Mass General Brigham
Health Plan

# Ilumya (tildrakizumab-asmn)
# Effective 01/01/2024

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| **Plan** | ☐ MassHealth UPPL<br>☒Commercial/Exchange | **Program Type** | ☒ Prior Authorization<br>☒ Quantity Limit<br>☐ Step Therapy |
| **Benefit** | ☒ Pharmacy Benefit<br>☒ Medical Benefit | | |
| **Specialty Limitations** | This medication has been designated specialty and must be filled at a contracted specialty pharmacy. | | |
| **Contact Information** | **Medical and Specialty Medications**<br>All Plans \| Phone: 877-519-1908 \| Fax: 855-540-3693 | | |
| | **Non-Specialty Medications**<br>All Plans \| Phone: 800-711-4555 \| Fax: 844-403-1029 | | |
| **Exceptions** | N/A | | |

**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 the plan 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 3% 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. Paid claims or physician documentation confirming minimum duration of 4-week trial and failure, intolerance, or contraindication to ONE of the following topical therapies
        i. Corticosteroids (e.g., betamethasone, clobetasol)
        ii. Vitamin D analogs (e.g., calcitriol, calcipotriene)
        iii. Tazarotene
        iv. Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

v. Anthralin
vi. Coal tar

b. Member has severe psoriasis that warrants a biologic DMARD as first-line therapy.

4. Trial and failure, intolerance, or contraindication to THREE of the following:
   i. Cimzia
   ii. Enbrel
   iii. Humira, Hadlima, Adalimumab-adaz, Adalimumab-fkjp
   iv. Skyrizi
   v. Stelara
   vi. Tremfya
5. Trial and failure, intolerance, or contraindication to Cosentyx

**Continuation of Therapy**

Authorization may be granted for members who 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

**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
10/31/2020 – Reviewed; Updated criteria to have preferred agent as Remicade for Comm/Exch strategy for implementation on 1/1/21.
05/10/2023 – Reviewed and Updated for May P&T; added pharmacy benefit preferred products. Effective 7/1/23
11/15/2023 – Reviewed and Updated for Nov P&T; Removed Appendix. Updated 5% BSA to at least 3%. Updated preferred agents to having prior use with 3 of the following agents: Cimzia, Enbrel, Humira or biosimilars, Skyrizi, Stelara, Tremfya AND Cosentyx. Effective 1/1/2024