Mass General Brigham
Health Plan

Omvoh SC (mirikizumab-mrkz)
Effective 08/16/2026

Plan	☐ MassHealth UPPL ☒Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit		
Specialty Limitations	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	**Medical Benefit** **Pharmacy Benefit**	Phone: 833-895-2611 Phone: 800-711-4555	Fax: 888-656-6671 Fax: 844-403-1029
Exceptions	Omvoh IV is available on Medical Benefit Only Omvoh SC is available on Pharmacy Benefit Only		

Overview
Omvoh (mirikizumab-mrkz) is an interleukin-23 antagonist indicated for the treatment of:

- Moderately to severely active ulcerative colitis in adults
- Moderately to severely active Crohn's disease in adults

Coverage Guidelines
If member is new to the plan (as evidenced by coverage effective date of less than or equal to 90 days), submission of medical records documenting that the member is currently receiving treatment with the requested drug, excluding when the product is obtained as samples or via manufacturer's patient assistance programs
OR
Authorization may be granted when all of the following diagnosis-specific criteria have been met:

Moderately to Severely Active Ulcerative Colitis

1. Diagnosis of moderately to severely active ulcerative colitis.
2. Subcutaneous formulation will be used as maintenance therapy following IV induction

Moderately to Severely Active Crohn's Disease

1. Diagnosis of moderately to severely active Crohn's disease
2. Subcutaneous formulation will be used as maintenance therapy following IV induction

<u>Continuation of Therapy</u>
Requests for reauthorization will be approved when all of the following criteria are met:

1. Submission of medical records (e.g., chart notes) documenting an improvement in the member's condition, as evidenced by low disease activity or improvement in signs and symptoms of the condition

Limitations

1. Initial approvals and reauthorizations for Omvoh SC will be granted for 24 months
2. The following quantity limitations apply:

Drug Name and Dosage Form	Quantity Limit
UC pack: Omvoh 100 mg/mL autoinjector	2 autoinjectors per 28 days

UC pack: Omvoh 100 mg/mL prefilled syringe	2 prefilled syringes per 28 days
Omvoh 200 mg/2 mL autoinjector	1 autoinjector per 28 days
Omvoh 200 mg/2 mL prefilled syringe	1 prefilled syringe per 28 days
CD pack: Omvoh 100 mg/mL autoinjector + Omvoh 200 mg/2mL autoinjector	2 autoinjectors per 28 days
CD pack: Omvoh 100 mg/mL prefilled syringe + Omvoh 200 mg/2 mL prefilled syringe	2 prefilled syringes per 28 days

References

1. Feuerstein JD, Isaacs KL, Schneider Y, et al. AGA clinical practice guidelines on the management of moderate to severe ulcerative colitis. Gastroenterol. 2020;158:1450-1461.
2. Omvoh (mirikizumab-mrkz) [prescribing information]. Indianapolis, IN: Eli Lilly; November 2025.
3. Rubin DT, Ananthakrishnan AN, Siegel CA, et al. ACG clinical guideline: ulcerative colitis in adults. Am J Gastroenterol. 2019;114:384-413.

Review History

3/10/2024 - Created and Reviewed at March P&T, Effective 4/1/2024
09/11/2024 – Reviewed and updated at September P&T. Updated criteria for ulcerative colitis to include Skyrizi as a step through agent. Removed specialist prescriber requirement. Administrative update to add quantity limits to the Limitations section. Effective 12/01/2024.
10/09/2024 – Reviewed and updated at October P&T. Effective 12/1/2024: updated language for trial with biologics remove requirement for documentation of medical records to demonstrate trial. Effective 1/1/2025: removed biologic step through requirement and updated reauthorization criteria to require documentation of clinical response to therapy.
05/14/2025 – Reviewed and updated at May P&T. Added criteria for supplemental indication of Crohn's disease. Updated criteria for ulcerative colitis to remove disease characteristic requirement and allow for approval if disease severity warrants systemic biologic as first-line therapy. Updated approval length to 24 months for SC injection. Updated Limitations section to reflect quantity limits for Crohn's disease packs. Effective 7/1/2025.
10/08/2025 – Reviewed and updated at October P&T. Adding language for the SC formulation to the UC and CD diagnoses to require that either the member has either received IV induction therapy or will receive the IV induction. Effective 01/01/2026.
11/12/2025 – Reviewed and updated at November P&T. Removed IV from the policy. Updated title of policy to "Omvoh SC." Effective 1/1/2026.
02/11/2026 – Reviewed and updated at February P&T. Added Omvoh 200 mg/2 mL prefilled syringe and autoinjector to the quantity limitations section. Effective 03/01/2026.
03/11/2026 – Reviewed and updated for March P&T. Administrative update - changing verbiage in reauthorization criteria from "documentation is submitted" to "submission of medical records (e.g., chart notes…" and updating language for members who are new to the Plan. Effective 05/01/2026.
04/15/2026 – Reviewed and updated at April P&T. Updated initial criteria for ulcerative colitis and Crohn's disease to remove conventional therapy requirements and instead require that the subcutaneous formulation will be used as maintenance therapy following IV induction therapy. Effective 08/16/2026.