Medical Policy

Healthcare Services Department

Policy Name	Policy Number	Scope
Monoclonal Antibodies to Interleukin-23 [Ilumya (tildrakizumab-asmn), Skyrizi (risankizumab-rzaa), Tremfya (guselkumab)]	MP-RX-FP-61-23	☒ MMM MA ☒ MMM Multihealth

Service Category

☐ Anesthesia
☐ Surgery
☐ Radiology Procedures
☐ Pathology and Laboratory Procedures
☐ Medicine Services and Procedures
☐ Evaluation and Management Services
☐ DME/Prosthetics or Supplies
☒ Part B DRUG

Service Description

This document addresses the use of monoclonal antibodies which bind to the interleukin-23 (IL-23) cytokine and disrupt its interaction with the IL-23 receptor thereby inhibiting the release of proinflammatory cytokines and chemokines. IL-23 inhibitors are approved for the treatment of plaque psoriasis. Agents addressed in this clinical criteria document include:

- Ilumya (tildrakizumab-asmn)
- Tremfya (guselkumab)
- Skyrizi (risankizumab-rzaa)

Background Information

Plaque Psoriasis (otherwise known as psoriasis vulgaris): The American Academy of Dermatology (AAD) and National Psoriasis Foundation (NPF) published joint guidelines on the management and treatment of psoriasis with biologics. The guidelines do not include a treatment algorithm or compare biologics to each other or conventional therapy. The guideline notes that patients with mild- moderate disease may be adequately controlled with topical therapy and/or phototherapy while moderate to severe disease may necessitate treatment with a biologic. Moderate to severe disease is defined as involvement in > 3% of body surface area (BSA) or involvement in sensitive areas that significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia). Tumor necrosis factor inhibitor (TNFi) biologics, ustekinumab, IL17 inhibitors, and IL23 inhibitors are all recommended as monotherapy treatment options for adult patients with moderate to severe plaque psoriasis.

Psoriatic Arthritis: The American College of Rheumatology (ACR) guidelines recommend that initial treatment of patients with active severe PsA or concomitant psoriasis should include a TNFi biologic over an oral small molecule (OSM; including methotrexate, sulfasalazine, cyclosporine, leflunomide, and apremilast). For initial therapy, OSMs are preferred over IL-17 and ustekinumab; and may be considered over TNFi biologics in mild to moderate disease without comorbid conditions or in those who prefer oral therapy. Recommendations involving biologics over OSMs as first line therapy are conditional and based on low quality evidence. Evidence cited includes

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indirect comparisons of placebo-controlled trials, studies with open-label design, and extrapolation from studies in plaque psoriasis. Furthermore, most pivotal trials for TNFi biologics included a study population that were DMARD experienced. Overall, there is a lack of definitive evidence for the safety and efficacy of biologic drugs over conventional therapy for the initial treatment of most patients with psoriatic arthritis. The ACR guidelines precede FDA approval of guselkumab and risankizumab for psoriatic arthritis.

Crohn's Disease: According to the American Gastrointestinal Association clinical practice guidelines, evidence supports the use of methotrexate, corticosteroids, TNFi +/- immunomodulator, ustekinumab, or vedolizumab for induction of remission. Among the biologics, infliximab, adalimumab, ustekinumab, or vedolizumab are recommended or suggested over certolizumab for induction of remission. Evidence supports biologic agents, thiopurines, and methotrexate for maintenance of remission. Ustekinumab and vedolizumab are options for individuals with primary nonresponse to initial treatment with TNFi. Adalimumab, ustekinumab, or vedolizumab may be used in cases where an individual previously responded to infliximab and then lost response (secondary nonresponse). The AGA guidelines precede FDA approval of risankizumab for CD.

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Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS

J1628	Injection, guselkumab, 1 mg [Tremfya]
J3245	Injection, tildrakizumab, 1 mg [Ilumya]
J2327	Injection, risankizumab-rzaa, intravenous, 1 mg [Skyrizi]
J3490	Unclassified drugs (when specified as (risankizumab-rzaa, intravenous, 1 mg) [Skyrizi]
J3590	Unclassified biologics (when specified as (risankizumab-rzaa, intravenous, 1 mg) [Skyrizi]
C9399	Unclassified drugs or biologicals (when specified as (risankizumab-rzaa, intravenous, 1 mg) [Skyrizi]

ICD-10 Diagnosis

K50.0-K50.019	Crohn's disease of small intestine
K50.1-K50.119	Crohn's disease of large intestine
K50.8-K50.819	Crohn's disease of both small and large intestine
K50.9-K50.919	Crohn's disease, unspecified
L40.0	Plaque psoriasis
L40.50	Arthropathic psoriasis, unspecified
L40.51	Distal interphalangeal psoriatic arthropathy
L40.52	Psoriatic arthritis mutilans
L40.53	Psoriatic spondylitis
L40.59	Other psoriatic arthropathy
L40.8	Other psoriasis
L40.9	Psoriasis, unspecified

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Medical Necessity Guidelines

When a drug is being reviewed for coverage under a member's medical benefit plan or is otherwise subject to clinical review (including prior authorization), the following criteria will be used to determine whether the drug meets any applicable medical necessity requirements for the intended/prescribed purpose.

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

Ilumya (tildrakizumab-asmn)

Initial requests for Ilumya (tildrakizumab-asmn) may be approved for the following:

I. Plaque psoriasis (Ps) when each of the following criteria are met:
   A. Individual is 18 years of age or older with chronic moderate to severe (that is, extensive or disabling) plaque Ps with either of the following (AAD 2019):
      1. Plaque Ps involving greater than three percent (3%) body surface area (BSA); **OR**
      2. Plaque Ps involving less than or equal to three percent (3%) BSA involving sensitive areas or areas that significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia); **AND**
   B. Individual has had an inadequate response to, is intolerant of, or has a contraindication to phototherapy or other systemic therapy (such as acitretin, cyclosporine, or methotrexate).

Continuation requests for Ilumya (tildrakizumab-asmn) may be approved if the following criterion is met:

I. There is confirmation of clinically significant improvement or stabilization in clinical signs and symptoms of disease.

Requests for Ilumya (tildrakizumab-asmn) may not be approved for the following:

I. In combination with phototherapy; **OR**
II. In combination with topical or oral JAK inhibitors, apremilast, deucravacitinib, ozanimod, or any of the following biologic immunomodulators: TNF antagonists, other IL-23 inhibitors, IL-17 inhibitors, vedolizumab, ustekinumab, abatacept, IL-1 inhibitors, IL-6 inhibitors, rituximab or natalizumab; **OR**
III. Tuberculosis, other active serious infections, or a history of recurrent infections; **OR**
IV. If initiating therapy, individual has not had a tuberculin skin test (TST) or a Centers for Disease Control (CDC-) and Prevention -recommended equivalent to evaluate for latent tuberculosis (unless switching therapy

from another targeted immune modulator and no new risk factors); **OR**

V. When the above criteria are not met and for all other indications.

Skyrizi (risankizumab-rzaa)

Initial requests for Skyrizi (risankizumab-rzaa) may be approved for the following:

I. Plaque psoriasis (Ps) when each of the following criteria are met:
   A. Individual is 18 years of age or older with chronic moderate to severe (that is, extensive or disabling) plaque Ps with either of the following (AAD 2019):
      1. Plaque Ps involving greater than three percent (3%) body surface area (BSA); **OR**
      2. Plaque Ps involving less than or equal to three percent (3%) BSA involving sensitive areas or areas that significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia); **AND**
   B. Individual has had an inadequate response to, is intolerant of, or has a contraindication to phototherapy or other systemic therapy (such as acitretin, cyclosporine, or methotrexate); **OR**

II. Psoriatic arthritis (PsA) when each of the following criteria are met:
   A. Individual is 18 years of age or older with moderate to severe PsA; **AND**
   B. Individual has had an inadequate response to, is intolerant of, or has a contraindication to conventional therapy [nonbiologic DMARDs (such as methotrexate, sulfasalazine, cyclosporine or leflunomide)]; **OR**

III. Crohn's Disease (CD) when each of the following criteria are met:
   A. Individual is 18 years of age or older with moderate to severe CD; **AND**
   B. Individual has had an inadequate response to, is intolerant of, or has a contraindication to conventional therapy (such as systemic corticosteroids or immunosuppressants [such as thiopurines or methotrexate]).

Continuation requests for Skyrizi (risankizumab-rzaa) may be approved if the following criterion is met:

I. There is confirmation of clinically significant improvement or stabilization in clinical signs and symptoms of disease.

Requests for Skyrizi (risankizumab-rzaa) may not be approved for the following:

I. In combination with phototherapy; **OR**

II. In combination with topical or oral JAK inhibitors, apremilast, deucravacitinib, ozanimod, or any of the following biologic immunomodulators: TNF antagonists, other IL-23 inhibitors, IL-17 inhibitors, vedolizumab, ustekinumab, abatacept, IL-1

inhibitors, IL-6 inhibitors, rituximab or natalizumab; **OR**

III. Tuberculosis, other active serious infections, or a history of recurrent infections; **OR**

IV. If initiating therapy, individual has not had a tuberculin skin test (TST) or a Centers for Disease Control (CDC-) and Prevention -recommended equivalent to evaluate for latent tuberculosis (unless switching therapy from another targeted immune modulator and no new risk factors); **OR**

V. When the above criteria are not met and for all other indications.

Tremfya (guselkumab)

Initial requests for Tremfya (guselkumab) may be approved for the following:

I. Plaque psoriasis (Ps) when each of the following criteria are met:
   A. Individual is 18 years of age or older with chronic moderate to severe (that is, extensive or disabling) plaque Ps with either of the following (AAD 2019):
      1. Plaque Ps involving greater than three percent (3%) body surface area (BSA); **OR**
      2. Plaque Ps involving less than or equal to three percent (3%) BSA involving sensitive areas or areas that significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia); **AND**
   B. Individual has had an inadequate response to, is intolerant of, or has a contraindication to phototherapy or other systemic therapy (such as acitretin, cyclosporine, or methotrexate);

OR

II. Psoriatic arthritis (PsA) when each of the following criteria are met:
   A. Individual is 18 years of age or older with moderate to severe PsA; **AND**
   B. Individual has had an inadequate response to, is intolerant of, or has a contraindication to conventional therapy [nonbiologic DMARDs (such as methotrexate, sulfasalazine, cyclosporine or leflunomide)].

Continuation requests for Tremfya (guselkumab) may be approved if the following criterion is met:

I. There is confirmation of clinically significant improvement or stabilization in clinical signs and symptoms of disease.

Requests for Tremfya (guselkumab) may not be approved for the following:

I. In combination with phototherapy; **OR**

II. In combination with topical or oral JAK inhibitors, apremilast, deucravacitinib, ozanimod, or any of the following biologic immunomodulators: TNF antagonists, other IL-23 inhibitors, IL-17 inhibitors, vedolizumab, ustekinumab, abatacept, IL-1 inhibitors, IL-6 inhibitors, rituximab or natalizumab; **OR**

III. Tuberculosis, other active serious infections, or a history of recurrent infections; **OR**

IV. If initiating therapy, individual has not had a tuberculin skin test (TST) or a Centers for Disease Control (CDC-) and Prevention -recommended equivalent to evaluate for latent tuberculosis (unless switching therapy

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from another targeted immune modulator and no new risk factors); **OR**

V. When the above criteria are not met and for all other indications.

Limits or Restrictions

A. Step Therapy

This medical policy may be subject to Step Therapy. Please refer to the document published on the MMM Website: https://www.mmm-pr.com/planes-medicos/formulario-medicamentos

B. Quantity Limitations

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines. The chart below includes dosing recommendations as per the FDA-approved prescribing information.

Ilumya (tildrakizumab-asmn) Quantity Limit

Drug	Limit
Ilumya (tildrakizumab-asmn) 100 mg/mL	1 prefilled syringe per 84 days (12 weeks)
Override Criteria	
*Initiation of therapy for Plaque Psoriasis (Ps): May approve up to 1 additional syringe (100 mg/mL) in the first 28 days (4 weeks) of treatment.	

Skyrizi (risankizumab-rzaa) Quantity Limit

Drug	Limit
Skyrizi (risankizumab-rzaa) 75 mg/ 0.83 mL syringe*	2 prefilled syringes [1 carton] per 84 days (12 weeks)
Skyrizi (risankizumab-rzaa) 150 mg/mL syringe/pen*	1 prefilled syringe/pen [1 carton] per 84 days (12 weeks)
Skyrizi (Risankizumab-rzaa) 180 mg/ 1.2 mL prefilled cartridge with on-body injector	1 kit per 56 days (8 weeks)
Skyrizi (Risankizumab-rzaa) 360 mg/ 2.4 mL prefilled cartridge with on-body injector	1 kit per 56 days (8 weeks)
Skyrizi (Risankizumab-rzaa) 600 mg/ 10 mL single-dose vial	3 vials total to last 12 weeks
Override Criteria	
*Initiation of therapy for Plaque Psoriasis (Ps) or Psoriatic Arthritis (PsA): May approve 1 additional carton [two 75 mg syringes or one 150 mg pen/syringe] in the first 28 days (4 weeks) of treatment.	

Tremfya (guselkumab) Quantity Limit

Drug	Limit
Tremfya (guselkumab) 100 mg/mL	1 prefilled syringe/autoinjector per 56 days (8 weeks)
Override Criteria	
*Initiation of therapy for Plaque Psoriasis (Ps) or Psoriatic Arthritis (PsA): May approve up to 1 additional syringe (100 mg/mL) in the first 28 days (4 weeks) of treatment.	

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Reference Information

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3. DrugPoints® System [electronic version]. Truven Health Analytics, Greenwood Village, CO. Updated periodically.
4. Lexi-Comp ONLINE™ with AHFS™, Hudson, Ohio: Lexi-Comp, Inc.; 2022; Updated periodically.
5. Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. *J Am Acad Dermatol*. 2019; 80: 1029-72.
6. Singh JA, Guyatt G, Ogdie A, et al. 2018 American College of Rheumatology/National Psoriasis Foundation Guideline for the Treatment of Psoriatic Arthritis. Arthritis Rheum. 2019; 71(1): 5-32.
7. Feuerstein JD, Ho EY, Shmidt E et al. American Gastroenterological Association Clinical Practice Guidelines on the Medical Management of Moderate to Severe Luminal and Perianal Fistulizing Crohn's Disease. Gastroenterology 2021; 160:2496-2508.
8. Centers for Disease Control and Prevention (CDC). Tuberculosis (TB). Available at: https://www.cdc.gov/tb/topic/basics/risk.htm. Last updated: March 18, 2016. Accessed October 5, 2022.

Policy History

Revision Type	Summary of Changes	P&T Approval Date	MPCC Approval Date
Policy Inception	Elevance Health's Medical Policy adoption.	N/A	11/30/2023

Revised: 11/18/2022