PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS

Omvoh (pen or syringe) - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**.
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Omvoh (pen or syringe) - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Omvoh Prefilled Pen (mirikizumab-mrkz) Omvoh Prefilled Syringe (mirikizumab-mrkz)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.

[If yes, skip to question 10.]

2.	Does the patient have any of the following diagnoses: A) uveitis, B) sarcoidosis, C) graft-versus-host disease, D) interleukin-2 toxicity, E) Langerhans cell histiocytosis, F) myositis, G) nephrotic syndrome, H) amyloidosis, I) periodic fever syndrome, J) renal transplant syndrome, K) moderate to severe Crohn's disease in pediatric patient (as first line therapy), L) definitive radiographic axial spondyloarthritis with evidence of structural damage on sacroiliac joints?	Y N
	[If yes, no further questions.]	
3.	Has the patient previously received biologic therapy?	Y N
	[If yes, skip to question 6.]	
4.	Has the patient undergone tuberculosis screening within the past year?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
5.	Does the patient have an active tuberculosis infection prior to starting the requested biologic therapy?	Y N
	NOTE: Submission of medical records is required.	
	[If yes, no further questions.]	
6.	Does the patient have a diagnosis of moderate to severe ulcerative colitis?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
7.	Has the patient completed the induction regimen consisting of three Omvoh intravenous doses?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
8.	Will the patient be switching to self-administration for maintenance therapy?	Y N
	[If no, no further questions.]	
9.	Is the patient 18 years of age or older?	Y N
	[If yes, skip to question 13.]	
	[If no, no further questions.]	
10.	Does the patient have any of the following diagnoses: A) uveitis, B) sarcoidosis, C) graft-versus-host disease, D) interleukin-2 toxicity, E) Langerhans cell histiocytosis, F) myositis, G) nephrotic syndrome, H) amyloidosis, I) periodic fever syndrome, J) renal transplant syndrome, K) moderate to severe Crohn's disease in pediatric patient (as first line therapy), L) definitive radiographic axial spondyloarthritis with evidence of structural damage on sacroiliac joints?	Y N
	[If yes, no further questions.]	

11. Does the patient have a diagnosis of active ulcerative colitis?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
12. Is the patient experiencing clinical improvement from treatment as supported by one of the following outcomes: A) reduction in gastrointestinal signs and symptoms, B) prolonged clinical remission and mucosal healing, or C) reduced number of draining enterocutaneous or rectovaginal fistulas for at least a 3-month period (only applies to fistulizing Crohn's disease)?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
13. Is the requested drug being prescribed for FDA-approved dosages and dosing intervals?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
14. Will the requested drug be used concurrently with another biologic disease-modifying anti-rheumatic drug (DMARD)?	Y N	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date