Omvoh

CareFirst Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical*	❑ *Home*	❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital*	❑ *Office*	❑ *Pharmacy*

What is the ICD-10 code? _____

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

 CareFirst Omvoh SGM 6239-A – 07/2025.

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

Criteria Questions:

1. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) for the same indication?
❒ Yes, *Continue to 2*
❒ No, *Continue to 2*

2. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis?
❒ Yes, *Continue to 6*
❒ No, *Continue to 3*

3. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [TST], interferon-release assay [IGRA]) within 12 months of initiating therapy?
❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. What were the results of the tuberculosis (TB) test?
❒ Positive for TB, *Continue to 5*
❒ Negative for TB, *Continue to 6*
❒ Unknown, *Continue to 6*

5. Which of the following applies to the patient?
❒ Patient has latent TB and treatment for latent TB has been initiated, *Continue to 6*
❒ Patient has latent TB and treatment for latent TB has been completed, *Continue to 6*
❒ Patient has latent TB and treatment for latent TB has not been initiated, *Continue to 6*
❒ Patient has active TB, *Continue to 6*

6. What is the diagnosis?
❒ Ulcerative colitis, *Continue to 7*
❒ Crohn's disease, *Continue to 12*
❒ Other, please specify. _____, *No further questions*

7. Has the patient been diagnosed with moderately to severely active ulcerative colitis (UC)?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. Is the requested drug being prescribed by or in consultation with a gastroenterologist?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Which of the following applies to this request for the requested drug?
❒ Initiation of the intravenous (IV) loading dose, *Continue to 17*
❒ Initiation of the subcutaneous (SQ) maintenance dose, *Continue to 19*
❒ Continuation of the subcutaneous (SQ) maintenance dose, *Continue to 10*

10. Has the patient achieved or maintained remission OR achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug? ***ACTION REQUIRED***: *If Yes, please attach chart notes or medical record documentation of remission or positive clinical response to therapy*.

❒ Yes, achieved or maintained remission *Note: Submit supporting documentation*, *Continue to 19*
❒ Yes, achieved or maintained a positive clinical response, *Continue to 11*
❒ No or none of the above, *No further questions*

11. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED***: Please attach chart notes or medical record documentation supporting positive clinical response to therapy.
❒ Stool frequency ***ACTION REQUIRED****: Submit supporting documentation, Continue to 19*
❒ Rectal bleeding ***ACTION REQUIRED****: Submit supporting documentation, Continue to 19*
❒ Urgency of defecation ***ACTION REQUIRED****: Submit supporting documentation, Continue to 19*
❒ C-reactive protein (CRP) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 19*
❒ Fecal calprotectin (FC) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 19*
❒ Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound ***ACTION REQUIRED****: Submit supporting documentation, Continue to 19*
❒ Improvement on a disease activity scoring tool (e.g., Ulcerative Colitis Endoscopic Index of Severity [UCEIS], Mayo Score) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 19*
❒ None of the above, *Continue to 19*

12. Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)?
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. Is the requested drug being prescribed by or in consultation with a gastroenterologist?
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. Which of the following applies to this request for the requested drug?
❒ Initiation of the intravenous (IV) loading dose, *Continue to 21*
❒ Initiation of the subcutaneous (SQ) maintenance dose, *Continue to 23*
❒ Continuation of the subcutaneous (SQ) maintenance dose, *Continue to 15*

15. Has the patient achieved or maintained remission OR achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of remission or positive clinical response to therapy.
❒ Yes, achieved or maintained remission ***ACTION REQUIRED****: Submit supporting documentation, Continue to 23*
❒ Yes, achieved or maintained a positive clinical response, *Continue to 16*
❒ No or none of the above, *No further questions*

16. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED***: Please attach chart notes or medical record documentation supporting positive clinical response to therapy.
❒ Abdominal pain or tenderness ***ACTION REQUIRED****: Submit supporting documentation, Continue to 23*
❒ Diarrhea ***ACTION REQUIRED****: Submit supporting documentation, Continue to 23*
❒ Body weight ***ACTION REQUIRED****: Submit supporting documentation, Continue to 23*
❒ Abdominal mass ***ACTION REQUIRED****: Submit supporting documentation, Continue to 23*
❒ Hematocrit ***ACTION REQUIRED****: Submit supporting documentation, Continue to 23*
❒ Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound ***ACTION REQUIRED****: Submit supporting documentation, Continue to 23*
❒ Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index [CDAI] score) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 23*

❒ None of the above, *Continue to 23*

17. Does the prescribed dose exceed an intravenous loading dose of 300 mg at weeks 0, 4, and 8, and a subcutaneous maintenance dose of 200 mg thereafter?
❒ Yes, *Continue to 18*
❒ No, *Continue to 18*

18. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

19. Does the prescribed maintenance dose exceed 200 mg?
❒ Yes, *Continue to 20*
❒ No, *Continue to 20*

20. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

21. Does the prescribed dose exceed an intravenous loading dose of 900 mg at weeks 0, 4, and 8, and a subcutaneous maintenance dose of 300 mg thereafter?
❒ Yes, *Continue to 22*
❒ No, *Continue to 22*

22. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

23. Does the prescribed maintenance dose exceed 300 mg?
❒ Yes, *Continue to 24*
❒ No, *Continue to 24*

24. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**