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## DRUG POLICY

# Ilumya (tildrakizumab-asmn)

### NOTICE

This policy contains information which is clinical in nature. The policy is not medical advice. The information in this policy is used by Wellmark to make determinations whether medical treatment is covered under the terms of a Wellmark member's health benefit plan. Physicians and other health care providers are responsible for medical advice and treatment. If you have specific health care needs, you should consult an appropriate health care professional. If you would like to request an accessible version of this document, please contact customer service at 800-524-9242.

### BENEFIT APPLICATION

Benefit determinations are based on the applicable contract language in effect at the time the services were rendered. Exclusions, limitations or exceptions may apply. Benefits may vary based on contract, and individual member benefits must be verified. Wellmark determines medical necessity only if the benefit exists and no contract exclusions are applicable. This medical policy may not apply to FEP. Benefits are determined by the Federal Employee Program.

### DESCRIPTION

The intent of the Ilumya drug policy is to ensure appropriate selection of patients for therapy based on product labeling, clinical guidelines and clinical studies.

The indications below including FDA-approved indications and compendial uses are considered covered benefits provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

#### FDA-Approved Indication

Treatment of adult patients with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy

### POLICY

#### Required Documentation

Submission of the following information is necessary to initiate the prior authorization review:

- A. Initial requests:
  1. Chart notes or medical record documentation of affected area(s) and body surface area (BSA) affected.
  2. Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.
- B. Continuation requests: Chart notes or medical record documentation of decreased body surface area (BSA) affected and/or improvement in signs and symptoms.

### Criteria for Initial Approval

#### Moderate to severe plaque psoriasis

- A. Authorization of 12 months may be granted for members who have previously received Otezla or a biologic indicated for the treatment of moderate to severe plaque psoriasis.
- B. Authorization of 12 months may be granted for treatment of moderate to severe plaque psoriasis when any of the following criteria are met:
  1. Crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected.
  2. At least 10% of the body surface area (BSA) is affected
  3. At least 3% of body surface area (BSA) is affected and the member meets any of the following criteria:
    - a) Member has had an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine or acitretin.
    - b) Member has a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine and acitretin (see Appendix A).

### Continuation of Therapy

Authorization of 12 months may be granted for all members (including new members) who are using Ilumya for moderate to severe plaque psoriasis and who achieve or maintain a positive clinical response with Ilumya as evidenced by low disease activity or improvement in signs and symptoms of the condition when any of the following is met:

1. Reduction in body surface area (BSA) affected from baseline
2. Improvement in signs and symptoms from baseline (e.g., itching, redness, flaking, scaling, burning, cracking, pain)

### Other

For all indications: Member has had a documented negative TB test (which can include a tuberculosis skin test [PPD], an interferon-release assay [IGRA], or a chest x-ray)\* within 6 months of initiating therapy for persons who are naïve to biologic DMARDs or targeted synthetic DMARDs associated with an increased risk of TB, and repeated yearly for members with risk factors\*\* for TB that are continuing therapy with biologics.

\* If the screening testing for TB is positive, there must be further testing to confirm there is no active disease. Do not administer tildrakizumab-asmn to members with active TB infection. If there is latent disease, TB treatment must be started before initiation of tildrakizumab-asmn.

\*\* Risk factors for TB include: Persons with close contact to people with infectious TB disease; persons who have recently immigrated from areas of the world with high rates of TB (e.g., Africa, Asia, Eastern Europe, Latin America, Russia); children less than 5 years of age who have a positive TB test; groups with high rates of TB transmission (e.g., homeless persons, injection drug users, persons with HIV infection); persons who work or reside with people who are at an increased risk for active TB (e.g., hospitals, long-term care facilities, correctional facilities, homeless shelters).

For all indications: Member cannot use Ilumya concomitantly with any other biologic DMARD or targeted synthetic DMARD.

Ilumya is considered **not medically necessary** for members who do not meet the criteria set forth above.

### Dosage and Administration

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

### Appendix

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## Appendix A: Examples of Clinical Reasons to Avoid Pharmacologic Treatment with Methotrexate, Cyclosporine or Acitretin

1. Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease
2. Breastfeeding
3. Drug interaction
4. Cannot be used due to risk of treatment-related toxicity
5. Pregnancy or currently planning pregnancy
6. Significant comorbidity prohibits use of systemic agents (examples include liver or kidney disease, blood dyscrasias, uncontrolled hypertension)

### PROCEDURES AND BILLING CODES

To report provider services, use appropriate CPT\* codes, Alpha Numeric (HCPCS level 2) codes, Revenue codes, and/or ICD diagnostic codes.

- J3245 – Injection, tildrakizumab, 1 mg

### REFERENCES

- Ilumya [package insert]. Whitehouse Station, NJ: Merck & Co., Inc.; July 2020.
- Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Section 4: Guidelines of care for the management and treatment of psoriasis with traditional systemic agents. J Am Acad Dermatol. 2009;61:451-485.
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- 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(4):1029-1072.
- Tuberculosis (TB). TB risk factors. Centers for Disease Control and Prevention. Retrieved on 16 November 2020 from: <https://www.cdc.gov/tb/topic/basics/risk.htm>.

\*Some content reprinted from CVSHealth

### POLICY HISTORY

**Policy #:** 05.02.50

**Reviewed:** April 2021

**Revised:** April 2021

**Current Effective Date:** June 7, 2021