PRIOR AUTHORIZATION REQUEST

OMVOH

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is this request initial therapy or for a continuation of therapy? [] Initial (If checked, go to 8) [] Continuation (If checked, go to 2)		
2	Will the requested medication be used in combination with a biologic disease-modifying antirheumatic drug (DMARD) or targeted synthetic DMARD? [Note: Examples of biologics include but not limited to adalimumab SC products	Yes	No

If you have any questions, call: 1-888-258-8250

Version 11.2026

PRIOR AUTHORIZATION REQUEST

	(for example, Humira, biosimilars), Actemra (IV or SC), Cimzia, Cosentyx, an etanercept SC product (for example, Enbrel, biosimilars), Ilumya, Skyrizi, Kevzara, Kineret, Orencia (IV or SC), an infliximab IV product (for example, Remicade, biosimilars), a rituximab IV product (for example, Rituxan, biosimilars), Siliq, Stelara (IV or SC), Taltz, Tremfya, Entyvio, or Simponi (Aria or SC). Examples of targeted synthetic DMARD include, but are not limited to, Cibinqo, Olumiant, Rinvoq, Otezla, Xeljanz, Xeljanz XR.] [If yes, no further questions.]		
3	Is the patient currently receiving the requested medication? [If no, skip to question 8.]	Yes	No
4	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 8.]	Yes	No
5	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 8.]	Yes	No
6	Has the patient been established on therapy for at least 3 months? [If no, skip to question 8.]	Yes	No
7	Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
8	Will the requested medication be used in combination with a biologic disease-modifying antirheumatic drug (DMARD) or targeted synthetic DMARD? [Note: Examples of biologics include but not limited to adalimumab SC products (for example, Humira, biosimilars), Actemra (IV or SC), Cimzia, Cosentyx, an etanercept SC product (for example, Enbrel, biosimilars), Ilumya, Skyrizi, Kevzara, Kineret, Orencia (IV or SC), an infliximab IV product (for example, Remicade, biosimilars), a rituximab IV product (for example, Rituxan, biosimilars), Siliq, Stelara (IV or SC), Taltz, Tremfya, Entyvio, or Simponi (Aria or SC). Examples of targeted synthetic DMARD include, but are not limited to, Cibinqo, Olumiant, Rinvoq, Otezla, Xeljanz, Xeljanz XR.] [If yes, no further questions.]	Yes	No
9	What is the requested medication? [] Omvoh INTRAVENOUS (If checked, go to 10) [] Omvoh SUBCUTANEOUS (If checked, no further questions)		

PRIOR AUTHORIZATION REQUEST

10	What is the indication or diagnosis? [] Crohn's Disease (If checked, go to 11) [] Ulcerative Colitis (If checked, go to 21) [] Other (If checked, no further questions)		
11	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
12	Does the provider attest that the loading dose phase will be limited to 3 intravenous (IV) infusions (900 mg each) and 1 subcutaneous (SC) injection? [If no, no further questions.]	Yes	No
13	Has the patient tried or is the patient currently taking corticosteroids? [Note: Examples of corticosteroids are prednisone or methylprednisolone.] [If yes, skip to question 17.]	Yes	No
14	Does the patient have a contraindication to corticosteroids? [Note: Examples of corticosteroids are prednisone or methylprednisolone.] [If yes, skip to question 17.]	Yes	No
15	Has the patient tried TWO other conventional systemic therapies for Crohn's disease for at least 3 months? [Note: Examples of conventional systemic therapy for Crohn's disease include azathioprine, 6-mercaptopurine, or methotrexate.] [If yes, skip to question 17.]	Yes	No
16	Has the patient had an ileocolonic resection (to reduce the chance of Crohn's disease recurrence)? [If no, no further questions.]	Yes	No
17	Has documentation been submitted to confirm that the patient has had an intolerance, contraindication to, or failed treatment for at least 3 months with preferred tumor necrosis factor (TNF) inhibitor or an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
18	Has documentation been submitted to confirm that the patient has had a treatment failure with a preferred ustekinumab product (Yesintek, Pyzchiva, Steqeyma), for at least 3 months or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
19	Is the requested medication being prescribed by or in consultation with a gastroenterologist?	Yes	No

PRIOR AUTHORIZATION REQUEST

	[If no, no further questions.]		
20	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Induction dosing: 900 mg IV at weeks 0, 4, and 8. Maintenance dosing: 300 mg SC at week 12 and every 4 weeks thereafter.] [No further questions.]	Yes	No
21	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
22	Does the provider attest that the loading dose phase will be limited to 3 intravenous (IV) infusions (300 mg each) and 1 subcutaneous (SC) injection? [If no, no further questions.]	Yes	No
23	Has the patient tried or is the patient currently taking corticosteroids? [Note: Examples of corticosteroids are prednisone or methylprednisolone.] [If yes, skip to question 25.]	Yes	No
24	Does the patient have a contraindication to corticosteroids? [Note: Examples of corticosteroids are prednisone or methylprednisolone.] [If no, no further questions.]	Yes	No
25	Has the patient tried TWO other conventional systemic therapies for ulcerative colitis for at least 3 months? [Note: Examples of conventional systemic therapy for ulcerative colitis include azathioprine, 6-mercaptopurine, or methotrexate.] [If no, no further questions.]	Yes	No
26	Has the patient been diagnosed with moderate to severe ulcerative colitis? [If no, skip to question 29.]	Yes	No
27	Has documentation been submitted to confirm that the patient has moderate to severe symptoms? ACTION REQUIRED: Submit supporting documentation. [Note: Examples include Mayo endoscopy sub-score greater than or equal to 2, greater than 6 bowel movements per day, greater than or equal to 4 bloody stools per day, hemoglobin less than 75% normal (males less than 10 g/dL, females less than 9 g/dL).] [If yes, skip to question 32.]	Yes	No
28	Has documentation been submitted to confirm that the patient has mildly active symptoms with poor prognosis factors for disease severity? ACTION REQUIRED: Submit supporting documentation. [Note: Examples include Mayo endoscopy sub-score equal to 3, extensive colitis, corticosteroid dependence (unable to taper after 3 months of continuous therapy), elevated CRP greater than or equal to 10 mg/dL, low serum album less than 3.4 mg/dL.] [If yes, skip to question 32.]	Yes	No

PRIOR AUTHORIZATION REQUEST

29	Has documentation been submitted to confirm that the patient has had an intolerance, contraindication to, or failed treatment for at least 3 months with a preferred adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
30	Has documentation been submitted to confirm that the patient has had a treatment failure with a preferred ustekinumab product (Yesintek, Pyzchiva, Steqeyma) for at least 3 months or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
31	Has documentation been submitted to confirm that the patient has had a treatment failure with Xeljanz (tofacitinib) for at least 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 33.] [If no, no further questions.]	Yes	No
32	Has documentation been submitted to confirm that the patient has had an intolerance, contraindication to, or failed treatment for at least 3 months with a preferred infliximab product? ACTION REQUIRED: Submit supporting documentation. [Note: infusion dates and dosages required.] [If no, no further questions.]	Yes	No
33	Is the requested medication being prescribed by or in consultation with a gastroenterologist? [If no, no further questions.]	Yes	No
34	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Induction dosing: 300 mg IV at weeks 0, 4, and 8. Maintenance dosing: 300 mg SC at week 12 and every 8 weeks thereafter.]	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PRIOR AUTHORIZATION REQUEST

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

If you have any questions, call: 1-888-258-8250