# Skyrizi (risankizumab-rzaa)
# Effective 01/01/2022

| | | | |
|---|---|---|---|
| **Plan** | ☐ MassHealth<br>☒ MassHealth (PUF)<br>☐Commercial/Exchange | **Program Type** | ☒ Prior Authorization<br>☒ Quantity Limit<br>☐ Step Therapy |
| **Benefit** | ☒ Pharmacy Benefit<br>☐ 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
Authorization may be reviewed on a case by case basis for members new to AllWays Health Partners who are currently receiving treatment with Skyrizi excluding when the product is obtained as samples or via manufacturer's patient assistance programs.
**OR**
Authorization may be granted for members when ALL the following criteria are met, and documentation is provided:

Moderate to severe Plaque Psoriasis (PsO)
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
4. Prescriber provides clinical rationale for use of Skyrizi instead of Stelara®

**Continuation of Therapy**

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

## Limitations

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

| | |
|---|---|
| Skyrizi 75mg | One loading dose: 150mg at weeks 0 and 4<br>Maintenance dose: 150mg (2 syringes) every 12 weeks |

## Appendix

**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. 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

03/18/2020 – Reviewed at P&T (effective 6/1/20)

10/21/2020 – Reviewed and Updated; separated out Comm/Exch vs. MassHealth. Matched MassHealth Preferred Unified Formulary for implementation 1/1/2021

11/1/2021 – Reviewed and Updated for Nov P&T; Guideline updated to reflect multiple criteria changes and appendices changes based on clinical literature. Effective 01/01/2022

## Disclaimer

AllWays Health Partners complies with applicable federal civil rights laws and does not discriminate or exclude people on the basis of race, color, national origin, age, disability, or sex.