Mass General Brigham
Health Plan

Siliq (brodalumab)
Effective 01/01/2024

Plan	☐ MassHealth UPPL ☒Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ 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 **Non-Specialty Medications** 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 moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy or phototherapy and have failed to respond or have lost response to other systemic therapies

All other indications are considered experimental/investigational and are not a covered benefit.

Coverage Guidelines

Moderate to severe plaque psoriasis

1. Authorization may be granted for members who are currently receiving treatment with Siliq, excluding when the product is obtained as samples or via manufacturer's patient assistance programs.
   OR
2. Authorization may be granted for treatment of moderate to severe plaque psoriasis when all the following criteria are met:
   a. 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.
   b. Member meets ONE of the following criteria:
      i. Paid claims or physician documentation confirming minimum duration of 4-week trial and failure, intolerance, or contraindication to ONE of the following topical therapies
         - Corticosteroids (e.g., betamethasone, clobetasol)
         - Vitamin D analogs (e.g., calcitriol, calcipotriene)
         - Tazarotene
         - Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

- Anthralin
- Coal tar

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

c. 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
d. Trial and failure, intolerance, or contraindication to Cosentyx

Continuation of Therapy

Reauthorization may be granted for all members (including new members) who meet all initial authorization criteria and achieve or maintain positive clinical response after at least 3 months of therapy with Siliq 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

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. Cannot be used due to risk of treatment-related toxicity
4. Drug interaction
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. Siliq Prescribing Information. Valeant Pharmaceuticals Int. Bridgewater, NJ. April 2020.
2. Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. J Am Acad Dermatol 2019;80:1029-72.
3. Elmets CA, Korman NJ, Farley Prater E, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with topical therapy and alternative medicine modalities for psoriasis severity measures. J Am Acad Dermatol 2021;84:432-70.

Review History

02/26/18 – Reviewed
06/01/18 - Implemented
02/20/19 – Updated
11/20/19 – Added Skyrizi as a preferred trial for PS.
11/15/2023 – Reviewed and Updated at Nov P&T; 5% BSA changed to at least 3%. Removed TB requirement. Updated preferred agents from having prior use with ALL the preferred products (Cosentyx, Enbrel, Humira, Otezla, Skyrizi and Stelara) to having prior use with 3 of the following agents: Cimzia, Enbrel, Humira or biosimilars, Skyrizi, Stelara, Tremfya AND Cosentyx. Updated topical therapies. Effective 1/1/2024