

**Ilumya (tildrakizumab-asmn)  
Effective January 1, 2021**

<b>Plan</b>	<input type="checkbox"/> MassHealth <input checked="" type="checkbox"/> MassHealth (PUF) <input type="checkbox"/> Commercial/Exchange	<b>Program Type</b>	<input checked="" type="checkbox"/> Prior Authorization <input checked="" type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
<b>Benefit</b>	<input type="checkbox"/> Pharmacy Benefit <input checked="" type="checkbox"/> Medical Benefit (NLX)		
<b>Specialty Limitations</b>	N/A		
<b>Contact Information</b>	<b>Specialty Medications</b>		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	<b>Non-Specialty Medications</b>		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	<b>Medical Specialty Medications (NLX)</b>		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
<b>Exceptions</b>	N/A		

### Overview

Ilumya (tildrakizumab-asmn) is an Interleukin-23 blocker indicated for:

- Treatment of moderate-to-severe plaque psoriasis

### Coverage Guidelines

Authorization may be reviewed on a case by case basis 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 if the member meets ALL following criteria and documentation has been submitted:

#### Moderate to Severe Plaque Psoriasis

Prescriber provides documentation of **ALL** of the following:

1. Appropriate diagnosis
2. **ONE** of the following:
  - a. Paid claims or physician documented inadequate response or adverse reaction to **ONE** conventional therapy (see appendix A)
    - i. topical agent
    - ii. phototherapy
    - iii. systemic agent
  - b. Contraindication to **ALL** conventional therapies:
    - i. topical agents
    - ii. phototherapy



- iii. systemic agents
  - c. Paid claims or physician documented inadequate response or adverse reaction to **ONE** biologic DMARD that is FDA-approved for plaque psoriasis
3. Appropriate dosing

**Continuation of Therapy**

Reauthorization requires physician documentation of continuation of therapy, positive response to therapy, FDA approved indication and appropriate dosing.

**Limitations**

1. Initial approvals will be granted for: 3 months.
2. Reauthorizations will be granted for 12 months
3. The following quantity limits apply:

Ilumya 100mg/mL	1 injections per 84 days
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**Appendix A. Conventional Therapies for Plaque Psoriasis**

Conventional Treatment Lines	Agents Used
Topical Agents	emollients, keratolytics, corticosteroids, coal tar, anthralin, calcipotriene, tazarotene, calcitriol, calcineurin inhibitors
Systemic Agents	Traditional DMARDs: methotrexate, apremilast, acitretin,
Phototherapy	ultraviolet A and topical psoralens (topical PUVA), ultraviolet A and oral psoralens (systemic PUVA), narrow band UV-B (NUVB)

**References**

1. Ilumya (tildrakizumab-asmn) [prescribing information]. Whitehouse Station, NJ: Merck & Co Inc; August 2018.
2. Menter A, Tyring SK, Gordon K, et al. Adalimumab therapy for moderate to severe psoriasis: A randomized, controlled phase III trial. *J Am Acad Dermatol* 2008; 58:106
3. Menting SP, Coussens E, Pouw MF, et al. Developing a Therapeutic Range of Adalimumab Serum Concentrations in Management of Psoriasis: A Step Toward Personalized Treatment. *JAMA Dermatol* 2015; 151:616
4. Bagel J, Lynde C, Tyring S, et al. Moderate to severe plaque psoriasis with scalp involvement: a randomized, double-blind, placebo-controlled study of etanercept. *J Am Acad Dermatol* 2012; 67:86
5. Nast A, Spuls PI, van der Kraaij G, et al. European S3-Guideline on the systemic treatment of psoriasis vulgaris - Update Apremilast and Secukinumab - EDF in cooperation with EADV and IPC. *J Eur Acad Dermatol Venereol* 2017; 31:1951
6. Nast A, Spuls PI, van der Kraaij G, et al. European S3-Guideline on the systemic treatment of psoriasis vulgaris - Update Apremilast and Secukinumab - EDF in cooperation with EADV and IPC. *J Eur Acad Dermatol Venereol* 2017; 31:1951

**Review History**

06/19/19 – Reviewed  
 11/20/19 - Added Skyrizi as required preferred product  
 10/21/2020 – Reviewed and Updated; separated out Comm/Exch vs. MassHealth. Matched MassHealth Preferred Unified Formulary for implementation 1/1/2021



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