MEDICATION POLICY:

IL-23 Inhibitors

Generic Name:

Therapeutic Class or Brand Name: IL-23 Inhibitors

Applicable Drugs (if Therapeutic Class): Guselkumab (Tremfya®), Risankizumab (Skyrizi™), Tildrakizumab (Ilumya™)

GPI Code: 90250542, 90250570, 90250580

Preferred: Risankizumab (Skyrizi™)

Non-preferred: Guselkumab (Tremfya®), Tildrakizumab (Ilumya™)

Date of Origin: 5/15/2019

Date Last Reviewed / Revised: N/A

PRIOR AUTHORIZATION CRITERIA

(May be considered medically necessary when criteria I - IV are met)

I. Moderate to Severe Chronic Plaque Psoriasis and criteria A through D are met:
   A. History of treatment failure, intolerance, or contraindications with phototherapy or photochemotherapy.
   B. History of treatment failure, intolerance, or contraindication with at least one appropriate systemic agent (i.e. cyclosporine, methotrexate, acitretin, etc.).
   C. Diagnosis must be established by a dermatologist.
   D. Minimum age requirement: 18 years old.

II. Absence of active serious infection.

III. Negative TB skin test within the previous 12 months or history of treatment for latent TB infection.

IV. Refer to plan document for the list of preferred products. If requested agent is not listed as a preferred product, must have a documented failure, intolerance, or contraindication to preferred product(s).

EXCLUSION CRITERIA

- Co-administration with another biologic DMARD, Olumiant® (baricitinib), Otezla® (apremilast), or Xeljanz®/XR (tofacitinib). Examples of biologic DMARDS include the following:
  - Actemra® (tocilizumab)
  - Cosentyx® (secukinumab)
  - Entyvio® (vedolizumab)
  - Kevzara® (sarilumab)
  - Kineret® (anakinra)
  - Orencia® (abatacept)
  - Rituxan® (rituximab)
  - Siliq® (brodalumab)
  - Stelara® (Ustekinumab)

- Taltz® (Ixekizumab)
- TNF inhibitors [Cimzia® (certolizumab pegol), Enbrel® (etanercept), Simponi®/Simponi® Aria® (golimumab), Inflectra® (infliximab-dyyb), Remicade® (infliximab), Renflexis® (infliximab-abda)]
- Tysabri® (natalizumab)

Other Criteria

- N/A

Quantity / Days Supply Restrictions

- Tremfya™
  - Quantities up to 2 x 100 mg prefilled syringes for the first 28 days, then in quantities up to one prefilled 100 mg syringe every 56 days (8 weeks).
- Skyrizi™
  - Quantities up to 4 x 75 mg prefilled syringes for the first 28 days, then in quantities up to two prefilled 75 mg syringes every 84 days (12 weeks).
- Ilumya™
  - Quantities up to 2 x 100 mg prefilled syringes for the first 28 days, then in quantities up to one prefilled 100 mg syringe every 84 days (12 weeks).

Approval Length

- **Authorization:** 1 year.
- **Re-Authorization:** An updated letter of medical necessity or progress notes showing improvement or maintenance with medication.

Appendix

N/A

References

1. American Academy of Dermatology Psoriasis Clinical Guideline. https://www.aad.org/practicecenter/quality/clinical-guidelines/psoriasis
2. Tremfya™ package insert. http://www.janssenlabels.com/package-insert/product-monograph/prescribing-information/TREMFYA-pi.pdf
3. Skyrizi™ package insert. https://www.rxabbvie.com/pdf/skyrizi_pi.pdf

4. Ilumya™ package insert. https://www.ilumya.com/pdfs/Sun_Pharma_ILUMYA_US_Prescribing_Information.pdf
5. Medispan®

HISTORICAL TRACKING OF CHANGES MADE TO POLICY

Date	Notes/Changes
5/15/2019	1. New policy.