Mountain Pacific
INNOVATING BETTER HEALTH

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Montana Healthcare Programs Prior Authorization Request Form for Use of Omvoh® (mirikizumab-mrkz)

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	
Prescriber Name/Specialty if applicable:	Prescriber Fax:	
Dosage Requested:		

Please complete below information for applicable situation, Initiation or Continuation of therapy:

☐ **INITIATION OF THERAPY**

1. Member has a diagnosis of moderately to severely active ulcerative colitis (UC): ☐ Yes ☐ No
2. Member is 18 years of age or greater: ☐ Yes ☐ No
3. Medication is prescribed by or in consultation with a gastroenterology specialist: ☐ Yes ☐ No

   Action required: If not in a specialty clinic or written by a specialist, copy of annual specialty consult with an appropriate specialist is required (please attach copy of consult):

   Name of specialist: _____ **Contact date:** _____
4. Member has trialed and has had an inadequate treatment response, intolerance or contraindication to a preferred drug with the same indication from the Montana Healthcare Programs Preferred Drug List 19 (mt.gov) (unless preferred product[s] do not have the appropriate indication): ☐ Yes ☐ No

   Name: _____ **Dates:** _____
5. Provider attests to **all the following**:
   - Member or caregiver has been trained in subcutaneous injection technique prior to maintenance phase of treatment: ☐ Yes ☐ No
   - Member or caregiver have been made aware that maintenance dose is two consecutive injections administered at different anatomic locations: ☐ Yes ☐ No
6. Provider attests the member will not use Omvoh® concomitantly with other biologics: ☐ Yes ☐ No

LIMITATIONS:

Maximum dose for initial authorization: 200mg every 4 weeks subcutaneous starting at week 12.

Initial authorization will be issued for 12 months.

☐ CONTINUATION OF THERAPY

1. Member has documentation of positive clinical response to Omvoh® therapy (e.g., reduction in the frequency and/or severity of symptoms and exacerbations): ☐ Yes ☐ No
2. Annual specialist consult attached if prescriber is not a specialist: ☐ Yes ☐ No ☐ N/A - prescriber is specialist.
3. Provider attests the member will not use Omvoh® concomitantly with other biologics: ☐ Yes ☐ No

LIMITATIONS:

Maximum dose for continuation of therapy: 200mg every 4 weeks.

Reauthorization will be issued for 12 months.

Please complete form, including required attachments, and fax to Drug Prior Authorization Unit at 1-800-294-1350.

02/2024