09-J4000-71

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Subject: Mirikizumab-mrkz (Omvoh®) Injection and Infusion

THIS MEDICAL COVERAGE GUIDELINE IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS MEDICAL COVERAGE GUIDELINE APPLIES TO ALL LINES OF BUSINESS UNLESS OTHERWISE NOTED IN THE PROGRAM EXCEPTIONS SECTION.

DESCRIPTION:

Mirikizumab (Omvoh) is an injectable monoclonal antibody and interleukin 23 (IL-23) antagonist that was approved by the US Food and Drug Administration (FDA) in November 2023 for "the treatment of moderately to severely active ulcerative colitis (UC) in adults". It is the third IL-23 specific antagonist to be approved by the FDA, the second to be approved for an inflammatory bowel disease (IBD), and the first to be approved for ulcerative colitis (UC). The other IL-23 specific antagonists include guselkumab, first approved in July 2017 and currently approved for plaque psoriasis and psoriatic arthritis; and risankizumab (Skyrizi), first approved in April 2019, and currently approved for plaque psoriasis, psoriatic arthritis, and Crohn's disease (CD). Intravenous (IV) risankizumab was approved in June 2022 with the approval for CD. Ustekinumab (Stelara) also targets IL-23; however, it targets both IL-12 and IL-23. Mirikizumab is a humanized IgG4 monoclonal antibody that selectively binds to the p19 subunit of human IL-23 cytokine and inhibits its interaction with the IL-23 receptor. IL-23 is involved in mucosal inflammation and affects the differentiation, expansion, and survival of T cell subsets, and innate immune cell subsets, which represent sources of pro-inflammatory cytokines. Research in animal models has shown that pharmacologic inhibition of IL-23p19 can ameliorate intestinal inflammation. Mirikizumab inhibits the release of pro-inflammatory cytokines and chemokines. Treatment with mirikizumab requires three intravenous (IV) loading doses prior to converting to subcutaneous (SC) maintenance dosing every 4 weeks.

In two randomized controlled trials in adults with moderate to severe active UC, mirikizumab was associated with a significantly greater proportion of patients achieving clinical remission vs. placebo. Clinical remission was defined as stool frequency subscore of 0 or 1, rectal bleeding subscore of 0, and endoscopy score of 1 or less (excluding friability) on the modified Mayo score (mMS). In study UC-1,

patients were randomized 3:1 at week 0 to receive 300 mg mirikizumab or placebo by IV infusion at week 0, week 4, and week 8. Of the patients treated with mirikizumab (n=795), 24% achieved clinical remission at week 12 vs.15% in patients who received placebo (n=267). Study UC-2 included patients (n=506) where those who achieved clinical response at week 12 in study UC-1. They were randomized 2:1 to receive mirikizumab 200 mg or placebo SQ every 4 weeks for 40 weeks, for a total of 52 weeks of treatment. Significantly more patients achieved clinical remission at week 40 with mirikizumab vs. placebo (51% vs. 27%).

INFLAMMATORY BOWEL DISEASE

Ulcerative Colitis (UC)

Ulcerative colitis (UC) is a chronic immune-mediated inflammatory condition affecting the large intestine associated with inflammation of the rectum, but that can extend to involve additional areas of the colon. The American College of Gastroenterology (ACG) recommends a treat-to-target approach and recommend therapeutic management should be guided by diagnosis (i.e., Montreal classification), assessment of disease activity (i.e., mild, moderate, and severe), and disease prognosis. The ACG treatment recommendations are further broken down into induction therapies and maintenance of remission. The 2019 ACG treatment guidelines recommend the following for therapeutic management of UC:

<u>Induction of remission</u>:

- Mildly active disease:
    - Rectal 5-ASA at a dose of 1 g/day with or without oral 5-ASA at a dose of at least 2 g/day for left-sided UC
    - Rectal 5-ASA at a dose of 1 g/day for ulcerative proctitis
    - Oral 5-ASA at a dose of at least 2 g/day for extensive UC
    - Add oral budesonide multi-matrix (MMX) 9 mg/day for patients that are intolerant or non-responsive to oral and/or rectal and oral 5-ASA at appropriate doses
- Moderately active disease:
    - Oral budesonide multi-matrix (MMX) 9 mg/day for induction of remission
- Moderately to severely active disease:
    - Oral systemic corticosteroids, TNF inhibitors (i.e., adalimumab, golimumab, or infliximab), tofacitinib, or vedolizumab to induce remission
    - Combination of infliximab with thiopurine therapy when using infliximab for induction
    - Switch to tofacitinib or vedolizumab for induction in patients that have failed TNF inhibitors
    - Patients with initial response to TNF inhibitors that lose response should have antibody levels and serum drug levels tested to assess reason for loss of response. If serum levels are adequate, use of another TNF inhibitor is not likely to be of benefit.

<u>Maintenance of remission</u>:

- Previously mildly active disease:
    - Rectal 5-ASA at a dose of 1 g/day in patients with ulcerative proctitis
    - Oral 5-ASA at a dose of at least 2 g/day in patients with left-sided or extensive UC
- Previously moderately to severely active disease:
    - Thiopurines in patients that achieved remission due to corticosteroid induction
    - Continue TNF inhibitors (i.e., adalimumab, golimumab, or infliximab) for remission due to TNF induction
    - Continue vedolizumab for remission due to vedolizumab induction
    - Continue tofacitinib for remission due to tofacitinib induction

The American Gastroenterology Association (AGA) published recommendations for the management of mild to moderate UC:

- Use either standard-dose mesalamine (2-3 g/day) or diazo-bonded 5-ASA for patients with extensive UC for induction of remission and maintenance of remission
- May add rectal mesalamine to oral 5-ASA in patients with extensive or left-sided UC for induction of remission and maintenance of remission
- Use high dose mesalamine (>3 g/day) with rectal mesalamine in patients with suboptimal response to standard-dose mesalamine, diazo-bonded 5-ASA, or with moderate disease activity for induction of remission and maintenance of remission
- Add either oral prednisone or budesonide MMX in patients that are refractory to optimized oral and rectal 5-ASA regardless of disease extent

The American Gastroenterology Association (AGA) published recommendations for the management of moderate to severe UC.

- Standard of care is to continue agents initiated for induction therapy as maintenance therapy, if they are effective (excluding corticosteroids and cyclosporine)
- Adult outpatients with moderate to severe UC:
    - Infliximab, adalimumab, golimumab, vedolizumab, tofacitinib or ustekinumab are strongly recommended over no treatment
    - Biologic naïve patients:
        - infliximab or vedolizumab are conditionally recommended over adalimumab for induction of remission
        - Recommend tofacitinib only be used in the setting of a clinical or registry study
    - Previous exposure to infliximab, particularly those with primary non-response, ustekinumab or tofacitinib are conditionally recommended over vedolizumab or adalimumab for induction of remission
    - Conditionally recommend against use of thiopurine monotherapy for induction, but may be used for maintenance of remission over no treatment

POSITION STATEMENT:

Comparative Effectiveness

The Food and Drug Administration has deemed the subcutaneous formulations of the drug(s) or biological product(s) in this coverage policy to be appropriate for self-administration or administration by a caregiver (i.e., not a healthcare professional). Therefore, coverage (i.e., administration) of the subcutaneous formulations in certain provider-administered setting such as an outpatient hospital, ambulatory surgical suite, or emergency facility is not considered medically necessary.

NOTE: The self-administered products with prerequisites for certain indications are as follows:

Table 1

Disease State	Step 1		Step 2 (Directed to ONE step 1 agent)	Step 3a (Directed to TWO step 1 agents)	Step 3b (Directed to TWO agents from step 1 and/or step 2)	Step 3c (Directed to THREE step 1 agents)
	Step 1a	Step 1b (Directed to ONE TNF inhibitor) NOTE: Please see Step 1a for preferred TNF inhibitors				
Rheumatoid Disorders						
Ankylosing Spondylitis (AS)	SQ: Cosentyx, Enbrel, Hadlima, Humira	Oral: Rinvoq, Xeljanz, Xeljanz XR	N/A	SQ: Cimzia, Simponi, Taltz	N/A	SQ: Abrilada**, Amjevita**, Cyltezo**, Hulio**, Hyrimoz**, Idacio**, Simlandi**, Yuflyma**, Yusimry**
Nonradiographic Axial Spondyloarthritis (nr-axSpA)	SQ: Cimzia, Cosentyx	Oral: Rinvoq	N/A	SQ: Taltz	N/A	N/A
Polyarticular Juvenile Idiopathic Arthritis (PJIA)	SQ: Enbrel, Hadlima, Humira	Oral: Rinvoq, Rinvoq LQ, Xeljanz	SQ: Actemra (Hadlima, or Humira is a required Step 1 agent)	N/A	SQ: Orencia	SQ: Abrilada**, Amjevita**, Cyltezo**, Hulio**, Hyrimoz**, Idacio**, Simlandi**, Yuflyma**, Yusimry**
Psoriatic Arthritis (PsA)	SQ: Cosentyx, Enbrel, Hadlima, Humira, Skyrizi, Stelara, Tremfya Oral: Otezla	Oral: Rinvoq, Rinvoq LQ, Xeljanz, Xeljanz XR	N/A	SQ: Cimzia, Orencia, Simponi, Taltz	N/A	SQ: Abrilada**, Amjevita**, Cyltezo**, Hulio**, Hyrimoz**, Idacio**, Simlandi**, Yuflyma**, Yusimry**
Rheumatoid Arthritis (RA)	SQ: Enbrel, Hadlima, Humira	Oral: Rinvoq, Xeljanz, Xeljanz XR	SQ: Actemra (Hadlima, or Humira is a	Oral: Olumiant SQ: Cimzia, Kevzara,	N/A	SQ: Abrilada**, Amjevita**, Cyltezo**, Hulio**,

			required Step 1 agents)	Kineret, Orencia, Simponi		Hyrimoz**, Idacio**, Simlandi**, Yuflyma**, Yusimry**
Dermatological Disorders						
Hidradenitis Suppurativa (HS)	SQ: Cosentyx, Hadlima, Humira	N/A	N/A	N/A	N/A	SQ: Abrilada**, Amjevita**, Cyltezo**, Hulio**, Hyrimoz**, Idacio**, Simlandi**, Yuflyma**, Yusimry**
Psoriasis (PS)	SQ: Cosentyx, Enbrel, Hadlima, Humira, Skyrizi, Stelara, Tremfya Oral: Otezla	N/A	Oral: Sotyktu	SQ: Cimzia	N/A	SQ: Abrilada**, Amjevita**, Bimzelx, Cyltezo**, Hulio**, Hyrimoz**, Idacio**, Siliq, Simlandi**, Taltz, Yuflyma**, Yusimry**
Inflammatory Bowel Disease						
Crohn's Disease (CD)	SQ: Hadlima, Humira, Skyrizi, Stelara	Oral: Rinvoq	N/A	SQ: Cimzia (Hadlima, or Humira are required Step 1 agents)	SQ: Entyvio	SQ: Abrilada**, Amjevita**, Cyltezo**, Hulio**, Hyrimoz**, Idacio**, Simlandi**, Yusimry**, Zymfentra
Ulcerative Colitis (UC)	SQ: Hadlima, Humira, Stelara	Oral: Rinvoq, Xeljanz, Xeljanz XR	SQ: Simponi (Hadlima or Humira is a required Step 1 agents)	N/A	SQ: Entyvio Oral: Zeposia (Hadlima, Humira, Rinvoq, Stelara, OR Xeljanz/Xeljanz XR are required Step agents)	SQ: Abrilada**, Amjevita**, Cyltezo**, Hulio**, Hyrimoz**, Idacio**, **Omvoh**, Simlandi**, Yuflyma**, Yusimry**, Zymfentra Oral: Velsipity
Other						
Uveitis	SQ: Hadlima, Humira	N/A	N/A	N/A	N/A	SQ: Abrilada**, Amjevita**, Cyltezo**, Hulio**, Hyrimoz**, Idacio**, Simlandi**, Yuflyma**, Yusimry**
Indications Without Prerequisite Biologic Immunomodulators						
Alopecia Areata (AA)	N/A	N/A	N/A	N/A	N/A	N/A

Atopic Dermatitis (AD) Deficiency of IL-1 Receptor Antagonist (DIRA) Enthesitis Related Arthritis (ERA) Giant Cell Arteritis (GCA) Juvenile Psoriatic Arthritis (JPsA) Neonatal-Onset Multisystem Inflammatory Disease (NOMID) Polymyalgia Rheumatica (PMR) Systemic Juvenile Idiopathic Arthritis (SJIA) Systemic Sclerosis-associated Interstitial Lung Disease (SSc-ILD)						

Note: Hadlima and Humira are required Step 1 agents

Note: For Xeljanz products (Xeljanz and Xeljanz XR) and Rinvoq products (Rinvoq and Rinvoq LQ), a trial of either or both dosage forms collectively counts as **ONE** product

Note: Branded generic available for Cyltezo, Hulio, Hyrimoz, Idacio, Simlandi and Yuflyma are included as a target at the same step level in this program

SUBCUTANEOUS OMVOH (PHARMACY BENEFIT)

Initiation of subcutaneous mirikizumab (Omvoh) **meets the definition of medical necessity** when **ALL** of the following are met ("1" to "5"):

1. **BOTH** of the following ("a" and "b"):
    a. Subcutaneous mirikizumab will be used for the treatment of an indication listed in Table 2, and **ALL** of the indication-specific criteria are met
    b. **EITHER** of the following if the member has an FDA-approved indication ("i" or "ii")
        i. The member's age is within FDA labeling for the requested indication for subcutaneous mirikizumab
        ii. The prescriber has provided information in support of using subcutaneous mirikizumab for the member's age
2. The prescriber is a specialist in the area of the member's diagnosis (e.g., gastroenterologist for UC) or the prescriber has consulted with a specialist in the area of the member's diagnosis

3. Member does **NOT** have any FDA labeled contraindications to subcutaneous mirikizumab
4. Member will **NOT** be using subcutaneous mirikizumab in combination with another biologic immunomodulator agent (full list in "Other" section); Janus kinase (JAK) inhibitor [Cibinqo (abrocitinib), Litfulo (ritlecitinib), Olumiant (baricitinib), Opzelura (ruxolitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz (tofacitinib), and Xeljanz XR (tofacitinib extended release)]; Otezla (apremilast); Sotyktu (deucravacitinib); or sphingosine-1-phosphate (S1P) modulator [Velsipity (etrasimod) and Zeposia (ozanimod)]
5. **ANY** of the following ("a", "b", or "c"):
    a. The dosage does not exceed 200 mg subcutaneously every 4 weeks (28 days) [to be started 4 weeks after the last loading dose of IV mirikizumab (i.e., Week 12)]
        - QL: 100 mg/1 mL autoinjector/pen - 2 autoinjectors/pens (2 mL)/28 days
    b. The requested quantity (dose) exceeds the program quantity limit but does **NOT** exceed the maximum FDA labeled dose **OR** the maximum compendia-supported dose (i.e., DrugDex with 1 or 2a level of evidence, AHFS, or NCCN compendium recommended use 1 or 2a) for the requested indication, **AND** the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength and/or package size that does not exceed the program quantity limit
    c. The requested quantity (dose) exceeds the program quantity limit and exceeds the maximum FDA labeled dose **AND** the maximum compendia-supported dose (i.e., DrugDex with 1 or 2a level of evidence, AHFS, or NCCN compendium recommended use 1 or 2a) for the requested indication, **AND** the prescriber has provided information in support of therapy with a higher dose or shortened dosing interval for the requested indication (submitted copy of clinical trials, phase III studies, guidelines required)

Approval duration: 12 months

Table 2

Diagnosis	Criteria
Moderately to severely active ulcerative colitis (UC)	**ALL** of the following ("1", "2", and "3"): 1. **ONE** of the following: a. The member has tried and had an inadequate response to **ONE** conventional agent (i.e., 6-mercaptopurine, azathioprine, balsalazide, corticosteroids, cyclosporine, mesalamine, sulfasalazine) used in the treatment of UC after at least a 3-month duration of therapy **OR** b. The member has an intolerance or hypersensitivity to **ONE** of the conventional agents used in the treatment of UC **OR**

	c. The member has an FDA labeled contraindication to **ALL** of the conventional agents used in the treatment of UC **OR** d. The member's medication history indicates use of another biologic immunomodulator agent that is FDA labeled or supported in DrugDex with 1 or 2a level of evidence or AHFS for the treatment of UC **AND** 2. **ANY** of the following (submitted medical records/chart notes are required for confirmation): a. The member has tried and had an inadequate response to at least **THREE** of the following preferred products after at least a 3-month trial per product: • Hadlima (adalimumab-bwwd) • Humira (adalimumab) • Rinvoq (upadacitinib) • Stelara (ustekinumab) • Xeljanz/Xeljanz XR (tofacitinib) **OR** b. The member has an intolerance (defined as an intolerance to the drug or its excipients, not to the route of administration) or hypersensitivity to at least **THREE** of the following preferred products: • Hadlima (adalimumab-bwwd) • Humira (adalimumab) • Rinvoq (upadacitinib) • Stelara (ustekinumab) • Xeljanz/Xeljanz XR (tofacitinib) c. The member has an FDA labeled contraindication to **ALL** of the following: • Hadlima (adalimumab-bwwd) • Humira (adalimumab) • Rinvoq (upadacitinib) • Stelara (ustekinumab) • Xeljanz/Xeljanz XR (tofacitinib)

	OR d. **ALL** of the following are **NOT** clinically appropriate for the member, **AND** the prescriber has provided a complete list of previously tried agents for the requested indication: • Hadlima (adalimumab-bwwd) • Humira (adalimumab) • Rinvoq (upadacitinib) • Stelara (ustekinumab) • Xeljanz/Xeljanz XR (tofacitinib) **AND** 3. The member has received IV mirikizumab (Omvoh) for induction therapy
Other indications	The member has another FDA labeled indication or an indication supported in DrugDex with 1 or 2a level of evidence, AHFS, or NCCN compendium recommended use 1 or 2a

Continuation of subcutaneous mirikizumab (Omvoh) **meets the definition of medical necessity** when **ALL** of the following are met ("1" to "6"):

1. An authorization or reauthorization for subcutaneous mirikizumab has been previously approved by Florida Blue [Note: members not previously approved for the requested agent will require initial evaluation review]
2. Member has had clinical benefit with subcutaneous mirikizumab therapy
3. The prescriber is a specialist in the area of the member's diagnosis (e.g., gastroenterologist for UC) or the prescriber has consulted with a specialist in the area of the member's diagnosis
4. Member does **NOT** have any FDA-labeled contraindications to subcutaneous mirikizumab
5. Member will **NOT** be using subcutaneous mirikizumab in combination with another biologic immunomodulator agent (full list in "Other" section); Janus kinase (JAK) inhibitor [Cibinqo (abrocitinib), Litfulo (ritlecitinib), Olumiant (baricitinib), Opzelura (ruxolitinib), Rinvoq (upadacitinib), Xeljanz (tofacitinib), and Xeljanz XR (tofacitinib extended release)]; Otezla (apremilast); Sotyktu (deucravacitinib); or sphingosine-1-phosphate (S1P) modulator [Velsipity (etrasimod) and Zeposia (ozanimod)]
6. **ANY** of the following ("a", "b", or "c"):
    a. The dosage does not exceed 200 mg subcutaneously every 4 weeks (28 days)
        • QL: 100 mg/1 mL autoinjector/pen - 2 autoinjectors/pens (2 mL)/28 days
    b. The requested quantity (dose) exceeds the program quantity limit but does **NOT** exceed the maximum FDA labeled dose **OR** the maximum compendia-supported dose (i.e., DrugDex with 1 or 2a level of evidence, AHFS, or NCCN compendium recommended use 1 or 2a) for the

requested indication, **AND** the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength and/or package size that does not exceed the program quantity limit

c. The requested quantity (dose) exceeds the program quantity limit and exceeds the maximum FDA labeled dose **AND** the maximum compendia-supported dose (i.e., DrugDex with 1 or 2a level of evidence, AHFS, or NCCN compendium recommended use 1 or 2a) for the requested indication, **AND** the prescriber has provided information in support of therapy with a higher dose or shortened dosing interval for the requested indication (submitted copy of clinical trials, phase III studies, guidelines required)

Approval duration: 12 months

INTRAVENOUS OMVOH (MEDICAL BENEFIT)

Initiation of intravenous (IV) mirikizumab (Omvoh) **meets the definition of medical necessity** when **ALL** of the following criteria are met ("1" to "5"):

1. Intravenous mirikizumab will be used for the treatment of an indication listed in **Table 3**, and **ALL** of the indication-specific and maximum-allowable dose criteria are met
2. The prescriber is a specialist in the area of the member's diagnosis (e.g., gastroenterologist for UC) or the prescriber has consulted with a specialist in the area of the member's diagnosis
3. Member does **NOT** have any FDA labeled contraindications to IV mirikizumab
4. Member will **NOT** be using IV mirikizumab in combination with another biologic immunomodulator agent (full list in "Other" section); Janus kinase (JAK) inhibitor [Cibinqo (abrocitinib), Litfulo (ritlecitinib), Olumiant (baricitinib), Opzelura (ruxolitinib), Rinvoq (upadacitinib), Xeljanz (tofacitinib), and Xeljanz XR (tofacitinib extended release)]; Otezla (apremilast); or sphingosine-1-phosphate (S1P) modulator [Velsipity (etrasimod) and Zeposia (ozanimod)]
5. Member has not received a previous dose of mirikizumab (IV or SC) in the past 6 months

Approval duration:

- UC - 3 months (to allow for 3 doses total)
- Other indications – 12 months

Table 3

Indication	Criteria	Max Allowable Dosage
Moderately to severely active ulcerative colitis (UC)	**BOTH** of the following ("1" and "2"): 1. **ONE** of the following: a. The member has tried and had an inadequate response to **ONE** conventional agent (i.e., 6-mercaptopurine, azathioprine, balsalazide, corticosteroids, cyclosporine, mesalamine,	• 300 mg IV at Weeks 0, 4, and 8 (3 doses total)

	sulfasalazine) used in the treatment of UC after at least a 3-month duration of therapy **OR** b. The member has an intolerance or hypersensitivity to **ONE** of the conventional agents used in the treatment of UC **OR** c. The member has an FDA labeled contraindication to **ALL** of the conventional agents used in the treatment of UC **OR** d. The member's medication history indicates use of another biologic immunomodulator agent that is FDA labeled or supported in DrugDex with 1 or 2a level of evidence or AHFS for the treatment of UC **AND** 2. **ANY** of the following (submitted medical records/chart notes are required for confirmation): a. The member has tried and had an inadequate response to at least **THREE** of the following preferred products after at least a 3-month trial per product: • Hadlima (adalimumab-bwwd) • Humira (adalimumab) • Rinvoq (upadacitinib) • Stelara (ustekinumab) • Xeljanz/Xeljanz XR (tofacitinib) **OR** b. The member has an intolerance (defined as an intolerance to the drug or its excipients, not to the route of administration) or hypersensitivity to at least **THREE** of the following preferred products: • Hadlima (adalimumab-bwwd) • Humira (adalimumab) • Rinvoq (upadacitinib)	

	• Stelara (ustekinumab) • Xeljanz/Xeljanz XR (tofacitinib) c. The member has an FDA labeled contraindication to **ALL** of the following: • Hadlima (adalimumab-bwwd) • Humira (adalimumab) • Rinvoq (upadacitinib) • Stelara (ustekinumab) • Xeljanz/Xeljanz XR (tofacitinib) **OR** d. **ALL** of the following are **NOT** clinically appropriate for the member, **AND** the prescriber has provided a complete list of previously tried agents for the requested indication: • Hadlima (adalimumab-bwwd) • Humira (adalimumab) • Rinvoq (upadacitinib) • Stelara (ustekinumab) • Xeljanz/Xeljanz XR (tofacitinib)	
Other indications	The member has another FDA labeled indication or an indication supported in DrugDex with 1 or 2a level of evidence, AHFS, or NCCN compendium recommended use 1 or 2a	Maximum dose supported by the FDA labeled indication or maximum dose supported in DrugDex with 1 or 2a level of evidence, AHFS, or NCCN compendium recommended use 1 or 2a

DOSAGE/ADMINISTRATION:

THIS INFORMATION IS PROVIDED FOR INFORMATIONAL PURPOSES ONLY AND SHOULD NOT BE USED AS A SOURCE FOR MAKING PRESCRIBING OR OTHER MEDICAL DETERMINATIONS. PROVIDERS SHOULD REFER TO THE MANUFACTURER'S FULL PRESCRIBING INFORMATION FOR DOSAGE GUIDELINES AND OTHER INFORMATION RELATED TO THIS MEDICATION BEFORE MAKING ANY CLINICAL DECISIONS REGARDING ITS USAGE.

FDA-approved:

- Indicated for the treatment of moderately to severely active ulcerative colitis in adults.
- The recommended induction dosage is 300 mg administered by IV infusion over at least 30 minutes at Week 0, Week 4, and Week 8.
- The recommended maintenance dosage is 200 mg administered by SQ injection (given as two consecutive injections of 100 mg each) at Week 12, and every 4 weeks thereafter.
- Omvoh for IV use is intended for administration by a healthcare provider using aseptic technique. Each vial is for single use only. Administer the infusion over at least 30 minutes.
- Omvoh for SC use is intended for use under the guidance and supervision of a healthcare professional. Patients may self-inject after training in SQ injection technique. Before injection, remove prefilled pen from the refrigerator and leave at room temperature for 30 minutes. Do not shake the prefilled pen. Sites for injection include the abdomen, thigh, and back of the upper arm. Instruct patients to inject in a different location every time. For example, if the first injection was in the abdomen, administer the second injection (to complete a full dose) in another area of the abdomen, or upper arm, or thigh.

Dose Adjustment:

- No specific guidelines for dosage adjustments for renal or hepatic impairment are available. It appears that no dosage adjustments are needed.

Drug Availability:

- IV infusion - 300 mg/15 mL (20 mg/mL) solution in a single-dose vial
- Subcutaneous use - 100 mg/mL solution in a single-dose prefilled pen
- Store refrigerated at 2°C to 8°C (36°F to 46°F). Do not freeze. Do not use OMVOH if it has been frozen. Do not shake. Keep in the original carton to protect from light until the time of use. Omvoh is sterile and preservative-free. Discard any unused portion. If needed, the prefilled pen may be stored at room temperature up to 30°C (86°F) for up to 2 weeks in the original carton to protect from light. Once Omvoh has been stored at room temperature, do not return to the refrigerator. If these conditions are exceeded, Omvoh must be discarded. The vial and prefilled pen are not made with dry natural rubber latex.

PRECAUTIONS:

Boxed Warning:

- None

Contraindication:

- Patients with a history of serious hypersensitivity reaction to mirikizumab-mrkz or any of the excipients.

Precautions/Warnings

- **Hypersensitivity Reactions**: Serious hypersensitivity reactions, including anaphylaxis and infusion-related reactions, have been reported. If a severe hypersensitivity reaction occurs, discontinue and initiate appropriate treatment.
- **Infections**: Omvoh may increase the risk of infection. Do not initiate treatment with Omvoh in patients with a clinically important active infection until the infection resolves or is adequately treated. If a serious infection develops, do not administer Omvoh until the infection resolves.
- **Tuberculosis**: Do not administer Omvoh to patients with active TB infection. Monitor patients receiving Omvoh for signs and symptoms of active TB during and after treatment.
- **Hepatotoxicity**: Drug-induced liver injury has been reported. Monitor liver enzymes and bilirubin levels at baseline and for at least 24 weeks of treatment and thereafter according to routine patient management. Interrupt treatment if drug-induced liver injury is suspected, until this diagnosis is excluded.
- **Immunizations**: Avoid use of live vaccines.

BILLING/CODING INFORMATION:

HCPCS Coding:

J2267	Injection, mirikizumab-mrkz, 1 mg [for IV formulation only]
J3590	Unclassified biologicals [for SC formulation only]

ICD-10 Diagnosis Codes That Support Medical Necessity of Intravenous Injection (C9168, J3590, NDC):

K51.00 – K51.919	Ulcerative colitis

ICD-10 Diagnosis Codes That Support Medical Necessity of Subcutaneous Injection (J3590, NDC):

K51.00 – K51.919	Ulcerative colitis

REIMBURSEMENT INFORMATION:

Refer to section entitled **POSITION STATEMENT**.

PROGRAM EXCEPTIONS:

Federal Employee Program (FEP): Follow FEP guidelines.

State Account Organization (SAO): Follow SAO guidelines.

Medicare Advantage Products: No National Coverage Determination (NCD) and/or Local Coverage Determination (LCD) were found at the time of the last guideline review date.

Medicare Part D: Florida Blue has delegated to Prime Therapeutics authority to make coverage determinations for the Medicare Part D services referenced in this guideline.

DEFINITIONS:

Bacillus Calmette-Guérin (BCG): a vaccine against tuberculosis that is prepared from a strain of the attenuated (weakened) live bovine tuberculosis bacillus, Mycobacterium bovis.

DMARDs: An acronym for disease-modifying antirheumatic drugs. These are drugs that modify the rheumatic disease processes, and slow or inhibit structural damage to cartilage and bone. These drugs are unlike symptomatic treatments such as NSAIDs that do not alter disease progression. DMARDs can be further subcategorized. With the release of biologic agents (e.g., anti-TNF drugs), DMARDs were divided into either: (1) conventional, traditional, synthetic, or non-biological DMARDs; or as (2) biological DMARDs. However, with the release of newer targeted non-biologic drugs and biosimilars, DMARDs are now best categorized as: (1) conventional synthetic DMARDs (csDMARD) (e.g., MTX, sulfasalazine), (2) targeted synthetic DMARDs (tsDMARD) (e.g., baricitinib, tofacitinib, apremilast), and (3) biological DMARDs (bDMARD), which can be either a biosimilar DMARD (bsDMARD) or biological originator DMARD (boDMARD).

RELATED GUIDELINES:

Adalimumab Products, 09-J0000-46
Apremilast (Otezla) Tablet, 09-J2000-19
Brodalumab (Siliq) Injection, 09-J2000-74
Certolizumab Pegol (Cimzia), 09-J0000-77
Etanercept (Enbrel), 09-J0000-38
Golimumab (Simponi, Simponi Aria), 09-J1000-11
Guselkumab (Tremfya), 09-J2000-87
Infliximab Products, 09-J0000-39
Ixekizumab (Taltz), 09-J2000-62
Natalizumab (Tysabri) Injection, 09-J0000-73
Psoralens with Ultraviolet A (PUVA), 02-10000-16
Risankizumab (Skyrizi), 09-J3000-45
Secukinumab (Cosentyx), 09-J2000-30
Tildrakizumab-asmn (Ilumya), 09-J3000-04
Vedolizumab (Entyvio), 09-J2000-18

OTHER:

Biologic Immunomodulator Agents Not Permitted as Concomitant Therapy

Abrilada (adalimumab-afzb)
Actemra (tocilizumab)
Adalimumab
Adbry (tralokinumab-ldrm)
Amjevita (adalimumab-atto)
Arcalyst (rilonacept)
Avsola (infliximab-axxq)
Benlysta (belimumab)
Bimzelx (bimekizumab-bkzx)

Cimzia (certolizumab)
Cinqair (reslizumab)
Cosentyx (secukinumab)
Cyltezo (adalimumab-adbm)
Dupixent (dupilumab)
Enbrel (etanercept)
Entyvio (vedolizumab)
Fasenra (benralizumab)
Hadlima (adalimumab-bwwd)
Hulio (adalimumab-fkjp)
Humira (adalimumab)
Hyrimoz (adalimumab-adaz)
Idacio (adalimumab-aacf)
Ilaris (canakinumab)
Ilumya (tildrakizumab-asmn)
Inflectra (infliximab-dyyb)
Infliximab
Kevzara (sarilumab)
Kineret (anakinra)
Nucala (mepolizumab)
Omvoh (mirikizumab-mrkz)
Orencia (abatacept)
Remicade (infliximab)
Renflexis (infliximab-abda)
Riabni (rituximab-arrx)
Rituxan (rituximab)
Rituxan Hycela (rituximab/hyaluronidase human)
Ruxience (rituximab-pvvr)
Selarsdi (ustekinumab-aekn)
Siliq (brodalumab)
Simlandi (adalimumab-ryvk)
Simponi (golimumab)
Simponi Aria (golimumab)
Skyrizi (risankizumab-rzaa)
Spevigo (spesolimab-sbzo)
Stelara (ustekinumab)
Taltz (ixekizumab)
Tezspire (tezepelumab-ekko)
Tofidence (tocilizumab-bavi)
Tremfya (guselkumab)
Truxima (rituximab-abbs)
Tyenne (tocilizumab-aazg)
Tyruko (natalizumab-sztn)
Tysabri (natalizumab)
Wezlana (ustekinumab-auub)

Xolair (omalizumab)
Yuflyma (adalimumab-aaty)
Yusimry (adalimumab-aqvh)
Zymfentra (infliximab-dyyb)

Table 4: Conventional Synthetic DMARDs

Generic Name	Brand Name
Auranofin (oral gold)	Ridaura
Azathioprine	Imuran
Cyclosporine	Neoral, Sandimmune
Hydroxychloroquine	Plaquenil
Leflunomide	Arava
Methotrexate	Rheumatrex, Trexall
Sulfasalazine	Azulfidine, Azulfidine EN-Tabs

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COMMITTEE APPROVAL:

This Medical Coverage Guideline (MCG) was approved by the Florida Blue Pharmacy Policy Committee on 02/14/24.

GUIDELINE UPDATE INFORMATION:

04/01/24	New Medical Coverage Guideline.
07/01/24	Revision to guideline consisting of updating the position statement, related guidelines, and other section. Amjevita low-concentration removed as a required prerequisite agent. Updates to the positioning of agents in Table 1. Removal of latent TB testing requirement. New drugs added to the list of Biologic Immunomodulator Agents Not Permitted as Concomitant Therapy. Added HCPCS code J2267 and deleted code C9168.