Mass General Brigham
Health Plan

Targeted Immunomodulators
Omvoh (mirikizumab-mrkz)
Effective 01/06/2025

Plan	☒ MassHealth UPPL ☐Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☐ Pharmacy Benefit ☒ Medical Benefit		
Specialty Limitations	N/A		
Contact Information	**Medical and Specialty Medications** All Plans | Phone: 877-519-1908 | Fax: 855-540-3693 **Non-Specialty Medications** All Plans | Phone: 800-711-4555 | Fax: 844-403-1029		
Notes	Omvoh is also available on the pharmacy benefit. Please see the MassHealth Drug List for coverage and criteria. Additional agents from this class are available through the pharmacy benefit. Please see the MassHealth Drug List for coverage and criteria.		

Overview
Omvoh (mirikizumab-mrkz) is indicated for the treatment of moderately to severely active ulcerative colitis in adults.

Coverage Guidelines
Authorization may be reviewed on a case by case basis for members who are new to the plan currently receiving treatment with requested medication excluding when the product is obtained as samples or via manufacturer's patient assistance programs.
OR
Authorization may be granted for members when all the following criteria are met:

Ulcerative Colitis
1. Diagnosis of moderate-to-severe ulcerative colitis
2. Appropriate dosing (300 mg IV at weeks 0, 4, and 8, followed by 200 mg SC at week 12 and every four weeks thereafter)

Requests for more frequent or higher doses
1. Severe disease
2. Inadequate response or adverse reaction to **ONE** or contraindication to **ALL** other injectable biologic which is FDA-approved for the requested indication
3. Partial response to FDA-approved dosing of current biologic therapy
4. Prescriber is a specialist or consult notes for the requested indication from a specialist are provided

Continuation of Therapy

Limitations

1. Initial approvals will be granted for **6 months** unless request is for more frequent/higher doses then it will be granted for **3 months**.
2. Reauthorizations will be granted for **12 months**

References

1. Omvoh® [package insert]. Indianappolis (IN): Eli Lilly, Inc.; 2023 Oct.

Review History

09/11/24 – Created criteria for P&T. Adopted MH criteria for new drug, Omvoh. This is the MB policy while PB policy exist on MHDL. Effective 10/1/24
12/11/24 – Reviewed and updated for P&T. Omvoh has been designated as preferred. Removed step-through Stelara. Effective 1/6/25