



## OmvoH

### HMSACOM - 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 1-866-237-5512.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414**. 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](mailto: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:** \_\_\_\_\_  
**Patient's Phone Number:** \_\_\_\_\_  
**Physician's Name:** \_\_\_\_\_  
**Specialty:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Physician Office Telephone:** \_\_\_\_\_ **Physician Office Fax:** \_\_\_\_\_

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

#### Additional Demographic Information:

*Patient Weight:* \_\_\_\_\_ kg  
*Patient Height:* \_\_\_\_\_ ft \_\_\_\_\_ inches

#### Indicate where the drug is being dispensed:

- Office  Outpatient Hospital  Ambulatory Surgical  Inpatient Hospital
- Off Campus Outpatient Hospital  Urgent Care  Emergency Room  Birthing Center
- Military Facility  Skilled Nursing Facility  Nursing Facility  Hospice
- Inpatient Psychiatric  Psychiatric Residential Treatment  End Stage Renal Facility
- Psychiatric Facility  Pharmacy  Other

#### Indicate where the drug is being administered:

- Ambulatory surgical  Home  Inpatient Hospital
- Office  Outpatient Hospital  Pharmacy

What is the ICD-10 code? \_\_\_\_\_

What drug is being requested?  OmvoH IV  OmvoH SC

**Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512**

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. OmvoH HMSACOM C18701-D, C13273-A – 01/2026.

**CVS Caremark Specialty Programs • 2969 Mapunapuna Place • Honolulu, HI 96819**  
**Phone: 1-808-254-4414 • Fax: 1-866-237-5512 • www.caremark.com**

**Exception Criteria Questions:**

A. Is the product being requested for the treatment of an ADULT patient (18 years of age or older) with one of the following indications?

- Ankylosing spondylitis
- Crohn's disease
- Plaque psoriasis
- Psoriatic arthritis
- Rheumatoid arthritis
- Ulcerative colitis

- Yes, *Continue to Question B*  
 No, *skip to Criteria Questions*

B. These are the preferred products for which coverage is provided for the treatment of the following indications:

- Ankylosing spondylitis: adalimumab-adaz, Avsola, Cosentyx IV/SQ, Enbrel, Hadlima, Hyrimoz (Cordavis brand), Inflectra, Rinvoq, Simponi Aria, and Taltz
- Crohn's disease: adalimumab-adaz, Avsola, Entyvio, Hadlima, Hyrimoz (Cordavis brand), Inflectra, Pyzchiva IV/SQ (Cordavis or Sandoz brand), Rinvoq, Skyrizi IV/SQ, Tremfya IV/SQ, and Yesintek IV/SQ
- Plaque psoriasis: adalimumab-adaz, Avsola, Cosentyx SQ, Enbrel, Hadlima, Hyrimoz (Cordavis brand), Inflectra, Otezla, Pyzchiva SQ (Cordavis or Sandoz brand), Skyrizi SQ, Taltz, Tremfya SQ, and Yesintek SQ
- Psoriatic arthritis: adalimumab-adaz, Avsola, Cosentyx IV/SQ, Enbrel, Hadlima, Hyrimoz (Cordavis brand), Inflectra, Otezla, Pyzchiva SQ (Cordavis or Sandoz brand), Rinvoq, Simponi Aria, Skyrizi SQ, Taltz, Tremfya SQ, Xeljanz/Xeljanz XR, and Yesintek SQ
- Rheumatoid arthritis: adalimumab-adaz, Avsola, Enbrel, Hadlima, Hyrimoz (Cordavis brand), Inflectra, Rinvoq, Simponi Aria, and Xeljanz/Xeljanz XR
- Ulcerative colitis: adalimumab-adaz, Avsola, Entyvio, Hadlima, Hyrimoz (Cordavis brand), Inflectra, Pyzchiva IV/SQ (Cordavis or Sandoz brand), Rinvoq, Skyrizi IV/SQ, Tremfya IV/SQ, Velsipity, Xeljanz/Xeljanz XR, and Yesintek IV/SQ

Can the patient's treatment be switched to a preferred product?

- Yes, *Please obtain Form for preferred product and submit for corresponding PA.*  
 No, *Continue to Question C*

C. Is this request for continuation of therapy with the requested product?

- Yes, *Continue to Question D*  
 No, *Continue to Question E*

D. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer 'Yes'

- Yes, *Continue to Question E*  
 No, *skip to Criteria Questions*

E. What is the diagnosis?

- Ankylosing spondylitis, *Continue to Question F*  
 Crohn's disease, *Continue to Question I*  
 Plaque psoriasis, *Continue to Question L*  
 Psoriatic arthritis, *Continue to Question O*  
 Rheumatoid arthritis, *Continue to Question R*  
 Ulcerative colitis, *Continue to Question U*

**Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512**

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Omvoh HMSACOM C18701-D, C13273-A – 01/2026.

**CVS Caremark Specialty Programs • 2969 Mapunapuna Place • Honolulu, HI 96819  
Phone: 1-808-254-4414 • Fax: 1-866-237-5512 • www.caremark.com**

F. Is the requested product self-administered (oral or self-injected)?

- Yes, *Continue to Question G*  
 No, *Continue to Question H*

G. Does the patient have a documented inadequate response, intolerable adverse event or contraindication to all of the following preferred products indicated for ankylosing spondylitis: Cosentyx SQ, Enbrel, Rinvoq, Taltz, and adalimumab-adaz, Hyrimoz (Cordavis brand) or Hadlima? **ACTION REQUIRED:** *Please submit supporting documentation*

- Yes, *skip to Criteria Questions*  
 No, *skip to Criteria Questions*

H. Does the patient have a documented inadequate response, intolerable adverse event or contraindication to all of the following preferred products indicated for ankylosing spondylitis: Cosentyx IV, Avsola or Inflectra IV, and Simponi Aria? **ACTION REQUIRED:** *Please submit supporting documentation*

- Yes, *skip to Criteria Questions*  
 No, *skip to Criteria Questions*

I. What is the requested product?

- Omvoh IV, *Continue to Question K*  
 Omvoh SQ, *Continue to Question J*

J. Does the patient have a documented inadequate response, intolerable adverse event or contraindication to ALL of the following preferred products indicated for Crohn's disease? **ACTION REQUIRED:** *Please submit supporting documentation*

- Rinvoq, Skyrizi SQ AND Tremfya SQ
- adalimumab-adaz, Hyrimoz (Cordavis brand) OR Hadlima
- Pyzchiva SQ (Cordavis or Sandoz brand) OR Yesintek SQ

- Yes, *skip to Criteria Questions*  
 No, *skip to Criteria Questions*

K. Does the patient have a documented inadequate response, intolerable adverse event, or contraindication to ALL of the following preferred products indicated for Crohn's disease? **ACTION REQUIRED:** *Please submit supporting documentation*

- Entyvio, Skyrizi IV, AND Tremfya IV
- Pyzchiva IV (Cordavis or Sandoz brand) OR Yesintek IV
- Avsola OR Inflectra

- Yes, *skip to Criteria Questions*  
 No, *skip to Criteria Questions*

L. Is the requested product self-administered (oral or self-injected)?

- Yes, *Continue to Question M*  
 No, *Continue to Question N*

**Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512**

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Omvoh HMSACOM C18701-D, C13273-A – 01/2026.

**CVS Caremark Specialty Programs • 2969 Mapunapuna Place • Honolulu, HI 96819  
Phone: 1-808-254-4414 • Fax: 1-866-237-5512 • www.caremark.com**

M. Does the patient have a documented inadequate response, intolerable adverse event or contraindication to ALL of the following preferred products indicated for plaque psoriasis? **ACTION REQUIRED:** Please submit supporting documentation

- Cosentyx SQ, Enbrel, Otezla, Skyrizi SQ, Taltz AND Tremfya SQ
- adalimumab-adaz, Hyrimoz (Cordavis brand) OR Hadlima
- Pyzchiva SQ (Cordavis or Sandoz brand) OR Yesintek SQ

Yes, skip to Criteria Questions

No, skip to Criteria Questions

N. Does the patient have a documented inadequate response, intolerable adverse event, or contraindication to the following preferred products indicated for plaque psoriasis: Avsola OR Inflectra? **ACTION REQUIRED:** Please submit supporting documentation

Yes, skip to Criteria Questions

No, skip to Criteria Questions

O. Is the requested product self-administered (oral or self-injected)?

Yes, Continue to Question P

No, Continue to Question Q

P. Does the patient have a documented inadequate response, intolerable adverse event, or contraindication to ALL of the following preferred products indicated for psoriatic arthritis? **ACTION REQUIRED:** Please submit supporting documentation

- Cosentyx SQ, Enbrel, Otezla, Rinvoq, Skyrizi SQ, Taltz, Tremfya SQ AND Xeljanz/Xeljanz XR
- adalimumab-adaz, Hyrimoz (Cordavis brand) OR Hadlima?
- Pyzchiva SQ (Cordavis or Sandoz brand) OR Yesintek SQ

Yes, skip to Criteria Questions

No, skip to Criteria Questions

Q. Does the patient have a documented inadequate response, intolerable adverse event, or contraindication to all of the following preferred products indicated for psoriatic arthritis: Cosentyx IV, Avsola OR Inflectra and Simponi Aria?

**ACTION REQUIRED:** Please submit supporting documentation

Yes, skip to Criteria Questions

No, skip to Criteria Questions

R. Is the requested product self-administered (oral or self-injected)?

Yes, Continue to Question S

No, Continue to Question T

S. Does the patient have a documented inadequate response, intolerable adverse event or contraindication to all of the following preferred products indicated for rheumatoid arthritis: Enbrel, Rinvoq, Xeljanz/Xeljanz XR, and adalimumab-adaz, Hyrimoz (Cordavis brand) or Hadlima? **ACTION REQUIRED:** Please submit supporting documentation

Yes, skip to Criteria Questions

No, skip to Criteria Questions

T. Does the patient have a documented inadequate response, intolerable adverse event, or contraindication to both of the following preferred products indicated for rheumatoid arthritis: Avsola OR Inflectra and Simponi Aria? **ACTION**

**REQUIRED:** Please submit supporting documentation

Yes, skip to Criteria Questions

No, skip to Criteria Questions

**Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512**

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Omvoh HMSACOM C18701-D, C13273-A – 01/2026.

**CVS Caremark Specialty Programs • 2969 Mapunapuna Place • Honolulu, HI 96819**

**Phone: 1-808-254-4414 • Fax: 1-866-237-5512 • www.caremark.com**

U. What is the requested product?

Omvoh IV, *Continue to Question W*

Omvoh SQ, *Continue to Question V*

V. Does the patient have a documented inadequate response, intolerable adverse event, or contraindication to ALL of the following preferred products indicated for ulcerative colitis? **ACTION REQUIRED:** *Please submit supporting documentation*

- Rinvoq, Skyrizi SQ, Tremfya SQ, Velsipity, AND Xeljanz/Xeljanz XR
- adalimumab-adaz, Hyrimoz (Cordavis brand) OR Hadlima
- Pyzchiva SQ (Cordavis or Sandoz brand) OR Yesintek SQ

Yes, *skip to Criteria Questions*

No, *skip to Criteria Questions*

W. Does the patient have a documented inadequate response, intolerable adverse event, or contraindication to ALL of the following preferred products indicated for ulcerative colitis? **ACTION REQUIRED:** *Please submit supporting documentation*

- Entyvio, Skyrizi IV, AND Tremfya IV
- Pyzchiva IV (Cordavis or Sandoz brand) OR Yesintek IV
- Avsola OR Inflectra

Yes, *Continue to Criteria Questions*

No, *Continue to Criteria Questions*

**Criteria Questions:**

101. Is this request for a Fed member?

Yes, *Continue to #103*

No, *Continue to #102*

102. Is the requested drug being prescribed for any of the following diagnoses: A) Alopecia (A51.3, L63, L64, L65, L66, Z41), B) Weight Loss, C) Vitiligo (L80), or D) Cosmetic (Z40, Z41)?

Yes, *Continue to #104*

No, *Continue to #104*

103. Is the requested drug being prescribed for any of the following diagnoses: A) Alopecia (A51.3, L63, L64, L65, L66, Z41), B) Vitiligo (L80), or C) Cosmetic (Z40, Z41)?

Yes, *Continue to #107*

No, *Continue to #107*

104. Is this request for a QUEST member?

Yes, *Continue to #105*

No, *Continue to #107*

105. Is the requested drug being prescribed for infertility or to enhance fertilization?

Yes, *Continue to #106*

No, *Continue to #106*

106. Is there an FDA-approved A-rated generic equivalent or an over-the-counter (OTC) drug that has a generic equivalent for the requested drug?

Yes, *Continue to #107*

**Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512**

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Omvoh HMSACOM C18701-D, C13273-A – 01/2026.

**CVS Caremark Specialty Programs • 2969 Mapunapuna Place • Honolulu, HI 96819  
Phone: 1-808-254-4414 • Fax: 1-866-237-5512 • www.caremark.com**

No, *Continue to #107*

107. Is the drug prescribed for an FDA-approved indication?

Yes, *Continue to #108*

No, *Continue to #108*

108. Is this request for a new start or continuation of therapy?

New Start, *Continue to #112*

Continuation of Therapy, *Continue to #109*

109. Was this drug previously authorized by CVS/HMSA for this member?

Yes, *Continue to #110*

No, *Continue to #112*

110. Is the requested drug Tepezza?

Yes, *Continue to #112*

No, *Continue to #111*

111. Is there evidence to support response to treatment? *Please attach current clinical documentation (e.g., office visit notes and applicable studies) that supports a response to treatment*

Yes, *No Further Questions*

No, *No Further Questions*

112. The following documentation is required for authorization: 1) chart notes or clinical information supporting the diagnosis, and 2) proposed treatment plan. Will these be submitted by the prescriber?

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)**

**Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512**

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Omvoh HMSACOM C18701-D, C13273-A – 01/2026.

**CVS Caremark Specialty Programs • 2969 Mapunapuna Place • Honolulu, HI 96819  
Phone: 1-808-254-4414 • Fax: 1-866-237-5512 • www.caremark.com**