# Omvoh (mirikizumab-mrkz)
# Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

**MEMBER'S LAST NAME:** _____ **MEMBER'S FIRST NAME:** _____

**Instructions:** Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

| **MEMBER INFORMATION** | | |
|---|---|---|
| **LAST NAME:** | **FIRST NAME:** | |
| **PHONE NUMBER:** | **DATE OF BIRTH:** | |
| **STREET ADDRESS:** | | |
| **CITY:** | **STATE:** | **ZIP CODE:** |
| **PATIENT INSURANCE ID NUMBER:** | | |

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

**IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP**

**PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE):** _____
**AUTHORIZED REPRESENTATIVE'S PHONE NUMBER:** _____

| **PRESCRIBER INFORMATION** | | |
|---|---|---|
| **LAST NAME:** | **FIRST NAME:** | |
| **PRESCRIBER SPECIALTY:** | **EMAIL ADDRESS:** | |
| **NPI NUMBER:** | **DEA NUMBER:** | |
| **PHONE NUMBER:** | **FAX NUMBER:** | |
| **STREET ADDRESS:** | | |
| **CITY:** | **STATE:** | **ZIP CODE:** |
| **REQUESTER (if different than prescriber):** | **OFFICE CONTACT PERSON:** | |

| **MEDICATION OR MEDICAL DISPENSING INFORMATION** | | | |
|---|---|---|---|
| **MEDICATION NAME:** | | | |
| **DOSE/STRENGTH:** | **FREQUENCY:** | **LENGTH OF THERAPY/REFILLS:** | **QUANTITY:** |
| ☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES): | | | |

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| **1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?** ☐ **YES** (if yes, complete below) ☐ **NO** | | |
|---|---|---|
| **MEDICATION/THERAPY** (SPECIFY DRUG NAME AND DOSAGE)**:** | **DURATION OF THERAPY** (SPECIFY DATES)**:** | **RESPONSE/REASON FOR FAILURE/ALLERGY:** |
| | | |

| **2. LIST DIAGNOSES:** | **ICD-10:** |
|---|---|
| ☐ **Ulcerative colitis(UC)**<br>☐ **Crohn's disease(CD)**<br>☐ Other diagnosis: _____ ICD-10 Code(s): | |

**3. REQUIRED CLINICAL INFORMATION:** PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

**Is patient going to be using drug in combination with a clinical trial?** ☐ **Yes** ☐ **No**

**Is prescriber a gastroenterologist or rheumatologist?** □ **Yes** □ **No**

**Has patient tried and failed at least three months with the biosimilar for Humira, adalimumab-aacf product?** □ **Yes** □ **No Please submit chart documentation.**

**Does patient have an absolute contraindication to the biosimilar adalimumab-aacf?** □ **Yes** □ **No Please submit chart documentation.**

**Has the patient tried and had an inadequate response to a 4-month trial of the biosimilar for Stelara, Otulfi(usekinumab-aauz)?** ☐ **Yes** ☐ **No (Please submit documentation)**

**Does patient have a absolute contraindication to the biosimilar for Stelara, Otulfi(usekinumab-aauz)?** ☐ **Yes** ☐ **No (Please submit documentation)**

**Will the patient use drug in combination with another biologic response modifier or immunomodulatory agent?** □ **Yes** □ **No**

**For moderate-to-severe ulcerative colitis, please answer the following:**

**Is request for maintenance therapy ONLY (NOT INDUCTION THERAPY- medical)?** □ **Yes** □ **No**

**Has patient tried and failed at least one of the following three therapies: corticosteroids, azathioprine and/or 6-mercaptopurine?** □ **Yes** □ **No Please submit chart documentation.**

**For diagnosis with Crohn's disease, answer the following:**
**Has patient had a trial of glucocorticoid therapy or methotrexate or azathioprine or 6-mercaptopurine or 5-ASA/mesalamine?** □ **Yes** □ **No Please submit chart documentation.**

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***Renewal Request*:**

**Is patient continuing to demonstrate a positive clincial response? □ Yes □ No Please submit chart documentation.**

**Is prescriber a gastroenterologist or rheumatologist? □ Yes □ No**

**Will the patient use drug in combination with another biologic response modifier or immunomodulatory agent? □ Yes □ No**

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

_____

_____

**Please note:** Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

**ATTESTATION:** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or 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 or Electronic I.D. Verification:** _____ **Date:** _____



**FAX THIS FORM TO:** 800-424-7640
**MAIL REQUESTS TO:** Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
P.O. Box 64811
St. Paul, MN 55164-0811
**Phone**: 877-228-7909