Mass General Brigham
Health Plan

Targeted Immunomodulators
Skyrizi IV (risankizumab-rzaa vial)
Effective 03/03/2025

Plan	☒ MassHealth ☐Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☐ Pharmacy Benefit ☒ Medical Benefit		
Specialty Limitations	N/A		
Contact Information	**Specialty Medications** All Plans | Phone: 877-519-1908 | Fax: 855-540-3693 **Non-Specialty Medications** All Plans | Phone: 800-711-4555 | Fax: 844-403-1029		
Notes	Additional agents from this class are available through the pharmacy benefit. Please see the MassHealth Drug List for coverage and criteria.		

Overview
Skyrizi (risankizumab-rzaa) is an interleukin (IL)-23 antagonist that works by inhibiting the interaction with the IL-23 receptor which results in the inhibition of the of the release of proinflammatory cytokines and chemokines. It is indicated for the treatment of moderate-to-severe plaque psoriasis, active psoriatic arthritis in adults, moderate-to-severe active Crohn's disease in adults, ulcerative colitis, and pityriasis rubra pilaris (PRP) (off-label). Please note, the IV formulation is only indicated for Crohn's disease, ulcerative colitis, and pityriasis rubra pilaris (PRP) (off-label).

Coverage Guidelines
Authorization may be reviewed on a case by case basis for members new to the plan who are currently receiving treatment with requested medication 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:

Moderate to severe Crohn's disease
ALL of the following:
1. Diagnosis of moderate to severe Crohn's disease
2. Appropriate dosing (see appendix and availability and dosage section) †

Moderate to severe ulcerative colitis
ALL of the following:
1. Diagnosis of moderate to severe ulcerative colitis
2. Appropriate dosing (see appendix and availability and dosage section) †

Pityriasis rubra pilaris (PRP) – Off Label

ALL of the following:

1. Diagnosis of pityriasis rubra pilaris
2. Inadequate response or adverse reaction to **ONE** topical corticosteroid or contraindication to **ALL** topical corticosteroids
3. Clinical rationale for use of Skyrizi instead of Stelara and Taltz

† *Requests for More Frequent or Higher Doses*

More Frequent or Higher Doses requests

1. Documentation of severe disease
2. **ONE** of the following:
    a. Inadequate response or adverse reaction to **ONE** other injectable biologic which is FDA-approved for the requested indication
    b. Contraindication to **ALL** other injectable biologics which are FDA-approved for the requested indication
3. Documented partial response to FDA-approved dosing of current biologic therapy
4. Documentation of specialist consult for the requested indication

Continuation of Therapy

Resubmission by prescriber will infer a positive response to therapy.

Limitations

1. Initial authorizations will be granted for:
    a. Off-label indications: 3 months
    b. All other indications: 6 months
2. Reauthorizations will be granted for 12 months

References

1. Skyrizi (risankizumab-rzaa) [prescribing information]. North Chicago, IL: AbbVie Inc; June 2024.

Review History

03/18/2020 – Reviewed at P&T (effective 6/1/20)
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
06/22/2022 – Reviewed and Updated for June P&T; matched MH UPPL. Added criteria for newly FDA-approved indication: Psoriatic Arthritis. Continuation of therapy language was updated. Added approval duration for initial auths for PsO – 3 months. Updated Overview and Reference sections. Added Appendix B for More Frequent/Higher Doses. Effective 08/01/2022
11/16/2022 – Reviewed and updated for Nov P&T. Guideline was updated following FDA-approval in moderate to severe Crohn's disease. Clarified QLs. Effective 11/01/2022
01/11//2023 – Reviewed and updated for Jan P&T. Appropriate diagnosis was replaced with a specific indication throughout. Added language regarding stability of requested medication for new members. Off-label indications added for: PRP. Clarified initial approval durations: plaque psoriasis/off-label for 3 months, all other indications for 6 months. Effective 3/1/23.
12/13/23 – Reviewed and updated for P&T. Taltz was added as a step through agent for Skyrizi for plaque psoriasis and psoriatic arthritis. Effective 1/2/24

2/14/24 – Reviewed and updated for P&T. Skyrizi IV has been added to medical benefit requiring PA. Skyrizi SC will continue to have PA on pharmacy. Effective 3/4/24.
2/12/25 – Reviewed and updated for P&T. Medical benefit criteria has been updated to only include applicable indications for Skyrizi IV. Effective 3/3/25