Skyrizi (risankizumab-rzaa)
Effective January 1, 2020

Plan	☐ MassHealth ☒Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit (NLX)		
Specialty Limitations	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	**Specialty Medications**		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	Non-Specialty Medications		
	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
	Medical Specialty Medications (NLX)		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
Exceptions	N/A		

Overview

Skyrizi is an interleukin (IL)-23 antagonist. Inhibiting the interaction with the IL-23 receptor results in the inhibition of the of the release of proinflammatory cytokines and chemokines. .

Coverage Guidelines

1. Authorization may be granted for members who are currently receiving treatment with Skyrizi excluding when the product is obtained as samples or via manufacturer's patient assistance program

OR

2. Authorization may be granted for members who meet all the following criteria and documentation has been submitted:
   a. The member is at least 18 years of age
   b. The member has diagnosis of moderate to severe plaque psoriasis
   c. The member has at least 5% of body surface area (BSA) affected OR crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected
   d. The member has had an inadequate response or intolerance to TWO conventional therapies in any of the following combinations:
      - 1 topical agent + 1 systemic agent (methotrexate, cyclosporine or acitretin)
      - 1 topical agent + phototherapy
      - 1 systemic agent + phototherapy
      - 2 systemic agents

OR

3. The member has a clinical reason to avoid ALL conventional therapies. *(*See Appendix A*)*

Continuation of Therapy

Reauthorization approvals will be granted when documentation has been submitted supporting clinical improvement in member's condition

Limitations

1. Initial approvals will be granted for 24 months
2. Reauthorizations will be granted for 24 months
3. The following quantity limits apply:

Skyrizi 75mg	One loading dose: 150mg at weeks 0 and 4 Maintenance dose: 150mg every 12 weeks

Appendix

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. Drug interaction
4. Cannot be used due to risk of treatment-related toxicity
5. Pregnancy or planning pregnancy (male or female)
6. Significant comorbidity prohibits use of systemic agents (examples include liver or kidney disease, blood dyscrasias, uncontrolled hypertension)

References

1. Skyrizi (risankizumab-rzaa) [prescribing information]. North Chicago, IL: AbbVie Inc; August 2019.
2. Flytström I, Stenberg B, Svensson A, Bergbrant IM. Methotrexate vs. ciclosporin in psoriasis: effectiveness, quality of life and safety. A randomized controlled trial. Br J Dermatol 2008; 158:116.
3. Lebwohl M, Drake L, Menter A, et al. Consensus conference: acitretin in combination with UVB or PUVA in the treatment of psoriasis. J Am Acad Dermatol 2001; 45:544
4. Chen X, Yang M, Cheng Y, et al. Narrow-band ultraviolet B phototherapy versus broad-band ultraviolet B or psoralen-ultraviolet A photochemotherapy for psoriasis. Cochrane Database Syst Rev 2013; :CD009481
5. Krueger JG, Ferris LK, Menter A, et al. Anti-IL-23A mAb BI 655066 for treatment of moderate-to-severe psoriasis: Safety, efficacy, pharmacokinetics, and biomarker results of a single-rising-dose, randomized, double-blind, placebo-controlled trial. J Allergy Clin Immunol 2015; 136:116

Review History

11/20/19 – Reviewed at P&T

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