

Ilumya (tildrakizumab-asmn)
Effective 07/01/2025

Plan	<input type="checkbox"/> MassHealth UPPL <input checked="" type="checkbox"/> Commercial/Exchange	Program Type	<input checked="" type="checkbox"/> Prior Authorization <input checked="" type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
Benefit	<input checked="" type="checkbox"/> Pharmacy Benefit <input checked="" type="checkbox"/> 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		
	All Plans	Phone: 877-519-1908	Fax: 855-540-3693
Contact Information	Non-Specialty Medications		
	All Plans	Phone: 800-711-4555	Fax: 844-403-1029
Exceptions	N/A		

Overview

Ilumya (tildrakizumab-asmn) is an interleukin-23 antagonist indicated for the treatment of adults with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy.

Coverage Guidelines

Authorization may be granted for members new to the plan within the past 90 days who are currently receiving treatment with the requested medication, excluding when the product is obtained as samples or via manufacturer's patient assistance program

OR

Authorization may be granted if the member meets all the following diagnosis-specific criteria:

Moderate to severe plaque psoriasis (PsO)

1. 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. 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 (Abbvie), Hadlima, Adalimumab-adaz, Adalimumab-fkjp, Amjevita (Nuvaila)
- iv. Otezla
- v. Skyrizi
- vi. Stelara, Wezlana
- vii. Taltz
- viii. Tremfya

5. Trial and failure, intolerance, or contraindication to Bimzelx

Continuation of Therapy

Requests for reauthorization will be approved when the following criteria are met:

1. Documentation is submitted supporting improvement in member's condition as evidenced by low disease activity or improvement in signs and symptoms of the condition.

Limitations

1. Initial approvals and reauthorizations will be granted for 24 months
2. The following quantity limitations apply:

Drug Name and Dosage Form	Quantity Limit
Ilumya prefilled syringe	1 injection per 84 days

References

1. Bagel J, Lynde C, Tying 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
2. Ilumya (tildrakizumab-asmn) [prescribing information]. Cranbury, NJ: Sun Pharmaceutical Industries, Inc; April 2024.
3. Menter A, Tying 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
4. 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
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

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

10/09/2024 – Reviewed and updated for October P&T. Added Amjevita (Nuvaila) as a preferred adalimumab product. Added Otezla and Wezlana as step therapy options. Removed step requirement with Cosentyx and replaced and Taltz. Updated reauthorization criteria to require documentation of a positive response. Effective 1/1/2025.



04/09/2025 – Reviewed and updated for April P&T. Updated biologic step requirements to include Taltz as a preferred step option and require step through with Bimzelx. Effective 07/01/2025.

