

Generic Name: Ixekizumab**Preferred:** N/A**Therapeutic Class or Brand Name:** Taltz®**Non-preferred:** N/A**Applicable Drugs (if Therapeutic Class):** N/A**Date of Origin:** 8/25/2016**GPI Code:** 9025055400**Date Last Reviewed / Revised:** 11/21/2017

PRIOR AUTHORIZATION CRITERIA

(May be considered medically necessary when criteria I through VIII are met)

- I. Documented diagnosis of one OR both of the following conditions A or B:
 - A. Moderate to severe plaque psoriasis.
 - B. Active psoriatic arthritis.
- II. History of treatment failure, intolerance, or contraindication with phototherapy or photochemotherapy.
- III. History of treatment failure, intolerance, or contraindication with at least one systemic non-biologic agent (i.e. cyclosporine, methotrexate, acitretin, etc.).
- IV. Documented failure, intolerance, or contraindication to at least one preferred tumor necrosis factor (TNF) inhibitor (refer to plan document for the list of preferred products).
- V. Diagnosis must be established by a dermatologist or a rheumatologist.
- VI. Minimum age requirement: 18 years old.
- VII. Absence of active serious infection or sepsis.
- VIII. Negative TB skin test within the previous 12 months or history of treatment for latent TB infection.

EXCLUSION CRITERIA

- Coadministration of Taltz® with another biologic DMARD, 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)

- TNF inhibitors [Cimzia® (certolizumab pegol), Enbrel® (etanercept), Humira® (adalimumab), Inflectra® (infliximab-dyyb), Remicade® (infliximab), Renflexis™ (infliximab-abda), Simponi®/Simponi® Aria® (golimumab)]
- Tremfya™ (guselkumab)
- Tysabri® (natalizumab)

OTHER CRITERIA

- N/A

QUANTITY / DAYS SUPPLY RESTRICTIONS

- For moderate to severe plaque psoriasis with or without coexisting psoriatic arthritis:
 - Quantities of up to 4 syringes or autoinjectors for the first 28 days, then in quantities of up to 2 syringes or autoinjectors every 28 days for the next 56 days, then in quantities of 1 syringe or autoinjector every 28 days thereafter.
- For psoriatic arthritis only:
 - Quantities of up to 2 syringes or autoinjectors for the first 28 days, then in quantities of 1 syringe or autoinjector every 28 days thereafter.

APPROVAL LENGTH

- **Authorization:** 1 year.
- **Re-Authorization:** An updated letter of medical necessity or progress notes showing current medical necessity criteria are met and that the medication is effective.

APPENDIX

N/A

REFERENCES

1. <https://pi.lilly.com/us/taltz-uspi.pdf>.
2. Medi-Span®.

HISTORICAL TRACKING OF CHANGES MADE TO POLICY

Date	Notes/Changes
2/24/2019	1. Changed to account for new indication of psoriatic arthritis under Prior Authorization Criteria From:

	<p>I. Documented diagnosis of moderate to severe plaque psoriasis</p> <p>To:</p> <ol style="list-style-type: none"> I. Documented diagnosis of one OR both of the following conditions A or B: <ol style="list-style-type: none"> A. Moderate to severe plaque psoriasis. B. Active psoriatic arthritis. <p>2. Changed to account for new dosing information for psoriatic arthritis indication under Quantity/Days Supply Restrictions</p> <p>From:</p> <ul style="list-style-type: none"> • Quantities of up to 4 syringes or autoinjectors for the first 28 days, then in quantities up to 2 syringes or autoinjectors every 28 days for the next 56 days, then in quantities of 1 syringe or autoinjector every 28 days thereafter. <p>TO:</p> <ul style="list-style-type: none"> • For moderate to severe plaque psoriasis with or without coexisting psoriatic arthritis: <ul style="list-style-type: none"> ○ Quantities of up to 4 syringes or autoinjectors for the first 28 days, then in quantities of up to 2 syringes or autoinjectors every 28 days for the next 56 days, then in quantities of 1 syringe or autoinjector every 28 days thereafter. • For psoriatic arthritis only: <ul style="list-style-type: none"> ○ Quantities of up to 2 syringes or autoinjectors for the first 28 days, then in quantities of 1 syringe or autoinjector every 28 days thereafter.
11/21/2017	<ol style="list-style-type: none"> 1. Added “Kevzara® (sarilumab)”, “Siliq™ (brodalumab)”, and “Tremfya™ (guselkumab)” to list under Exclusion Criteria. 2. Added “Inflectra® (infliximab-dyyb)” and “Renflexis™ (infliximab-abda)” following TNF Inhibitors to list under Exclusion Criteria.
8/25/2016	<ol style="list-style-type: none"> 1. Changed “III. History of treatment failure, intolerance, or contraindication with at least one appropriate systemic agent (i.e. cyclosporine, methotrexate, acitretin, etc.)” to “III. History of treatment failure, intolerance, or contraindication with at least one systemic non-biologic agent (i.e. cyclosporine, methotrexate, acitretin, etc.)” under Prior Authorization Criteria. 2. Changed “IV. Documented failure, intolerance, or contraindication to two preferred biologic products (refer to plan document for the list of preferred products)” to “IV. Documented failure, intolerance, or contraindication to at least one preferred tumor necrosis factor (TNF) inhibitor (refer to plan document for the list of preferred products)” under Prior Authorization Criteria.

DISCLAIMER: Medication Policies are developed to help ensure safe, effective and appropriate use of selected medications. They offer a guide to coverage and are not intended to dictate to providers how to practice medicine. Refer to Plan for individual adoption of specific Medication Policies. Providers are expected to exercise their medical judgement in providing the most appropriate care for their patients.