Siliq (brodalumab)
Effective 03/01/2023

Plan	☐ MassHealth ☒ MassHealth (PUF) ☐Commercial/Exchange	**Program Type**	☒ Prior Authorization ☒ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit (NLX)		
Specialty Limitations	This medication has been designated a specialty medication and must be filled at a contracted specialty pharmacy.		
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
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
Authorization may be reviewed on a case by case basis for members new to the plan who are currently receiving treatment with Siliq excluding when the product is obtained as samples or via manufacturer's patient assistance programs.
OR
Authorization may be granted for members when ALL the following criteria are met, and documentation is provided:

Moderate to Severe Plaque Psoriasis
Prescriber provides documentation of **ALL** of the following:
1. Diagnosis of moderate to severe plaque psoriasis
2. **ONE** of the following:
    a. Paid claims or physician documented inadequate response or adverse reaction to **ONE** conventional therapy or contraindication to **ALL** conventional therapies (see appendix B):
        i. topical agent
        ii. phototherapy
        iii. systemic agent

b. 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 Siliq instead of Stelara®

Off Label Indications

Pityriasis rubra pilaris (PRP)

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

1. Diagnosis of pityriasis rubra pilaris (PRP)
2. Paid claims or physician documented of inadequate response or adverse reaction to **ONE** topical corticosteroid or contraindication to **ALL** topical corticosteroids
3. Clinical rationale for use of the requested agent instead of Stelara® and Taltz®

New members currently stable on Siliq® can be approved without documentation of failed trials with the conventional therapies.

Continuation of Therapy

Reauthorization requires physician documentation of a positive response to therapy.

Limitations

1. Initial approvals will be granted based on diagnosis:
    a. Plaque psoriasis and Off-label indications: 3 months.
2. Reauthorizations will be granted for 12 months.
3. The following quantity limits apply:

Siliq 210mg/1.5mL	2 syringes per 28 days

Appendix A: Dosing

Siliq (brodalumab)	SQ: 210 mg initially at week 0, 1 and 2; followed by 210 mg every two weeks

Appendix B. 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. Siliq [package insert]. Bridgewater, NJ: Valeant Pharmaceuticals North America LLC; February 2017.
2. Lebwohl M, Strober B, Menter A, et al. Phase 3 studies comparing brodalumab with ustekinumab in psoriasis. N Engl J Med. 2015;373(14):1318-1328.

Review History

03/01/18 – Reviewed (adopted MH RS)
02/20/19 – Reviewed in P&T Meeting
10/21/2020 – Reviewed and Updated; separated out Comm/Exch vs. MassHealth. Matched MassHealth

Preferred Unified Formulary for implementation 1/1/2021

11/17/2021 – 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

01/11/2023 – Reviewed and updated for Jan P&T. Matched MH criteria. Appropriate diagnosis was replaced with a specific indication throughout. Off-label indications added for: PRP. Added language regarding stability of requested medication for new members. Effective 3/1/23.

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