Mirikizumab-mrkz (OMVOH)
Intravenous and Subcutaneous Injection in Crohn's Disease
Criteria for Use
March 2025

VA Pharmacy Benefits Management Services and National Formulary Committee

The following recommendations are based on medical evidence, clinician input, and expert opinion. The content of the document is dynamic and will be revised as new information becomes available. The purpose of this document is to assist practitioners in clinical decision-making, to standardize and improve the quality of patient care, and to promote cost-effective drug prescribing. THE CLINICIAN SHOULD USE THIS GUIDANCE AND INTERPRET IT IN THE CLINICAL CONTEXT OF THE INDIVIDUAL PATIENT. INDIVIDUAL CASES THAT ARE EXCEPTIONS TO THE EXCLUSION AND INCLUSION CRITERIA SHOULD BE ADJUDICATED AT THE LOCAL FACILITY ACCORDING TO THE POLICY AND PROCEDURES OF ITS P&T COMMITTEE AND PHARMACY SERVICES.

The Product Information should be consulted for detailed prescribing information.

Exclusion Criteria

If ANY of the following are selected, the patient will NOT meet criteria for mirikizumab-mrkz.

- ☐ Uncontrolled, active, severe infection, including evidence of *C. difficile* and undrained abscess; however, mirikizumab-mrkz may be started / restarted once the infection is controlled.
- ☐ Untreated latent or active tuberculosis infection.
- ☐ Hepatitis B surface antigen (HBsAg)-positive and not on antiviral prophylaxis. Mirikizumab-mrkz may be initiated after starting antiviral prophylaxis.^1
- ☐ Untreated HIV infection. Treated, well-controlled, asymptomatic HIV-positive patients can be treated with mirikizumab-mrkz.
- ☐ Concomitant live or live-attenuated vaccines or administration of inactivated, live, or live-attenuated vaccines less than 2 weeks before initiation of mirikizumab-mrkz.^2
- ☐ Liver cirrhosis unless potential benefits outweigh risks based on shared decision-making.

Inclusion Criteria

All the following criteria must be selected to meet criteria.

- ☐ Current or prior moderate to severe Crohn's disease (CD) confirmed by endoscopy or imaging
- ☐ Prescribed and monitored by a VA / VA Community Care gastroenterologist or locally designated expert.
- ☐ Completed tuberculosis (TB) test using tuberculin skin test or interferon-gamma release assay [IGRA].
- ☐ Completed hepatitis B screening (at minimum, HBsAg, total antibody-to-hepatitis-B-core-antigen (anti-HBc) and antibody to hepatitis B surface antigen [anti-HBs]).
- ☐ Current or past completion of hepatitis C screening. (Mirikizumab-mrkz may be initiated while waiting for test results.)
- ☐ Obtained liver panel including bilirubin.
- ☐ Vedolizumab or upadacitinib was tried (unless medically inadvisable) and not tolerated or not adequate, or lost response^3,^4
- ☐ Risankizumab-rzaa was tried (unless medically inadvisable) and not tolerated or not adequate, or lost response.^3,^4

Additional Inclusion Criteria

ONE of the following must be selected to meet criteria.

- ☐ Tumor necrosis factor inhibitor (TNFI) is medically inadvisable. Infliximab / biosimilar and adalimumab are the preferred TNFIs in CD.
- ☐ Primary nonresponse, inadequate partial response, or loss of response after 12 weeks of one TNFI therapy in the presence of adequate TNFI levels (mechanistic failure).
- ☐ Loss of response to infliximab / biosimilar and another TNFI for CD despite therapeutic drug monitoring (TDM)-based optimized dosing to address pharmacokinetic failure. ^4, ^5

See footnote 6 for sequencing CD drugs.

Additional Inclusion Criteria

Select if applicable.

- ☐ If HBsAg-negative but anti-HBc-positive: A GI / liver or infectious diseases expert has been consulted for advice on whether to start antiviral prophylaxis or to preemptively monitor for HBV reactivation.
- ☐ For females who can become pregnant: Counseling provided on potential risks vs benefits of treatment and the use of effective contraception.

Other Justification

- ☐ _____

Footnotes

1. Antiviral prophylaxis for HBV: Agents with high genetic barrier to resistance such as entecavir or tenofovir should be used.
2. When possible, vaccinations should be updated before the patient initiates mirikizumab-mrkz. Unless contraindicated, recombinant zoster (SHINGRIX) vaccine should be completed or at least initiated by the end of the first year of treatment with mirikizumab-mrkz, preferably when dosage is low, disease is stable, or at other times when a robust immune response to vaccination can be expected.
3. Applies only to new starts for mirikizumab. Patients on mirikizumab who are stable (responded to induction and/or controlled on maintenance therapy) should not be switched to a criteria-required prior drug for nonmedical reasons.
4. Loss of response refers to active disease confirmed by endoscopy, imaging, or biochemical assessment.

[5] Pharmacokinetic failure resulting in low TNFI levels may be immune-mediated or non–immune-mediated.
If TNFI levels are undetectable with high antidrug antibody (AdAb) titers (i.e., immune-mediated pharmacokinetic failure): Consider adding an immunomodulator. In CD, a switch from infliximab / biosimilar to a second TNFI is preferred over a switch to another drug class (such as vedolizumab, risankizumab-rzaa, or upadacitinib). Infliximab / biosimilar and adalimumab / biosimilar are the preferred TNFIs in CD.
If TNFI levels are undetectable with low AdAb titers (i.e., also immune-mediated pharmacokinetic failure), optimize dosing (i.e., shorten dosing interval, increase dose, or both; add a conventional immunomodulator if not already started).
If trough TNFI levels are subtherapeutic with low or high AdAb titers, optimal management is uncertain.
If TNFI trough levels are subtherapeutic with no AdAbs (i.e., non–immune-mediated pharmacokinetic failure due to rapid drug clearance), shorten the TNFI dosing intervals, increase the dose, or both.

[6] **Sequencing CD Drugs (1L = First-line, 2L = Second-line, etc.)**
1L: Infliximab or adalimumab
2L / 3L: Vedolizumab, upadacitinib, or risankizumab-rzaa (one drug should be risankizumab-rzaa as 2L or 3L drug)
4L: Mirikizumab-mrkz or ustekinumab

Supplemental Information

This supplemental information is provided to assist in adjudication of requests for mirikizumab-mrkz in CD.

Section	Criterion	Issues for Consideration
Exclusion Criteria	HBsAg-negative but antibody-to-hepatitis-B-core-antigen (anti-HBc)-positive and not cleared by a hepatologist or infectious diseases expert.[1]	In patients who are HBsAg-negative but anti-HBc-positive, the presence of antibody to hepatitis B surface antigen (anti-HBs) does not guarantee protection against HBV reactivation, and the available evidence is insufficient to support the use of anti-HBs titers in deciding whether to give antiviral prophylaxis.* Consultation with a local hepatologist or infectious diseases expert is recommended to advise on whether to initiate prophylactic antiviral therapy or perform preemptive monitoring with deferred prophylactic therapy. * Reddy K, et al. American Gastroenterological Association Institute Guideline on the Prevention and Treatment of Hepatitis B Virus Reactivation During Immunosuppressive Drug Therapy. Gastroenterology. 2015;148(1):215–219. DOI:https://doi.org/10.1053/j.gastro.2014.10.039]
Inclusion Criteria	**Tumor necrosis factor inhibitor (TNFI)** is medically inadvisable. Infliximab / biosimilar and adalimumab are the preferred TNFIs in CD.	Another option is certolizumab.
	Completed tuberculosis (TB) test using tuberculin skin test or interferon-gamma release assay [IGRA].	Routine retesting is not required for prescription renewals. Retesting in high-risk patients should be considered. Anti-HBs may help to identify patients who require initial or booster vaccination (anti-HBs titers ≥ 10 IU/L are generally considered protective) or HBsAg-negative patients without past vaccination who have occult HBV from past infection (anti-HBs positive and lost anti-HBc).
	Current or past completion of hepatitis C screening. (Ustekinumab may be initiated while waiting for test results.)	Routine retesting is not required for prescription renewals. Retesting in high-risk patients should be considered.

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