Ilumya (tildrakizumab-asmn)
Effective 01/01/2022

Plan	☐ MassHealth ☒ MassHealth (PUF) ☐Commercial/Exchange	**Program Type**	☒ Prior Authorization ☒ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☒ Medical Benefit (NLX)		
Specialty Limitations	N/A		
Contact Information	**Specialty Medications** All Plans | Phone: 866-814-5506 | Fax: 866-249-6155 **Non-Specialty Medications** MassHealth | Phone: 877-433-7643 | Fax: 866-255-7569 Commercial | Phone: 800-294-5979 | Fax: 888-836-0730 Exchange | Phone: 855-582-2022 | Fax: 855-245-2134 **Medical Specialty Medications (NLX)** All Plans | Phone: 844-345-2803 | Fax: 844-851-0882		
Exceptions	N/A		

Overview
Ilumya (tildrakizumab-asmn) is an Interleukin-23 blocker indicated for:
- Treatment of moderate-to-severe plaque psoriasis

Coverage Guidelines
Authorization may be reviewed on a case by case basis for members new to AllWays Health Partners who are currently receiving treatment with Ilumya, 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 following criteria and documentation has been submitted:

Moderate to Severe Plaque Psoriasis

Prescriber provides documentation of **ALL** of the following:

1. Appropriate diagnosis
2. **ONE** of the following:
    a. Paid claims or physician documented inadequate response or adverse reaction to **ONE** conventional therapy (see appendix A)
        i. topical agent
        ii. phototherapy
        iii. systemic agent
    b. Contraindication to **ALL** conventional therapies:
        i. topical agents
        ii. phototherapy

iii. systemic agents

c. Paid claims or physician documented inadequate response or adverse reaction to **ONE** biologic DMARD that is FDA-approved for plaque psoriasis

3. Appropriate dosing
4. Prescriber provides clinical rationale for use of Ilumya instead of Stelara®

Continuation of Therapy

Reauthorization requires physician documentation of continuation of therapy, positive response to therapy, FDA approved indication and appropriate dosing.

Limitations

1. Initial approvals will be granted for: 3 months.
2. Reauthorizations will be granted for 12 months
3. The following quantity limits apply:

Ilumya 100mg/mL	1 injections per 84 days

Appendix A. Conventional Therapies for Plaque Psoriasis

Conventional Treatment Lines	Agents Used
Topical Agents	emollients, keratolytics, corticosteroids, coal tar, anthralin, calcipotriene, tazarotene, calcitriol, calcineurin inhibitors
Systemic Agents	Traditional DMARDs: methotrexate, apremilast, acitretin,
Phototherapy	ultraviolet A and topical psoralens (topical PUVA), ultraviolet A and oral psoralens (systemic PUVA), narrow band UV-B (NUVB)

References

1. Ilumya (tildrakizumab-asmn) [prescribing information]. Whitehouse Station, NJ: Merck & Co Inc; August 2018.
2. 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
3. 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
4. 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
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
6. 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
10/21/2020 – Reviewed and Updated; separated out Comm/Exch vs. MassHealth. Matched MassHealth Preferred Unified Formulary for implementation 1/1/2021

11/1/2021 – Reviewed and Updated for Nov P&T; Guideline updated to reflect multiple criteria changes and appendices changes based on clinical literature. Effective 01/01/2022

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