BlueCross BlueShield Federal Employee Program

OMVOH
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		

PHYSICIAN COMPLETES

For claims adjudicated through the pharmacy benefit

For Standard and Basic Option patients Humira including preferred Humira biosimilars, Rinvoq, Skyrizi, Stelara SC, and Tremfya are preferred products. Standard/Basic Option patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year.

Omvoh (mirikizumab-mrkz)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑ **YES –** this is a PA renewal for **CONTINUATION** of therapy, please answer questions on **PAGE 3**
   ❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:
2. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
3. Has the patient been tested for latent tuberculosis (TB)? ❑Yes* ❑No
   If YES, was the result of the test positive or negative for TB infection? ❑Negative ❑Positive*
   If POSITIVE, has the patient completed treatment or is the patient currently receiving treatment for latent TB? ❑Yes ❑No
4. Does the patient have any active infections including tuberculosis (TB) or hepatitis B virus (HBV)? ❑Yes ❑No
5. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least ONE conventional therapy option? ❑Yes ❑ No
6. Will this medication be used in combination with another biologic *DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify medication: _____
   DMARDs: Actemra or an Actemra biosimilar, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.
7. What is the patient's diagnosis?
   ❑ Ulcerative colitis (UC)
   a. Does the patient have moderately to severely active ulcerative colitis (UC)? ❑Yes ❑No
   b. Will the prescriber initiate dosing with three 300 mg intravenous infusions? ❑Yes ❑No
   c. Following the initial IV infusions, does the prescriber agree not to exceed the FDA labeled maintenance dose of 200 mg subcutaneously every 4 weeks? ❑Yes ❑No
   d. **Standard/Basic Option patient, for claims adjudicated through the pharmacy benefit**: Would you like to participate in this program and switch the patient to one of the preferred products: Humira including preferred Humira biosimilars, Rinvoq, Skyrizi, Stelara SC, or Tremfya? ❑Yes* ❑No
   If YES, please select the preferred product: ❑Humira/preferred biosimilar ❑Rinvoq ❑Skyrizi ❑Stelara SC ❑Tremfya

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT
REQUESTS FOR STANDARD AND BASIC OPTION PATIENTS REQUIRES PAGE 4 TO BE COMPLETED

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑ Crohn's disease (CD)

a. Does the patient have moderately to severely active Crohn's disease (CD)? ❑Yes ❑No

b. Will the prescriber initiate dosing with three 900 mg intravenous infusions? ❑Yes ❑No

c. Following the initial IV infusions, does the prescriber agree not to exceed the FDA labeled maintenance dose of 300 mg subcutaneously every 4 weeks? ❑Yes ❑No

d. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>**: Would you like to participate in this program and switch the patient to one of the preferred products: Humira including preferred Humira biosimilars, Rinvoq, Skyrizi, Stelara SC, or Tremfya? ❑Yes* ❑No

If YES, please select the preferred product: ❑Humira/preferred biosimilar ❑Rinvoq ❑Skyrizi ❑Stelara SC ❑Tremfya

❑ None of the above

<u>FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT</u>
REQUESTS FOR STANDARD AND BASIC OPTION PATIENTS REQUIRES <u>PAGE 4</u> TO BE COMPLETED

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Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: R			Physician Signature:		

PHYSICIAN COMPLETES

For claims adjudicated through the pharmacy benefit
For Standard and Basic Option patients Humira including preferred Humira biosimilars, Rinvoq, Skyrizi, Stelara SC, and Tremfya are preferred products. Standard/Basic Option patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year.

CONTINUATION OF THERAPY (PA RENEWAL)

Omvoh (mirikizumab-mrkz)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑ **NO** – this is **INITIATION** of therapy, please answer questions on **PAGE 1**
   ❑ **YES –** this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:
2. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
3. Has the patient's condition improved or stabilized with therapy? ❑Yes ❑No
4. Does the patient have any active infections including tuberculosis (TB) or hepatitis B virus (HBV)? ❑Yes ❑No
5. Will this medication be used in combination with another biologic *DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify medication: _____
   DMARDs: Actemra or an Actemra biosimilar, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.
6. What is the patient's diagnosis?
   ❑ Ulcerative colitis (UC)
   a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 200 mg subcutaneously every 4 weeks? ❑Yes ❑No
   b. **Standard/Basic Option patient, for claims adjudicated through the pharmacy benefit**: Would you like to participate in this program and switch the patient to one of the preferred products: Humira including preferred Humira biosimilars, Rinvoq, Skyrizi, Stelara SC, or Tremfya? ❑Yes* ❑No
   If YES, please select the preferred product: ❑Humira/preferred biosimilar ❑Rinvoq ❑Skyrizi ❑Stelara SC ❑Tremfya

   ❑ Crohn's disease (CD)
   a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 300 mg subcutaneously every 4 weeks? ❑Yes ❑No
   b. **Standard/Basic Option patient, for claims adjudicated through the pharmacy benefit**: Would you like to participate in this program and switch the patient to one of the preferred products: Humira including preferred Humira biosimilars, Rinvoq, Skyrizi, Stelara SC, or Tremfya? ❑Yes* ❑No
   If YES, please select the preferred product: ❑Humira/preferred biosimilar ❑Rinvoq ❑Skyrizi ❑Stelara SC ❑Tremfya

   ❑ None of the above

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
STANDARD AND BASIC OPTION PATIENT REQUESTS REQUIRES PAGE 4 TO BE COMPLETED

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PAGE 6 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
REQUESTS FOR STANDARD AND BASIC OPTION PATIENTS REQUIRES PAGE 4 TO BE COMPLETED

1. Please select the diagnosis and answer the following questions:

❑**Ulcerative colitis (UC)**

a. Does the patient have an intolerance or contraindication** or have they had an inadequate treatment response to **TWO** of the following preferred medications: Humira or a Humira biosimilar, Rinvoq, Skyrizi, Stelara (SC) or Tremfya? ❑Yes ❑No*

If NO, is there a clinical reason for not trying TWO of the preferred medications? ❑Yes ❑No

❑**Crohn's disease (CD)**

a. Does the patient have an intolerance or contraindication** or have they had an inadequate treatment response to **TWO** of the following preferred medications: Humira or a Humira biosimilar, Rinvoq, Skyrizi, or Stelara (SC) or Tremfya? ❑Yes ❑No*

If NO, is there a clinical reason for not trying TWO of the preferred medications? ❑Yes ❑No

Contraindications include (not all inclusive): allergy, autoantibody formation/lupus-like syndrome, or a history of congestive heart failure, hepatitis B virus infection, malignancy, or demyelinating disorder such as multiple sclerosis, Guillain-Barre syndrome, or optic neuritis.