Taltz® (ixekizumab)  
**Effective 01/01/2022**

<table>
<thead>
<tr>
<th>Plan</th>
<th>☐ MassHealth</th>
<th>☒ MassHealth (PUF)</th>
<th>☐ Commercial/Exchange</th>
<th>Program Type</th>
<th>☒ Prior Authorization</th>
<th>☒ Quantity Limit</th>
<th>☐ Step Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit</td>
<td>☒ Pharmacy Benefit</td>
<td>☐ Medical Benefit (NLX)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty Limitations</td>
<td>This medication has been designated specialty and must be filled at a contracted specialty pharmacy.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Specialty Medications

<table>
<thead>
<tr>
<th>Plan</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Plans</td>
<td>Phone: 866-814-5506</td>
</tr>
</tbody>
</table>

### Non-Specialty Medications

<table>
<thead>
<tr>
<th>Plan</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>MassHealth</td>
<td>Phone: 877-433-7643</td>
</tr>
<tr>
<td>Commercial</td>
<td>Phone: 800-294-5979</td>
</tr>
<tr>
<td>Exchange</td>
<td>Phone: 855-582-2022</td>
</tr>
</tbody>
</table>

### Medical Specialty Medications (NLX)

<table>
<thead>
<tr>
<th>Plan</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Plans</td>
<td>Phone: 844-345-2803</td>
</tr>
</tbody>
</table>

### Exceptions

N/A

---

**Overview**

Taltz® (ixekizumab) is a humanized interleukin-17A antagonist indicated for the treatment of:
- Moderate-to-severe plaque psoriasis (PsO)
- Active psoriatic arthritis (PsA)
- Active ankylosing spondylitis (AS)
- Non-radiographic axial spondyloarthritis

**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 Taltz 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**

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 B)
      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. Prescriber provides clinical rationale for use of the requested agent instead of Stelara
4. Appropriate dosing

**Psoriatic Arthritis (PsA)**
Prescriber provides documentation of **ALL** of the following:
1. Appropriate diagnosis
2. **BOTH** of the following:
   a. Paid claims or physician documented inadequate response, adverse reaction, or contraindication to Stelara
   b. **ONE** of the following:
      i. Paid claims or physician documented inadequate response or adverse reaction to **ONE** anti-TNF agent that is FDA-approved for the requested indication
      ii. Contraindication to **ALL** anti-TNF agents that are FDA-approved for the requested indication
3. Appropriate dosing

NOTE: Requests for Taltz® in non-radiographic axial spondylarthritis may be approved if all criteria are met.

**Ankylosing spondylitis (AS) and Non-radiographic axial spondyloarthritis**
Prescriber provides documentation of **ALL** of the following:
1. Appropriate diagnosis
2. Paid claims or physician documented inadequate response or adverse reaction to **TWO** NSAIDs or contraindication to **ALL** NSAIDs
3. **ONE** of the following:
   a. Paid claims or physician documented inadequate response or adverse reaction to **ONE** anti-TNF agent that is FDA-approved for the requested indication
   b. Contraindication to **ALL** anti-TNF agents that are FDA-approved for the requested indication
4. Appropriate dosing (see appendix A)

**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:
   a. Plaque Psoriasis: 3 months.
   b. All other diagnosis: 6 months.
2. Reauthorizations will be granted for 12 months
3. The following quantity limits apply:

| Taltz Inj 80mg/mL | 80mg (1mL) per 28 days |

399 Revolution Drive, Suite 810, Somerville, MA 02145 | allwayshealthpartners.org

AllWays Health Partners includes AllWays Health Partners, Inc. and AllWays Health Partners Insurance Company
Appendices

Appendix A: Dosing

<table>
<thead>
<tr>
<th>Taltz® (ixekizumab)</th>
<th>Plaque Psoriasis:</th>
</tr>
</thead>
<tbody>
<tr>
<td>SQ: 160 mg initially at week 0, followed by 80 mg at weeks 2, 4, 6, 8, 10 and 12; followed by 80 mg every four weeks</td>
<td></td>
</tr>
</tbody>
</table>

Psoriatic Arthritis and Ankylosing Spondylitis:

SQ: 160 mg initially at week 0, followed by 80 mg every 4 weeks.

For psoriatic arthritis patients with coexistent moderate-to-severe plaque psoriasis, use the dosing regimen for plaque psoriasis

---

Appendix B. Conventional Therapies for Plaque Psoriasis

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

Appendix C: Off-Label Indications

More Frequent/High Doses

Requests for more frequent or higher doses of injectable biologics may be approved if ALL of the following is provided:

1. Documentation of severe disease
2. ONE of the following:
   a. Paid claims or physician documented inadequate response or adverse reaction to ONE other injectable biologic which is FDA-approved for the requested indication
   b. Contraindication to ALL other injectable biologics which are FDA-approved for the requested indication
3. Documented partial response to FDA-approved dosing of current biologic therapy
4. Documentation of specialist consult for the requested indication

References

1. Taltz (ixekizumab) [prescribing information]. Indianapolis, IN: Eli Lilly and Co; May 2018

Review History
11/28/16 – Reviewed
02/27/17 – Adopted SGM & ST
03/20/17 – Effective
03/01/18 – Adopted MH RS
02/20/19 – Reviewed in P&T Meeting
4/15/20 – MH unified drug list to prefer Taltz; change previous use of ONE biologic DMARD to inadequate response to Enbrel OR Humira; added indication of ankylosing spondylitis; updated age requirement of plaque psoriasis to > 6 years. Change effective 6/22/20.
11/17/2021 – Reviewed and Updated for Nov P&T; matched MH UPPL; updated to reflect criteria changes based on literature; added appendix with higher dose/more frequent dosing
11/17/2021 – Updated per MH UPPL: criteria for Taltz revised for psoriatic arthritis, ankylosing spondylitis and non-radiographic axial spondyloarthritis based on contract. Additionally, recertification criteria regarding Cosentyx requests approved for ankylosing spondylitis or non-radiographic axial spondyloarthritis prior to Taltz require was removed as this is no longer a requirement in the criteria. 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.