



Drug Coverage Policy

Effective Date03/15/2026
Coverage Policy Number.....IP0663
Policy Title.....OmvoH Subcutaneous
Prior Authorization Policy

Inflammatory Conditions – OmvoH Subcutaneous Prior Authorization Policy

- OmvoH® (mirikizumab-mrkz subcutaneous injection – Eli Lilly)

INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

OVERVIEW

OmvoH subcutaneous (SC) injection, a monoclonal antibody against the p19 subunit of the interleukin (IL)-23 cytokine, is indicated for the **maintenance treatment of**:¹

- **Crohn's disease**, in adults with moderate to severe active disease; AND
- **Ulcerative colitis**, in adults with moderate to severe active disease.

OmvoH is also available in an intravenous (IV) formulation that is dually indicated as induction therapy in Crohn's disease and ulcerative colitis. It is given as an IV infusion at Weeks 0, 4, and 8, followed by OmvoH SC once every 4 weeks thereafter for maintenance.¹

Guidelines

- **Crohn's Disease (CD):** The American College of Gastroenterology (ACG) [2025] and the American Gastroenterological Association (AGA) [2025] have guidelines for the management of CD in adults.^{2,3} Both guidelines recommend upfront use of advanced therapies, rather than step-up therapy after failure of corticosteroids and/or immunomodulators. Advanced therapies recommended include tumor necrosis factor (TNF) inhibitors, Entyvio® (vedolizumab IV infusion, SC injection), IL-23 inhibitors, IL-12/23 inhibitors, and Rinvoq® (upadacitinib extended-release tablets).
- **Ulcerative colitis (UC):** The AGA (2024) and the ACG (2025) have clinical practice guidelines on the management of moderate to severe UC.^{4,5} In moderate to severe disease, systemic corticosteroids or advanced therapies may be utilized for induction of remission. Advanced therapies recommended include TNF inhibitors, Entyvio, IL-23 inhibitors, IL-12/23 inhibitors, sphingosine-1-phosphate (S1P) receptor modulators, and Janus kinase (JAK) inhibitors. If steroids are utilized for induction, efforts should be made to introduce steroid-sparing agents for maintenance therapy. Of note, guidelines state that corticosteroids may be avoided entirely when other effective induction strategies are planned.⁵ Both guidelines also recommend that any drug that effectively treats induction should be continued for maintenance.^{4,5}

Coverage Policy

POLICY STATEMENT

Prior Authorization is required for benefit coverage of OmvoH subcutaneous. All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days. Because of the specialized skills required for evaluation and diagnosis of patients treated with OmvoH subcutaneous as well as the monitoring required for adverse events and long-term efficacy, approval requires OmvoH subcutaneous to be prescribed by or in consultation with a physician who specializes in the condition being treated.

NOTE: This product also requires the use of preferred products before approval of the requested product for Individual and Family Plans. Refer to the respective *Inflammatory Conditions Preferred Specialty Management Policy for Individual and Family Plans (PSM002)* for additional preferred product criteria requirements and exceptions.

OmvoH subcutaneous is considered medically necessary when ONE of the following are met (1 or 2):

FDA-Approved Indications

1. **Crohn's Disease.** Approve for the duration noted if the patient meets ONE of the following (A or B):

- A) Initial Therapy.** Approve for 6 months if the patient meets ALL of the following (i, ii, and iii):
- i.** Patient is ≥ 18 years of age; AND
 - ii.** According to the prescriber, the patient will receive induction dosing with Omvoh intravenous within 3 months of initiating therapy with Omvoh subcutaneous; AND
 - iii.** The medication is prescribed by or in consultation with a gastroenterologist; OR
- B) Patient is Currently Receiving Omvoh Subcutaneous.** Approve for 1 year if the patient meets BOTH of the following (i and ii):
- i.** Patient has been established on therapy for at least 6 months; AND
Note: A patient who has received < 6 months of therapy or who is restarting therapy is reviewed under criterion A (Initial Therapy).
 - ii.** Patient meets at least ONE of the following (a or b):
 - a)** When assessed by at least one objective measure, patient experienced a beneficial clinical response from baseline (prior to initiating Omvoh); OR
Note: Examples of objective measures include fecal markers (e.g., fecal lactoferrin, fecal calprotectin), serum markers (e.g., C-reactive protein), imaging studies (magnetic resonance enterography, computed tomography enterography), endoscopic assessment, and/or reduced dose of corticosteroids.
 - b)** Compared with baseline (prior to initiating Omvoh), patient experienced an improvement in at least one symptom, such as decreased pain, fatigue, stool frequency, and/or blood in stool.

2. Ulcerative Colitis. Approve for the duration noted if the patient meets ONE of the following (A or B):

- A) Initial Therapy.** Approve for 6 months if the patient meets ALL of the following (i, ii, and iii):
- i.** Patient is ≥ 18 years of age; AND
 - ii.** According to the prescriber, the patient will receive three induction doses with Omvoh intravenous within 3 months of initiating therapy with Omvoh subcutaneous; AND
 - iii.** The medication is prescribed by or in consultation with a gastroenterologist; OR
- B) Patient is Currently Receiving Omvoh Subcutaneous.** Approve for 1 year if the patient meets BOTH of the following (i and ii):
- i.** Patient has been established on the requested drug for at least 6 months; AND
Note: A patient who has received < 6 months of therapy or who is restarting therapy with the requested drug is reviewed under criterion A (Initial Therapy).
 - ii.** Patient meets at least ONE of the following (a or b):
 - a)** When assessed by at least one objective measure, patient experienced a beneficial clinical response from baseline (prior to initiating the requested drug); OR
Note: Examples of assessment for inflammatory response include fecal markers (e.g., fecal calprotectin), serum markers (e.g., C-reactive protein), endoscopic assessment, and/or reduced dose of corticosteroids.
 - b)** Compared with baseline (prior to initiating the requested drug), patient experienced an improvement in at least one symptom, such as decreased pain, fatigue, stool frequency, and/or decreased rectal bleeding.

Conditions Not Covered

OmvoH subcutaneous for any other use is considered not medically necessary, including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

- 1. Concurrent Use with a Biologic or with a Targeted Synthetic Oral Small Molecule Drug.** This medication should not be administered in combination with another biologic or with a targeted synthetic oral small molecule drug used for an inflammatory condition (see [Appendix](#) for examples). Combination therapy is generally not recommended due to a potentially higher rate of adverse events and lack of controlled clinical data supporting additive efficacy.

Note: This does NOT exclude the use of conventional synthetic disease-modifying antirheumatic drugs (e.g., methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine) in combination with this medication.

References

1. Omvoh® intravenous infusion, subcutaneous injection [prescribing information]. Indianapolis, IN: Eli Lilly; January 2025.
2. Lichtenstein G, Loftus E, Afzali A, et al. ACG Clinical Guideline: Management of Crohn's Disease in Adults. *Am J Gastroenterol*. 2025 June;120(6):1225-1264.
3. Scott FI, Ananthakrishnan AN, Click B, et al. AGA Living Clinical Practice Guideline on the Pharmacologic Management of Moderate-to-Severe Crohn's Disease. *Gastroenterology*. 2025 Dec;169(7):1397-1448.
4. Singh S, Loftus EV Jr, Limketkai BN, et al. AGA Living Clinical Practice Guideline on Pharmacological Management of Moderate-to-Severe Ulcerative Colitis. *Gastroenterology*. 2024 Dec;167(7):1307-1343.
5. Rubin D, Ananthakrishnan A, Siegel C. ACG Clinical Guideline Update: Ulcerative Colitis in Adults. *Am J of Gastroenterol*. 2025 June;120(6):1187-1224.

Revision Details

Type of Revision	Summary of Changes	Date
New	New policy	11/01/2024
Selected Revision	Crohn's disease: This newly approved condition was added to the policy.	03/15/2025
Selected Revision	Removed: Employer Plans: Standard/Performance, Value/Advantage, Total Savings Prescription Drug Lists (PSM001), and Legacy Prescription Drug List Plans (PSM017) from the "Note" directing to additional preferred product criteria requirements and exceptions. Omvoh subcutaneous moved to a preferred product for these prescription drug lists.	04/01/2025
Selected Revision	Ulcerative Colitis: For initial therapy, removed the following options of approval: (1) the patient has tried one systemic therapy; (2) the patient has pouchitis and tried an antibiotic, probiotic, corticosteroid enema, or mesalamine enema.	09/01/2025
Annual Revision	No criteria changes. Appendix: Otezla XR (apremilast extended-release tablets) was added.	03/01/2026
Selected Revision	Crohn's Disease: For initial therapy, the following options of approval were removed: The patient has tried or is currently taking systemic corticosteroids, or corticosteroids are contraindicated; patient has tried one conventional systemic therapy for Crohn's	03/15/2026

	disease along with the associated Note; patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas; patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence).	
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The policy effective date is in force until updated or retired.

APPENDIX

	Mechanism of Action	Examples of Indications*
Biologics		
Adalimumab SC Products (Humira®, biosimilars)	Inhibition of TNF	AS, CD, JIA, PsO, PsA, RA, UC
Cimzia ® (certolizumab pegol SC injection)	Inhibition of TNF	AS, CD, nr-axSpA, PsO, PsA, RA
Etanercept SC Products (Enbrel®, biosimilars)	Inhibition of TNF	AS, JIA, PsO, PsA, RA
Infliximab IV Products (Remicade®, biosimilars)	Inhibition of TNF	AS, CD, PsO, PsA, RA, UC
Zymfentra ® (infliximab-dyyb SC injection)	Inhibition of TNF	CD, UC
Simponi ®, Simponi Aria ® (golimumab SC injection, golimumab IV infusion)	Inhibition of TNF	SC formulation: AS, PsA, RA, UC
		IV formulation: AS, PJIA, PsA, RA
Tocilizumab Products (Actemra® IV, biosimilar; Actemra SC, biosimilar)	Inhibition of IL-6	SC formulation: PJIA, RA, SJIA
		IV formulation: PJIA, RA, SJIA
Kevzara ® (sarilumab SC injection)	Inhibition of IL-6	RA
Orencia ® (abatacept IV infusion, abatacept SC injection)	T-cell costimulation modulator	SC formulation: JIA, PSA, RA
		IV formulation: JIA, PsA, RA
Rituximab IV Products (Rituxan®, biosimilars)	CD20-directed cytolytic antibody	RA
Kineret ® (anakinra SC injection)	Inhibition of IL-1	JIA [^] , RA
Omvoh ® (mirikizumab IV infusion, SC injection)	Inhibition of IL-23	CD, UC
Stelara ® (ustekinumab SC injection, ustekinumab IV infusion)	Inhibition of IL-12/23	SC formulation: CD, PsO, PsA, UC
		IV formulation: CD, UC
Siliq ® (brodalumab SC injection)	Inhibition of IL-17	PsO
Cosentyx ® (secukinumab SC injection; secukinumab IV infusion)	Inhibition of IL-17A	SC formulation: AS, ERA, nr-axSpA, PsO, PsA
		IV formulation: AS, nr-axSpA, PsA
Taltz ® (ixekizumab SC injection)	Inhibition of IL-17A	AS, nr-axSpA, PsO, PsA
Bimzelx ® (bimekizumab-bkzx SC injection)	Inhibition of IL-17A/17F	PsO, AS, nr-axSpA, PsA
Ilumya ® (tildrakizumab-asmn SC injection)	Inhibition of IL-23	PsO
Skyrizi ® (risankizumab-rzaa SC injection, risankizumab-rzaa IV infusion)	Inhibition of IL-23	SC formulation: CD, PSA, PsO, UC
		IV formulation: CD, UC
Tremfya ® (guselkumab SC injection, guselkumab IV infusion)	Inhibition of IL-23	SC formulation: PsA, PsO, UC
		IV formulation: UC

Entyvio [®] (vedolizumab IV infusion, vedolizumab SC injection)	Integrin receptor antagonist	CD, UC
Oral Therapies/Targeted Synthetic Oral Small Molecule Drugs		
Otezla [®] (apremilast tablets)	Inhibition of PDE4	PsO, PsA
Otezla XR [™] (apremilast extended-release tablets)	Inhibition of PDE4	PsO, PsA
Cibinqo [™] (abrocitinib tablets)	Inhibition of JAK pathways	AD
Olumiant [®] (baricitinib tablets)	Inhibition of JAK pathways	RA, AA
Litfulo [®] (ritlecitinib capsules)	Inhibition of JAK pathways	AA
Leqselvi [®] (deuruxolitinib tablets)	Inhibition of JAK pathways	AA
Rinvoq [®] (upadacitinib extended-release tablets)	Inhibition of JAK pathways	AD, AS, nr-axSpA, RA, PsA, UC
Rinvoq [®] LQ (upadacitinib oral solution)	Inhibition of JAK pathways	PsA, PJIA
Sotyktu [®] (deucravacitinib tablets)	Inhibition of TYK2	PsO
Xeljanz [®] (tofacitinib tablets/oral solution)	Inhibition of JAK pathways	RA, PJIA, PsA, UC
Xeljanz [®] XR (tofacitinib extended-release tablets)	Inhibition of JAK pathways	RA, PsA, UC
Zeposia [®] (ozanimod tablets)	Sphingosine 1 phosphate receptor modulator	UC
Velsipity [®] (etrasimod tablets)	Sphingosine 1 phosphate receptor modulator	UC

* Not an all-inclusive list of indications. Refer to the prescribing information for the respective agent for FDA-approved indications; SC – Subcutaneous; TNF – Tumor necrosis factor; AS – Ankylosing spondylitis; CD – Crohn’s disease; JIA – Juvenile idiopathic arthritis; PsO – Plaque psoriasis; PsA – Psoriatic arthritis; RA – Rheumatoid arthritis; UC – Ulcerative colitis; nr-axSpA – Non-radiographic axial spondyloarthritis; IV – Intravenous, PJIA – Polyarticular juvenile idiopathic arthritis; IL – Interleukin; SJIA – Systemic juvenile idiopathic arthritis; ^ Off-label use of Kineret in JIA supported in guidelines; ERA – Enthesitis-related arthritis; DMARD – Disease-modifying antirheumatic drug; PDE4 – Phosphodiesterase 4; JAK – Janus kinase; AD – Atopic dermatitis; AA – Alopecia areata; TYK2 – Tyrosine kinase 2.

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