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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 while steering utilization to the most cost-effective medication within the therapeutic class. For this program, Humira, Enbrel, Cosentyx, Otezla and Stelara are the preferred products. The criteria will require the use of two of the health plan's preferred products before the use of non-preferred products unless there are clinical circumstances that exclude the use of all the preferred products, or the patient is currently receiving treatment with the non-preferred drug and experience a positive therapeutic outcome.

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

Must meet BOTH the Preferred Drug Plan Design and Criteria for Initial Approval/Continuation of Therapy when both are applicable.

Preferred Drug Plan Design

A) Moderate to severe plaque psoriasis

1. Criteria for initial approval on moderate to severe plaque psoriasis will only apply when at least ONE of the following criteria are met:

- a) Member has had an inadequate response to treatment or intolerable adverse event with at least TWO of the preferred products (Humira, Enbrel, Cosentyx, Otezla and Stelara)
- b) Member has a clinical reason to avoid Enbrel and Humira (See Appendix A) AND has had an inadequate response to treatment or intolerable adverse event with at least TWO of the preferred products (Cosentyx, Otezla and Stelara)
- c) Member is currently receiving treatment with the requested product through insurance (excludes obtainment as samples or via manufacturer's patient assistance programs) and experiencing a positive therapeutic outcome

Note: Submission of chart notes detailing the outcomes of treatment, intolerable adverse event(s) experienced, contraindication(s), or exclusion(s) to treatment with preferred product(s) is required (where applicable).

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 all of the following criteria are met:
 - 1. At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected.
 - 2. 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 B).
 - c) Member has severe psoriasis that warrants a biologic DMARD as first-line therapy (i.e. at least 10% of the body surface area (BSA) or crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected).

Continuation of Therapy

Authorization of 12 months may be granted for all members (including new members) who are using Ilumya for an indication outlined in the initial authorization criteria and who achieve or maintain positive clinical response with Ilumya as evidenced by low disease activity or improvement in signs and symptoms of the condition.

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 (e.g., Xeljanz), 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 documentation of 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.

Quantity Limits

Trade Name	Generic Name	Quantity Limit
Ilumya®	tildrakizumab	Initiation of therapy: 2 syringes per first 28 days (4 weeks); Maintenance: 1 syringe per 84 days (12 weeks)

Appendix

Appendix A: Clinical reasons to avoid TNF-inhibitors

1. History of demyelinating disorder
2. History of congestive heart failure
3. History of hepatitis B infection
4. Autoantibody formation/lupus-like syndrome
5. Risk of lymphoma

Note: Primary failure to respond to a TNF-inhibitor does not preclude successful response to a different TNF-inhibitor per 2019 AAD-NPF guidelines and therefore is not consider a clinical reason to avoid TNF-inhibitors.

Appendix B: 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. Cannot be used due to risk of treatment-related toxicity
4. Drug interaction
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.

- N/A

REFERENCES

- Ilumya [package insert]. Whitehouse Station, NJ: Merck & Co., Inc.; October 2019.
- 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.
- Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Section 6: Guidelines of care for the treatment of psoriasis and psoriatic arthritis: case-based presentations and evidence-based conclusions. J Am Acad Dermatol. 2011;65(1):137-174.

- 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 21 June 2019 from: <https://www.cdc.gov/tb/topic/basics/risk.htm>.

*Some content reprinted from CVSHealth

POLICY HISTORY

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