

## mirikizumab-mrkz (Omvoh IV)

### Commercial Medical Benefit Drug Policy

#### Place of Service

Home Infusion Administration  
Infusion Center Administration  
Office Administration  
Outpatient Facility Administration

#### **Drug Details**

**USP Category:** GASTROINTESTINAL AGENTS

**Mechanism of Action:** Interleukin-23 antagonist

#### **HCPCS:**

J2267:Injection, mirikizumab-mrkz, 1 mg

#### **How Supplied:**

300 mg/15 mL (20 mg/mL) solution in a single-dose vial

#### **Condition(s) listed in policy** *(see coverage criteria for details)*

- Crohn's Disease, moderate to severe
- Ulcerative Colitis, moderate to severe

Any condition not listed in this policy requires a review to confirm it is medically necessary. For conditions that have not been approved for intended use by the Food and Drug Administration (i.e., off-label use), the criteria outlined in the Health and Safety Code section 1367.21 must be met.

#### **Special Instructions and Pertinent Information**

Provider must submit documentation (such as office chart notes, lab results or other clinical information) to ensure the member has met all medical necessity requirements.

The member's specific benefit may impact drug coverage. Other utilization management processes, and/or legal restrictions may take precedence over the application of this clinical criteria.

For billing purposes, drugs must be submitted with the drug's assigned HCPCS code (as listed in the drug policy) and the corresponding NDC (national drug code). An unlisted, unspecified, or miscellaneous code should not be used if there is a specific code assigned to the drug.

**Omvo** given by intravenous (IV) injection is managed under the Medical Benefit. Omvo given by subcutaneous (SC) injection can be obtained through the patient's pharmacy benefit. Please refer to the "Self-Administered Drugs" medical benefit drug policy for more information.

#### **Coverage Criteria**

**The following condition(s) require Prior Authorization/Preservice.**

#### **Crohn's Disease, moderate to severe**

**Meets medical necessity if all the following are met:**

1. Age is consistent with the FDA approved indication (18 years and older)
2. Prescribed by or in consultation with a gastroenterologist

3. Inadequate response, intolerable side effect or contraindication with two preferred products [i.e., infliximab (Avsola, Inflectra), Skyrizi, Yesintek SC, adalimumab-aacf, Simlandi, Tremfya, Rinvoq]
4. Not being used in combination with other targeted immunomodulators

**Covered Doses:**

Induction: 900 mg given intravenously at Week 0, Week 4, and Week 8.

This is followed by maintenance given subcutaneously. Subcutaneous Omvoh can be requested from your pharmacy benefit.

**Coverage Period:**

Induction: 2 months

**ICD-10:**

K50.00-K50.119, K50.80-K50.919

**Ulcerative Colitis, moderate to severe**

**Meets medical necessity if all the following are met:**

1. Age is consistent with the FDA approved indication (18 years and older)
2. Prescribed by or in consultation with a gastroenterologist
3. Inadequate response or intolerable side effect with two preferred agents [e.g., adalimumab-aacf, Simlandi, infliximab (Avsola or Inflectra), Rinvoq, Skyrizi SC, Yesintek SC, Tremfya SC, and Xeljanz], or contraindication to all preferred agents
4. Not being used in combination with other targeted immunotherapies

**Covered Doses:**

Induction: 300 mg given intravenously at Week 0, Week 4, and Week 8.

This is followed by maintenance given subcutaneously. Subcutaneous Omvoh can be requested from your pharmacy benefit.

**Coverage Period:**

Induction: 2 months

**ICD-10:**

K51.0-K51.319, K51.5-K51.519, K51.80-K51.919

**References**

1. AHFS. Available by subscription at <http://www.lexi.com>
2. DrugDex. Available by subscription at <http://www.micromedexsolutions.com/home/dispatch>
3. Omvoh (mirikizumab-mrkz) Prescribing Information. Eli Lilly and Company, Indianapolis, IN: 10/2025.

**Review History**

Date of Last Annual Review: 4Q2025

Changes from previous policy version:

- Addition of Simlandi 40 mg to the preferred therapy options

*Blue Shield of California Medication Policy to Determine Medical Necessity*

*Reviewed by P&T Committee*