adalimumab-adaz, adalimumab-adbm, adalimumab-fkjp, adalimumab-aaty, adalimumab-ryvk, Simlandi, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Yuflyma, and Yusimry. Examples of ustekinumab products include Stelara, Wezlana, Otufli, Pyzchiva, ustekinumab-ttwe, Selarsdi, Steqeyma, and Yesintek. Examples of infliximab intravenous products include Avsola, Inflectra, infliximab intravenous infusion, Remicade, and Renflexis. A trial of multiple adalimumab products counts as ONE product. A trial of multiple ustekinumab products counts as ONE product. A trial of multiple infliximab products counts as ONE product. ☐ Yes ☐ No

(if no) According to the prescriber, has the patient started on or is currently undergoing induction therapy with Omvoh intravenous?
☐ Yes
☐ No - The preferred products are adalimumab products (Cyltezo/adalimumab-adbm, adalimumab-adaz, Simlandi/adalimumab-ryvk), Skyrizi IV, ustekinumab products (Stelara IV, Selarsdi IV, ustekinumab-ttwe IV, Yesintek IV), Tremfya IV, infliximab IV Products (Avsola, Inflectra), Entyvio IV. A request for one of these products may be reviewed.

(if Crohn's) Has the patient tried one the following: an adalimumab product, Skyrizi intravenous, Tremfya intravenous, a ustekinumab intravenous product, Entyvio intravenous, an infliximab IV product, Simponi subcutaneous, Entyvio subcutaneous, Skyrizi subcutaneous, Tremfya subcutaneous, ustekinumab subcutaneous, or Zymfentra? Please Note: Examples of adalimumab products include Humira, Abrilada, adalimumab-aacf, adalimumab-adaz, adalimumab-adbm, adalimumab-fkjp, adalimumab-aaty, adalimumab-ryvk, Simlandi, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Yuflyma, and Yusimry. Examples of ustekinumab products include Stelara, Wezlana, Otufli, Pyzchiva, ustekinumab-ttwe, Selarsdi, Steqeyma, and Yesintek. Examples of infliximab intravenous products include Avsola, Inflectra, infliximab intravenous infusion, Remicade, and Renflexis. A trial of multiple adalimumab products counts as ONE product. A trial of multiple ustekinumab products counts as ONE product. A trial of multiple infliximab products counts as ONE product. ☐ Yes ☐ No

(if no) According to the prescriber, has the patient started on or is currently undergoing induction therapy with Omvoh intravenous?
☐ Yes
☐ No - The preferred products are adalimumab products (Cyltezo/adalimumab-adbm, adalimumab-adaz, Simlandi/adalimumab-ryvk), Skyrizi IV, ustekinumab IV products (Stelara IV, Selarsdi IV, ustekinumab-ttwe IV, Yesintek IV), Tremfya IV, infliximab IV products (Avsola, Inflectra), Entyvio IV. A request for one of these products may be reviewed.

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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