Ilumya (tildrakizumab-asbn)
Effective January 1, 2020

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<tr>
<th>Plan</th>
<th>☐ MassHealth</th>
<th>☒ Commercial/Exchange</th>
<th>Program Type</th>
<th>☒ Prior Authorization</th>
<th>☒ Quantity Limit</th>
<th>☐ Step Therapy</th>
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<tbody>
<tr>
<td>Benefit</td>
<td>☒ Pharmacy Benefit</td>
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<td>Specialty Limitations</td>
<td>This medication has been designated specialty and must be filled through a contracted specialty pharmacy.</td>
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### Overview
The indications below including FDA-approved indications and compendial uses are considered a covered benefit 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

All other indications are considered experimental/investigational and are not a covered benefit.

### Coverage Guidelines

**Moderate to severe plaque psoriasis (PsO)**
Authorization may be granted for members new to AllWays Health Partners who are currently receiving treatment with Ilumya, excluding when the product is obtained as samples or via manufacturer’s patient assistance programs.

**OR**
Authorization may be granted when all the following criteria are met:
1. The member has a diagnosis of moderate to severe plaque psoriasis
2. At least 5% of body surface area (BSA) is affected OR crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected.
3. Member meets ONE of the following criteria:
   a. Member has experienced an inadequate response or adverse reaction to TWO conventional therapies in any one of the following combinations:
i. 1 topical agent + 1 systemic agent (methotrexate, acitretin or cyclosporine)
ii. 1 topical agent + 1 phototherapy (e.g., UVB, PUVA)
iii. 1 systemic agent + 1 phototherapy (e.g., UVB, PUVA)
iv. 2 systemic agents

b. Member has a clinical reason to avoid ALL conventional therapies (topical agents, phototherapy and systemic agents). (See Appendix C)
c. Member has severe psoriasis that warrants a biologic DMARD as first-line therapy.

**Continuation of Therapy**
Authorization may be granted for all members (including new members) who meet all initial authorization criteria and achieve or maintain positive clinical response after at least 4 months of therapy with Ilumya as evidenced by low disease activity or improvement in signs and symptoms of the condition.

**Limitations**
Initial approvals and reauthorizations will be granted for 24 months

**Appendices**

**Appendix A: Examples of Clinical Reasons to Avoid Pharmacologic Treatment with Methotrexate, Cyclosporine or Acitretin**
1. Alcoholism, 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 planning pregnancy (male or female)

Significant comorbidity prohibits use of systemic agents (examples include liver or kidney disease, blood dyscrasias, uncontrolled hypertension)

**References**
1. Ilumya (tildrakizumab-asmn) [prescribing information]. Whitehouse Station, NJ: Merck & Co Inc; August 2018.

**Review History**
06/19/19 – Reviewed
11/20/19 - Added Skyrizi as required preferred product
10/31/2020 – Reviewed; Updated criteria to have preferred agent as Remicade for Comm/Exch strategy for implementation on 1/1/21

Disclaimer
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