

UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 1425-2
Program	Prior Authorization/Notification
Medication	* Omvoh™ (mirikizumab-mrkz) *This program applies to the subcutaneous formulation of Omvoh.
P&T Approval Date	1/2024, 1/2025
Effective Date	4/1/2025

1. Background:

Omvoh (mirikizumab-mrkz) is an interleukin-23 antagonist indicated for the treatment of moderately to severely active ulcerative colitis in adults.

2. Coverage Criteria^a:

A. Initial Authorization for Maintenance Dosing

1. **Omvoh** will be approved based on **both** of the following criteria:

a. Diagnosis of moderately to severely active ulcerative colitis

-AND-

b. Patient is not receiving Omvoh in combination with another targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Entyvio (vedolizumab), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Stelara (ustekinumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), Zeposia (ozanimod)]

Authorization will be issued for 12 months.

B. Reauthorization

1. **Omvoh** will be approved based on **both** of the following criteria:

a. Documentation of positive clinical response to Omvoh therapy

-AND-

b. Patient is not receiving Omvoh in combination with another targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Entyvio (vedolizumab), Olumiant (baricitinib), Orencia (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Stelara (ustekinumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), Zeposia (ozanimod)]

Authorization will be issued for 12 months.

^a State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.
- The intravenous infusion is typically covered under the medical benefit. Please refer to the UnitedHealthcare Drug Policy for Omvoh.

4. Reference:

1. Omvoh [package insert]. Indianapolis, IN: Eli Lilly and Company; April 2024.

Program	Prior Authorization/Notification - Omvoh (mirikizumab-mrkz)
Change Control	
1/2024	New program
1/2025	Annual review with no change to clinical criteria. Updated examples with no change to clinical intent. Updated reference.