Mass General Brigham
Health Plan

Siliq (brodalumab)
Effective 05/01/2026

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
Siliq (brodalumab) is a human interleukin-17 receptor A (IL-17RA) antagonist indicated for the 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.

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 when all the following criteria have been met:

Moderate to severe plaque psoriasis
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 TWO of the following:
    a. Cimzia
    b. Enbrel
    c. Humira (Abbvie), Hadlima, Simlandi, Yuflyma

d. Otezla/Otezla XR
e. Skyrizi
f. Sotyktu
g. Selarsdi, Steqeyma, Yesintek
h. Tremfya

5. Trial and failure, intolerance, or contraindication to BOTH of the following:
    a. Taltz
    b. Bimzelx

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 an improvement in the member's clinical 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 limits apply:

Drug Name and Dosage Form	Quantity Limit
Siliq prefilled syringe	2 syringes per 28 days

References

1. 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.
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. Siliq (brodalumab) [prescribing information]. Bridgewater, NJ: Bausch Health US, LLC; August 2024.

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
10/09/2024 – Reviewed and updated for October P&T. Updated criteria for conventional therapies to remove submission of documentation requirement. Added Amjevita (Nuvaila) as a preferred adalimumab product. Updated biologic step options to include Otezla and Wezlana. Removed Cosentyx step through requirement and replaced with Taltz. Updated reauthorization criteria to require documentation of improvement. Removed appendix from policy. Effective 1/1/2025.
04/09/2025 – Reviewed and updated for April P&T. Updated criteria for plaque psoriasis to require step through with two preferred immunomodulators AND Taltz AND Bimzelx. Added quantity limit to the Limitations section of the policy. Effective 07/01/2025.
06/11/2025 – Reviewed and updated for June P&T. Updated criteria for plaque psoriasis to include Sotyktu as a previous trial option. 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. 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.