Mass General Brigham
Health Plan

Ilumya (tildrakizumab-asmn)
Effective 01/01/2027

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 Benefit** **Pharmacy Benefit**	Phone: 833-895-2611 Phone: 800-711-4555	Fax: 888-656-6671 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
If member is new to the plan (as evidenced by coverage effective date of less than or equal to 90 days), submission of medical records documenting that the member is currently receiving treatment with the requested drug, excluding when the product is obtained as samples or via manufacturer's patient assistance programs
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 or targeted synthetic therapy as first-line therapy.
4. Trial and failure, intolerance, or contraindication to FOUR of the following:
        i. Cimzia
        ii. Bimzelx
        iii. Enbrel

iv. Adalimumab-aaty, adalimumab-adaz, or Hadlima
v. Icotyde
vi. Otezla or Otezla XR
vii. Skyrizi
viii. Selarsdi, Steqeyma, or Yesintek
ix. Taltz
x. Tremfya

Continuation of Therapy

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

1. Submission of medical records (e.g. chart notes) demonstrating improvement in the 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 limit for maintenance dosing applies:

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

References

1. 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
2. Ilumya (tildrakizumab-asmn) [prescribing information].Cranbury, NJ: Sun Pharmaceutical Industries, Inc; April 2024.
3. 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
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.
06/11/2025 – Reviewed and updated for June P&T. Updated previous trial options for plaque psoriasis to include Sotyktu. Effective 09/01/2025.
09/10/2025 – Reviewed and updated at September P&T. Added Yesintek as an Ustekinumab trial option. Effective 10/15/2025.
10/08/2025 – Reviewed and updated at October P&T. Updated policy to reflect that Selarsdi, Steqeyma and Yesintek are the preferred Ustekinumab trial options. Updated policy to reflect that Humira, Hadlima, Simlandi and Yuflyma are the preferred adalimumab trial options. Updated policy to reflect that policy only applies to the pharmacy benefit. Effective 01/01/2026.
01/14/2026 – Reviewed and updated at January P&T. Updated criteria for plaque psoriasis to include Otezla XR as a previous trial option. Effective 02/01/2026.
03/11/2026 – Reviewed and updated for March P&T. Administrative update - changing verbiage in reauthorization criteria from “documentation is submitted” to “submission of medical records (e.g., chart notes…” and updating language for members who are new to the Plan. Effective 05/01/2026.
04/15/2026 - Updated previous trial language for plaque psoriasis, allowing for bypassing conventional therapy if member has severe psoriasis that warrants a biologic DMARD or targeted synthetic therapy as first-line therapy. Effective 08/16/2026.
09/09/2026 – Reviewed and updated at September P&T. Updated previous trial requirements to remove Bimzelx as a stand alone requirement, instead adding it as an option among all other biologics. Removing Sotyktu as a previous trial option. Adding Icotyde as a previous trial option. Updating the preferred adalimumab products in the criteria to adalimumab-aaty, adalimumab-adaz and Hadlima. Members must have a trial and failure of four biologics. Effective 01/01/2027.