Mass General Brigham
Health Plan

# Skyrizi (risankizumab-rzaa)
# Effective 10/18/2026

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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 Benefit**<br>**Pharmacy Benefit** | Phone: 833-895-2611<br>Phone: 800-711-4555 | Fax: 888-656-6671<br>Fax: 844-403-1029 |
| **Exceptions** | N/A | | |

**Overview**

Skyrizi is an interleukin (IL)-23 antagonist indicated for the treatment of:

- Moderate-to-severe plaque psoriasis in adults and pediatric patients 6 years of age and older who are candidates for systemic therapy or phototherapy
- Active psoriatic arthritis in adults and pediatric patients 6 years of age and older
- Moderately to severely active Crohn's disease in adults
- Moderately to severely active ulcerative colitis in adults

**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 of the following diagnosis-specific criteria have been met:

**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. ONE of the following:
    a. Minimum duration of 4-week trial and failure, contraindication, or intolerance 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.

**Psoriatic arthritis (PsA)**

1. Diagnosis of active psoriatic arthritis
2. ONE of the following:
    a. Actively inflamed joints
    b. Dactylitis
    c. Enthesitis
    d. Axial disease
    e. Active skin and/or nail involvement

**Crohn's disease (CD)**

**IV:**

1. Diagnosis of moderately to severely active Crohn's disease
2. ONE of the following:
    a. Trial and failure, contraindication, or intolerance to ONE of the following conventional therapies:
        i. 6-mercaptopurine
        ii. Azathioprine
        iii. Corticosteroids (e.g., prednisone)
        iv. Methotrexate
    b. Disease severity warrants systemic biologic or targeted synthetic therapy as first-line therapy
3. Will be administered as an intravenous induction dose

**SC:**

1. Diagnosis of moderately to severely active Crohn's disease
2. Subcutaneous formulation will be used as maintenance therapy following IV induction

**Ulcerative colitis (UC)**

**IV:**

1. Diagnosis of moderately to severely active ulcerative colitis
2. ONE of the following:
    a. Trial and failure, contraindication, or intolerance to ONE of the following conventional therapies:
        i. 6-mercaptopurine
        ii. Aminosalicylate (e.g., mesalamine, olsalazine, sulfasalazine)
        iii. Azathioprine
        iv. Corticosteroids (e.g., prednisone)
    b. Disease severity warrants systemic biologic or targeted synthetic therapy as first-line therapy
3. Will be administered as an intravenous induction dose

**SC:**

1. Diagnosis of moderately to severely active ulcerative colitis
2. Subcutaneous formulation will be used as maintenance therapy following IV induction

**Continuation of Therapy**

Requests for reauthorizations for all diagnoses will be granted when the following criteria are met:

1. Submission of medical records (e.g. chart notes) documenting an improvement in the member's condition, as evidenced by low disease activity or improvement in signs and symptoms of the condition

**Limitations**

1. Approvals of Skyrizi IV will be limited to 12 weeks.

2. Initial approvals and reauthorizations for Skyrizi SC will be granted for 24 months
3. Skyrizi IV will be approved for ulcerative colitis and Crohn's disease.
4. Skyrizi SC 55 mg and 150 mg strengths will be approved for plaque psoriasis and psoriatic arthritis.
5. Skyrizi SC 180 mg and 360 mg strengths will be approved for ulcerative colitis and Crohn's disease.
6. The following quantity limits apply on the pharmacy benefit:

| Drug Name and Dosage Form | Quantity Limitations |
|---|---|
| Skyrizi SC 55 mg prefilled syringe<br>Skyrizi SC 150mg prefilled syringe/autoinjector | *Psoriatic Arthritis and Plaque Psoriasis:*<br>1 injection every 12 weeks |
| Skyrizi IV 600mg/10mL | *Crohn's Disease, Ulcerative Colitis:*<br>2 vials per fill, 3 fills per 365 days |
| Skyrizi SC 180 mg/1.2 mL SC cartridge | *Ulcerative Colitis and Crohn's Disease*<br>1 injection every 8 weeks |
| Skyrizi SC 360 mg/2.4 mL SC cartridge | *Ulcerative Colitis and Crohn's Disease*<br>1 injection every 8 weeks |

**References**


1. Flytström I, Stenberg B, Svensson A, Bergbrant IM. Methotrexate vs. ciclosporin in psoriasis: effectiveness, quality of life and safety. A randomized controlled trial. Br J Dermatol 2008; 158:116.
2. Krueger JG, Ferris LK, Menter A, et al. Anti-IL-23A mAb BI 655066 for treatment of moderate-to-severe psoriasis: Safety, efficacy, pharmacokinetics, and biomarker results of a single-rising-dose, randomized, double-blind, placebo-controlled trial. J Allergy Clin Immunol 2015; 136:116
3. Lebwohl M, Drake L, Menter A, et al. Consensus conference: acitretin in combination with UVB or PUVA in the treatment of psoriasis. J Am Acad Dermatol 2001; 45:544
4. Skyrizi (risankizumab-rzaa) [prescribing information]. North Chicago, IL: AbbVie Inc; June 2026.


**Review History**

11/20/2019 – Reviewed at P&T
07/22/2020 – Reviewed and Updated July P&T; Updated Program Type to PA and QL; added TB testing requirement under Limitations. Effective 10/01/2020.
03/16/2022 – Reviewed and Updated March P&T; Added new indication psoriatic arthritis; added severe psoriasis may warrant a biologic DMARD as first-line therapy. Effective 05/01/2022
09/21/2022 – Reviewed and Updated for Sept P&T; added new indication for Crohn's disease. Effective 11/1/22
01/11/2023 – Reviewed for Jan P&T; updated 'exceptions' to allow new formulation of Skyrizi IV under the Medial Benefit only. Effective 2/1/2023
06/14/2023 – Reviewed and Updated for Jun P&T; added Skyrizi IV to exceptions as it is available under Medical Benefit Only.
11/15/2023 – Reviewed and Updated for Nov P&T; removed TB requirement. Psoriatic arthritis – removed conventional therapies and added member meets one of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque psoriasis – changed from 5% BSA to 3% BSA. Removed appendix. Consolidated conventional therapies for plaque psoriasis. Crohn's disease – added Frequent diarrhea and abdominal pain, at least 10% weight loss, Complications such as obstruction, fever, abdominal mass, Abnormal lab values (e.g., C-reactive protein [CRP]), or CD Activity Index (CDAI) great than 20. Effective 1/1/24
09/11/2024 – Reviewed and updated for September P&T. Added criteria for ulcerative colitis. Updated approval length for Skyrizi IV to 8 weeks. Effective 12/1/24.

10/09/2024 – Reviewed and updated for October P&T. Updated Crohn's disease criteria to require moderately to severely active disease. Updated reauthorization criteria to require documentation of clinical improvement to therapy. Effective 1/1/2025.
05/14/2025 – Reviewed and updated for May P&T. Updated criteria for Crohn's disease and ulcerative colitis to remove disease characteristic requirement and allow for approval if disease severity warrants systemic biologic as first-line therapy. Effective 07/01/2025.
07/09/2025 – Reviewed and updated for July P&T. Updated approval length for Skyrizi IV to 12 weeks. Effective 09/01/2025.
10/08/2025 – Reviewed and updated at October P&T. Adding language for the SC formulation to the UC and CD diagnoses to require that either the member has either received IV induction therapy or will use the SC formulation after IV induction. Updating policy to indicate it no longer applies to the medical benefit. Effective 01/01/2026.
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 – Reviewed and updated at April P&T. Updated previous trial language for plaque psoriasis, ulcerative colitis and Crohn's disease, allowing for bypassing conventional therapy if member has severe disease that warrants a biologic DMARD or targeted synthetic therapy as first-line therapy. Updated criteria for SC formulation for ulcerative colitis and Crohn's disease to require diagnosis and induction therapy with the IV. Effective 08/16/2026.
08/12/2026 – Reviewed and updated at August P&T. Administrative update - updating criteria for IV for UC and CD to clarify that the IV will be used for IV induction dosing. Effective 08/16/2026.
09/09/2026 – Reviewed and updated at September P&T. Adding new 55 mg strength to policy. Effective 10/18/2026.
10/12/2026 – Reviewed and updated at October P&T. Administrative update to Limitations section to clarify which strengths and formulations will be approved for each disease state. Effective 10/18/2026.