



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: <input type="checkbox"/> Standard <input type="checkbox"/> 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: <input type="checkbox"/> Omvoh 300mg/15ml vial <input type="checkbox"/> 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." <input type="checkbox"/> New start of therapy <input type="checkbox"/> Continuation of therapy					
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Other (please specify): <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Home Health / Home Infusion vendor <i>**Cigna's nationally preferred specialty pharmacy</i> 					
<i>**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</i>					
Facility and/or doctor dispensing and administering medication: Facility Name: _____ State: _____ Tax ID#: _____ Address (City, State, Zip Code): _____					
Where will this drug be administered? <input type="checkbox"/> Patient's Home <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Physician's Office <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No 					

What is the indication or diagnosis?

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

Clinical Information:

Will the requested medication be used in combination with a BIOLOGIC drug? Examples of biologic drugs include: 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. Yes No

(if no) Will the requested medication be used in combination with a targeted synthetic oral small molecule drug? Examples of targeted synthetic oral small molecule drugs include: Cibinqo, Leqselvi, Litfulo, Sotyktu, Olumiant, Otezla, Otezla XR, Rinvoq, Rinvoq LQ, Xeljanz, Xeljanz XR, Velsipity, or Zeposia. Yes No

(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 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 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/ustekinumab, Imuldosa, Otulfi, Pyzchiva, ustekinumab-ttwe, Selarsdi, ustekinumab-aekn, Starjemza, Steqeyma, Wezlana, 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-adbm, Cyltezo, adalimumab-ryvk [NDCs starting with 82009], Simlandi, Skyrizi IV, Imuldosa IV [NDCs starting with 69448], Selsardi IV, ustekinumab-ttwe IV, Yesintek IV, Tremfya IV, Avsola, Inflectra, and 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 intravenous 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/ustekinumab, Imuldosa, Otulfi, Pyzchiva, ustekinumab-ttwe, Selarsdi, ustekinumab-aekn, Starjemza, Steqeyma, Wezlana, 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

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Additional Pertinent Information:

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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