

## **Clinical Policy: Tildrakizumab-asmn (Ilumya)**

Reference Number: CP.PHAR.386

Effective Date: 05.01.18

Last Review Date: 05.22

Line of Business: Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### **Description**

Tildrakizumab-asmn (Ilumya<sup>™</sup>) is an interleukin-23 (IL-23) blocker.

### **FDA Approved Indication(s)**

Ilumya is indicated for the treatment of adult patients with moderate-to-severe plaque psoriasis (PsO) who are candidates for systemic therapy or phototherapy.

### **Policy/Criteria**

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

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that Ilumya is **medically necessary** when the following criteria are met:

#### **I. Initial Approval Criteria**

##### **A. Plaque Psoriasis (must meet all):**

1. Diagnosis of moderate-to-severe PsO as evidenced by involvement of one of the following (a or b):
  - a.  $\geq 3\%$  of total body surface area;
  - b. Hands, feet, scalp, face, or genital area;
2. Prescribed by or in consultation with a dermatologist or rheumatologist;
3. Age  $\geq 18$  years;
4. Member meets one of the following (a, b, or c):
  - a. Failure of a trial of  $\geq 3$  consecutive months of methotrexate (MTX) at up to maximally indicated doses;
  - b. Member has intolerance or contraindication to MTX (*see Appendix D*), and failure of a trial of  $\geq 3$  consecutive months of cyclosporine or acitretin at up to maximally indicated doses, unless clinically significant adverse effects are experienced or both are contraindicated;
  - c. Member has intolerance or contraindication to MTX, cyclosporine, and acitretin, and failure of phototherapy, unless contraindicated or clinically significant adverse effects are experienced;
5. Failure of a  $\geq 3$  consecutive month trial of both of the following, unless clinically significant adverse effects are experienced or all are contraindicated;
  - a. If member has not yet tried Taltz<sup>®</sup>, then failure of Taltz;
  - b. If member has failed Taltz, then failure of Enbrel<sup>®</sup> and Otezla<sup>®</sup>;

*\*Prior authorization may be required for Taltz, Enbrel, and Otezla*

6. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
7. Dose does not exceed 100 mg at weeks 0 and 4, followed by maintenance dose of 100 mg every 12 weeks.

**Approval duration: 6 months**

**B. Other diagnoses/indications**

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid.

**II. Continued Therapy**

**A. Plaque Psoriasis (must meet all):**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
4. If request is for a dose increase, new dose does not exceed 100 mg every 12 weeks.

**Approval duration: 12 months**

**B. Other diagnoses/indications (must meet 1 or 2):**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.  
**Approval duration: Duration of request or 6 months (whichever is less);** or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid.

**III. Diagnoses/Indications for which coverage is NOT authorized:**

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.PMN.53 for Medicaid or evidence of coverage documents;
- B. Combination use with biological disease-modifying antirheumatic drugs (bDMARDs) or potent immunosuppressants, including but not limited to any tumor necrosis factor (TNF) antagonists [e.g., Cimzia<sup>®</sup>, Enbrel<sup>®</sup>, Humira<sup>®</sup>, Simponi<sup>®</sup>, Avsola<sup>™</sup>, Inflectra<sup>™</sup>, Remicade<sup>®</sup>, Renflexis<sup>™</sup>], interleukin agents [e.g., Arcalyst<sup>®</sup> (IL-1 blocker), Ilaris<sup>®</sup> (IL-1 blocker), Kineret<sup>®</sup> (IL-1RA), Actemra<sup>®</sup> (IL-6RA), Kevzara<sup>®</sup> (IL-6RA), Stelara<sup>®</sup> (IL-12/23 inhibitor), Cosentyx<sup>®</sup> (IL-17A inhibitor), Taltz<sup>®</sup> (IL-17A inhibitor), Siliq<sup>™</sup> (IL-17RA), Ilumya<sup>™</sup> (IL-23 inhibitor), Skyrizi<sup>™</sup> (IL-23 inhibitor), Tremfya<sup>®</sup> (IL-23 inhibitor)], Janus kinase inhibitors (JAKi) [e.g., Xeljanz<sup>®</sup>/Xeljanz<sup>®</sup> XR, Cibinqo<sup>™</sup>, Olumiant<sup>™</sup>, Rinvoq<sup>™</sup>], anti-CD20 monoclonal antibodies [Rituxan<sup>®</sup>, Riabni<sup>™</sup>, Ruxience<sup>™</sup>, Truxima<sup>®</sup>, Rituxan Hycela<sup>®</sup>], selective co-stimulation modulators [Orencia<sup>®</sup>], and integrin receptor antagonists [Entyvio<sup>®</sup>] because of the additive

immunosuppression, increased risk of neutropenia, as well as increased risk of serious infections.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

FDA: Food and Drug Administration  
IL-23: interleukin-23  
JAKi: Janus kinase inhibitors

MTX: methotrexate  
PsO: plaque psoriasis

*Appendix B: Therapeutic Alternatives*

*This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.*

<b>Drug Name</b>	<b>Dosing Regimen</b>	<b>Dose Limit/ Maximum Dose</b>
acitretin (Soriatane <sup>®</sup> )	<b>PsO</b> 25 or 50 mg PO daily	50 mg/day
cyclosporine (Sandimmune <sup>®</sup> , Neoral <sup>®</sup> )	<b>PsO</b> 2.5 – 4 mg/kg/day PO divided BID	4 mg/kg/day
methotrexate (Rheumatrex <sup>®</sup> )	<b>PsO</b> 10 – 25 mg/week PO or 2.5 mg PO Q12 hr for 3 doses/week	30 mg/week
Taltz <sup>®</sup> (ixekizumab)	<b>PsO</b> <u>Initial dose:</u> 160 mg (two 80 mg injections) SC at week 0, then 80 mg SC at weeks 2, 4, 6, 8, 10, and 12 <u>Maintenance dose:</u> 80 mg SC every 4 weeks	80 mg every 4 weeks
Enbrel <sup>®</sup> (etanercept)	<b>PsO</b> Adults: <u>Initial dose:</u> 50 mg SC twice weekly for 3 months <u>Maintenance dose:</u> 50 mg SC once weekly  <i>Pediatrics:</i> Weight < 63 kg: 0.8 mg/kg SC once weekly Weight ≥ 63 kg: 50 mg SC once weekly	50 mg/week
Otezla <sup>®</sup> (apremilast)	<b>PsO</b> <u>Initial dose:</u> Day 1: 10 mg PO QAM Day 2: 10 mg PO QAM and 10 mg PO QPM	60 mg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	Day 3: 10 mg PO QAM and 20 mg PO QPM Day 4: 20 mg PO QAM and 20 mg PO QPM Day 5: 20 mg PO QAM and 30 mg PO QPM <u>Maintenance dose:</u> Day 6 and thereafter: 30 mg PO BID	

*Therapeutic alternatives are listed as Brand name<sup>®</sup> (generic) when the drug is available by brand name only and generic (Brand name<sup>®</sup>) when the drug is available by both brand and generic.*

*Appendix C: Contraindications/Boxed Warnings*

- Contraindication(s): Serious hypersensitivity reaction to tildrakizumab or to any of the excipients
- Boxed warning(s): none reported

*Appendix D: General Information*

- Definition of failure of MTX or DMARDs
  - Child-bearing age is not considered a contraindication for use of MTX. Each drug has risks in pregnancy. An educated patient and family planning would allow use of MTX in patients who have no intention of immediate pregnancy.
  - Social use of alcohol is not considered a contraindication for use of MTX. MTX may only be contraindicated if patients choose to drink over 14 units of alcohol per week. However, excessive alcohol drinking can lead to worsening of the condition, so patients who are serious about clinical response to therapy should refrain from excessive alcohol consumption.

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
PsO	<u>Initial dose:</u> 100 mg SC at weeks 0 and 4 <u>Maintenance dose:</u> 100 mg SC every 12 weeks  Ilumya should only be administered by a healthcare professional.	100 mg every 12 weeks

**VI. Product Availability**

Single-dose prefilled syringe: 100 mg/1 mL

**VII. References**

1. Ilumya Prescribing Information. Whitehouse Station, NJ: Merck & Co., Inc.; March 2018. Available at: [https://www.accessdata.fda.gov/drugsatfda\\_docs/label/2018/761067s000lbl.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/761067s000lbl.pdf). Accessed February 18, 2022.
2. 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. doi:10.1016/j.aad.201811.057.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	05.01.18	08.18
2Q 2019 annual review: no significant changes; added HIM-Medical Benefit; references reviewed and updated.	02.26.19	05.19
Removed HIM-Medical Benefit line of business, updated preferred redirections based on SDC recommendation and prior clinical guidance: for PsO, removed redirection to adalimumab and etancercept and added redirection to Taltz.	12.13.19	
2Q 2020 annual review: no significant changes; references reviewed and updated.	03.02.20	05.20
2Q 2021 annual review: added additional criteria related to diagnosis of moderate-to-severe PsO per 2019 AAD/NPF guidelines specifying at least 3% BSA involvement or involvement of areas that severely impact daily function; added combination of bDMARDs under Section III; references reviewed and updated.	02.23.21	05.21
Per August SDC and prior clinical guidance, added step-wise redirection requiring Talt, then Enbrel and Otezla.	08.30.21	11.21
2Q 2022 annual review: for PsO, allowed phototherapy as alternative to systemic conventional DMARD if contraindicated or clinically significant adverse effects are experienced; WCG.CP.PHAR.386 to be retired; reiterated requirement against combination use with a bDMARD or JAKi from Section III to Sections I and II; references reviewed and updated.	02.19.22	05.22

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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**Note:**

**For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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