

Clinical Policy: Risankizumab-rzaa (Skyrizi)

Reference Number: CP.PHAR.426

Effective Date: 06.04.19

Last Review Date: 06.25

Line of Business: Medicaid

[Coding Implications](#)[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Risankizumab-rzaa (Skyrizi®) is an interleukin-23 (IL-23) blocker.

FDA Approved Indication(s)

Skyrizi is indicated for the treatment of:

- Moderate-to-severe plaque psoriasis (PsO) in adults who are candidates for systemic therapy or phototherapy
- Active psoriatic arthritis (PsA) in adults
- Moderately to severely active Crohn's disease (CD) in adults
- Moderately to severely active ulcerative colitis (UC) in adults

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Skyrizi is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria**A. Plaque Psoriasis** (must meet all):

1. Diagnosis of moderate-to-severe PsO as evidenced by involvement of one of the following (a or b):
 - a. $\geq 3\%$ of total body surface area;
 - b. Hands, feet, scalp, face, or genital area;
2. Prescribed by or in consultation with a dermatologist or rheumatologist;
3. Age ≥ 18 years;
4. Member meets one of the following (a, b, or c):
 - a. Failure of a ≥ 3 consecutive month trial of methotrexate (MTX) at up to maximally indicated doses;
 - b. Member has intolerance or contraindication to MTX (*see Appendix D*), and failure of a ≥ 3 consecutive month trial of cyclosporine or acitretin at up to maximally indicated doses, unless clinically significant adverse effects are experienced or both are contraindicated;
 - c. Member has intolerance or contraindication to MTX, cyclosporine, and acitretin, and failure of phototherapy, unless contraindicated or clinically significant adverse effects are experienced;

5. Member meets ONE of the following, unless clinically significant adverse effects are experienced or all are contraindicated (a or b, *see Appendix D*):
 - a. Failure of a ≥ 3 consecutive month trial of one* adalimumab product (e.g., *Hadlima*[™], *Simlandi*[®], *Yusimry*[™], *adalimumab-aaty*, *adalimumab-adaz*, *adalimumab-adbm*, and *adalimumab-fkjp* are preferred);
 - b. History of failure of two TNF blockers;
**Prior authorization may be required for adalimumab products*
6. Failure of a ≥ 3 consecutive month trial of Taltz[®], unless contraindicated or clinically significant adverse effects are experienced;
**Prior authorization may be required for Taltz*
7. Failure of a ≥ 3 consecutive month trial of one* ustekinumab product (e.g. *Otulf*[®], *Pyzchiva*[®] (branded), *Selarsdi*[™], *Steqeyma*[®], *Yesintek*[™] are preferred), unless clinically significant adverse effects are experienced or all are contraindicated;
**Prior authorization may be required for ustekinumab products*
8. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
9. Dose does not exceed 150 mg at weeks 0 and 4, then every 12 weeks thereafter.

Approval duration: 6 months

B. Psoriatic Arthritis (must meet all):

1. Diagnosis of PsA;
2. Prescribed by or in consultation with a dermatologist or rheumatologist;
3. Age ≥ 18 years;
4. Failure of ALL* of the following, each used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated (a, b, c, d, and e, *see Appendix D*):
 - a. One adalimumab product (e.g., *Hadlima*, *Simlandi*, *Yusimry*, *adalimumab-aaty*, *adalimumab-adaz*, *adalimumab-adbm*, and *adalimumab-fkjp* are preferred), unless the member has had a history of failure of two TNF blockers;
 - b. *Otezla*[®];
 - c. Taltz;
 - d. One ustekinumab product (e.g., *Otulf*[®], *Pyzchiva*[®] (branded), *Selarsdi*[™], *Steqeyma*[®], *Yesintek*[™] are preferred);
 - e. If member has not responded or is intolerant to one or more TNF blockers, *Xeljanz*[®]/*Xeljanz XR*[®], unless member has cardiovascular risk and benefits do not outweigh the risk of treatment;
**Prior authorization may be required for adalimumab products, Otezla, Taltz, ustekinumab products, and Xeljanz/Xeljanz XR*
5. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
6. Dose does not exceed 150 mg at weeks 0 and 4, then every 12 weeks thereafter.

Approval duration: 6 months

C. Crohn's Disease (must meet all):

1. Diagnosis of CD;

2. Prescribed by or in consultation with a gastroenterologist;
3. Age ≥ 18 years;
4. Member meets one of the following (a or b):
 - a. Failure of a ≥ 3 consecutive month trial of at least ONE immunomodulator (e.g., azathioprine, 6-mercaptopurine [6-MP], MTX) at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated;
 - b. Medical justification supports inability to use immunomodulators (*see Appendix E*);
5. Member meets of one* of the following, unless clinically significant adverse effects are experienced or all are contraindicated (a or b, *see Appendix D*):
 - a. Failure of one adalimumab product (e.g., *Hadlima*, *Simlandi*, *Yusimry*, *adalimumab-aaty*, *adalimumab-adaz*, *adalimumab-adbm*, and *adalimumab-fkjp* are preferred), used for ≥ 3 consecutive months;
 - b. History of failure of two TNF blockers;
**Prior authorization may be required for adalimumab products*
6. Failure of a ≥ 3 consecutive month trial of one ustekinumab product (e.g. *Otulf[®]*, *Pyzchiva[®]* (branded), *Selarsdi[™]*, *Steqeyma[®]*, *Yesintek[™]* are preferred), unless clinically significant adverse effects are experienced or all are contraindicated;
**Prior authorization may be required for ustekinumab products*
7. Member does not have combination use of biological disease-modifying antirheumatic drugs or JAK inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
8. Dose does not exceed all of the following (a, b, and c):
 - a. Induction: 600 mg at weeks 0, 4, and 8;
 - b. Maintenance: 360 mg at week 12 and every 8 weeks thereafter;
 - c. Quantity does not exceed one single dose vial or pre-filled cartridge per dose.

Approval duration: 6 months

D. Ulcerative Colitis (must meet all):

1. Diagnosis of UC;
2. Prescribed by or in consultation with a gastroenterologist;
3. Age ≥ 18 years;
4. Documentation of a Mayo Score ≥ 6 or modified Mayo Score ≥ 5 (*see Appendix F*);
5. Failure of an 8-week trial of systemic corticosteroids, unless contraindicated or clinically significant adverse effects are experienced;
6. Failure of one of the following, used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated (a or b):
 - a. One adalimumab product (e.g., *Hadlima*, *Simlandi*, *Yusimry*, *adalimumab-aaty*, *adalimumab-adaz*, *adalimumab-adbm*, and *adalimumab-fkjp* are preferred), unless the member has had a history of failure of two TNF blockers;
 - b. One ustekinumab product (e.g. *Otulf[®]*, *Pyzchiva[®]* (branded), *Selarsdi[™]*, *Steqeyma[®]*, *Yesintek[™]* are preferred);
**Prior authorization may be required for adalimumab products and ustekinumab products*
7. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);

8. Dose does not exceed both of the following (a and b):
 - a. Induction: 1,200 mg at weeks 0, 4, and 8;
 - b. Maintenance (both i and ii):
 - i. 360 mg at week 12 and every 8 weeks thereafter;
 - ii. Quantity does not exceed one pre-filled cartridge per dose.

Approval duration: 6 months

E. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all):

1. Member meets one of the following (a or b):
 - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
 - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
2. Member is responding positively to therapy;
3. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
4. If request is for a dose increase, new dose does not exceed one of the following (a or b):
 - a. For PsA or PsO: 150 mg every 12 weeks;
 - b. For CD or UC: both (i and ii):
 - i. 360 mg every 8 weeks;
 - ii. 1 pre-filled cartridge every 8 weeks.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2):

1. This drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):

- a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
- b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 for Medicaid or evidence of coverage documents;
- B. Combination use with biological disease-modifying antirheumatic drugs (bDMARDs) or potent immunosuppressants, including but not limited to any tumor necrosis factor (TNF) antagonists [e.g., Cimzia[®], Enbrel[®], Humira[®] and its biosimilars, Remicade[®] and its biosimilars, Simponi[®]], interleukin agents [e.g., Actemra[®] (IL-6RA) and its biosimilars, Arcalyst[®] (IL-1 blocker), Bimzelx[®] (IL-17A and F antagonist), Cosentyx[®] (IL-17A inhibitor), Ilaris[®] (IL-1 blocker), Ilumya[™] (IL-23 inhibitor), Kevzara[®] (IL-6RA), Kineret[®] (IL-1RA), Omvoh[™] (IL-23 antagonist), Siliq[™] (IL-17RA), Skyrizi[™] (IL-23 inhibitor), Spevigo[®] (IL-36 antagonist), Stelara[®] (IL-12/23 inhibitor) and its biosimilars, Taltz[®] (IL-17A inhibitor), Tremfya[®] (IL-23 inhibitor)], Janus kinase inhibitors (JAKi) [e.g., Cibinco[™], Olumiant[™], Rinvoq[™], Xeljanz[®]/Xeljanz[®] XR,], anti-CD20 monoclonal antibodies [Rituxan[®] and its biosimilars], selective co-stimulation modulators [Orencia[®]], integrin receptor antagonists [Entyvio[®]], tyrosine kinase 2 inhibitors [Sotyktu[™]], and sphingosine 1-phosphate receptor modulator [Velsipity[™]] because of the additive immunosuppression, increased risk of neutropenia, as well as increased risk of serious infections;
- C. Asthma.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CD: Crohn's disease

FDA: Food and Drug Administration

IL-23: interleukin-23

JAKi: Janus kinase inhibitors

MTX: methotrexate

PsO: plaque psoriasis

UC: ulcerative colitis

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
acitretin (Soriatane [®])	PsO 25 or 50 mg PO daily	50 mg/day
azathioprine (Azasan [®] , Imuran [®])	CD* 1.5 – 2.5 mg/kg/day PO	2.5 mg/kg/day
corticosteroids	UC <i>Adult:</i> Prednisone 40 mg – 60 mg PO QD, then taper dose by 5 to 10 mg/week Budesonide (Uceris [®]) 9 mg PO QAM for up to 8 weeks	Various
cyclosporine (Sandimmune [®] , Neoral [®])	PsO 2.5 – 4 mg/kg/day PO divided BID	4 mg/kg/day
6-mercaptopurine (Purixan [®])	CD* 50 mg PO QD or 0.75 – 1.5 mg/kg/day	1.5 mg/kg/day
methotrexate (Trexall [®] , Otrexup [™] , Rasuvo [®] , RediTrex [®] , Rheumatrex [®] , Jylamvo [®])	CD* 15 – 25 mg/week IM or SC PsO 10 to 25 mg/week IM, SC or PO or 2.5 mg PO Q12 hr for 3 doses/week	30 mg/week
Cimzia [®] (certolizumab)	CD <u>Initial dose:</u> 400 mg SC at 0, 2, and 4 weeks <u>Maintenance dose:</u> 400 mg SC every 4 weeks	400 mg every 4 weeks
Hadlima (adalimumab- bwwd), Simlandi (adalimumab- ryvk), Yusimry (adalimumab- aqvh), adalimumab-aaty (Yuflyma [®]), adalimumab-adaz (Hyrimoz [®]), adalimumab-fkjp (Hulio [®]),	CD, UC <u>Initial dose:</u> 160 mg SC on Day 1, then 80 mg SC on Day 15 <u>Maintenance dose:</u> 40 mg SC every other week starting on Day 29 PsA 40 mg SC every other week PsO <u>Initial dose:</u> 80 mg SC	40 mg every other week

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
adalimumab-adbm (Cyltezo [®])	<u>Maintenance dose:</u> 40 mg SC every other week starting one week after initial dose	
Avsola [™] , Renflexis [™] , Inflectra [®] (infliximab)	CD <u>Initial dose:</u> 5 mg/kg IV at weeks 0, 2 and 6 <u>Maintenance dose:</u> 5 mg/kg IV every 8 weeks. Some adult patients who initially respond to treatment may benefit from increasing the dose to 10 mg/kg if they later lose their response	CD: 10 mg/kg every 8 weeks
Otezla [®] (apremilast)	PsA <u>Initial dose:</u> Day 1: 10 mg PO QAM Day 2: 10 mg PO QAM and 10 mg PO QPM Day 3: 10 mg PO QAM and 20 mg PO QPM Day 4: 20 mg PO QAM and 20 mg PO QPM Day 5: 20 mg PO QAM and 30 mg PO QPM <u>Maintenance dose:</u> Day 6 and thereafter: 30 mg PO BID	60 mg/day
Otulf [®] (ustekinumab-aauz), Pyzchiva [®] (ustekinumab-ttwe), Selarsdi [™] (ustekinumab-aekn), Steqeyma [®] (ustekinumab-stba), Yesintek [™] (ustekinumab-kfce)	CD, UC <u>Weight based dosing IV at initial dose:</u> Weight ≤ 55 kg: 260 mg Weight > 55 kg to 85 kg: 390 mg Weight > 85 kg: 520 mg <u>Maintenance dose:</u> 90 mg SC every 8 weeks PsO Weight based dosing SC at weeks 0 and 4, followed by maintenance dose every 12 weeks <i>Adult:</i> Weight ≤ 100 kg: 45 mg	CD, UC: 90 mg every 8 weeks PsO: 90 every 12 weeks PsA: 45 mg every 12 weeks

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	Weight > 100 kg: 90 mg <i>Pediatrics (age 6 years to 17 years):</i> Otulf, Pyzchiva, Yesintek: Weight < 60 kg: 0.75 mg/kg Otulf, Pyzchiva, Selarsdi, Steqeyma, Yesintek: Weight 60 to 100 kg: 45 mg Weight > 100 kg: 90 mg PsA Weight based dosing SC at weeks 0 and 4, followed by maintenance dose every 12 weeks <i>Adult:</i> 45 mg SC at weeks 0 and 4, followed by 45 mg every 12 weeks <i>Pediatrics (age 6 years to 17 years):</i> Weight based dosing SC at weeks 0 and 4, then every 12 weeks thereafter Otulf, Pyzchiva, Yesintek: Weight < 60 kg: 0.75 mg/kg Otulf, Pyzchiva, Selarsdi, Steqeyma, Yesintek: Weight ≥ 60 kg: 45 mg	
Taltz [®] (ixekizumab)	PsA <u>Initial dose:</u> 160 mg (two 80 mg injections) SC at week 0 <u>Maintenance dose:</u> 80 mg SC every 4 weeks PsO <u>Initial dose:</u> 160 mg (two 80 mg injections) SC at week 0, then 80 mg SC at weeks 2, 4, 6, 8, 10, and 12	80 mg every 4 weeks

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	<u>Maintenance dose:</u> 80 mg SC every 4 weeks	
Xeljanz [®] (tofacitinib)	PsA 5 mg PO BID UC <u>Induction:</u> 10 mg PO BID for 8 weeks, up to 16 weeks <u>Maintenance:</u> 5 mg PO BID	10 mg/day
Xeljanz XR [®] (tofacitinib extended-release)	PsA 11 mg PO QD UC <u>Induction:</u> 22 mg PO QD for 8 weeks, up to 16 weeks <u>Maintenance:</u> 11 mg PO QD	11 mg/day

Therapeutic alternatives are listed as Brand name[®] (generic) when the drug is available by brand name only and generic (Brand name[®]) when the drug is available by both brand and generic.

**Off-label*

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): history of serious hypersensitivity reaction to risankizumab-rzaa or any of the excipients
- Boxed warning(s): none reported

Appendix D: General Information

- Definition of failure of MTX or DMARDs
 - Child-bearing age is not considered a contraindication for use of MTX. Each drug has risks in pregnancy. An educated patient and family planning would allow use of MTX in patients who have no intention of immediate pregnancy.
 - Social use of alcohol is not considered a contraindication for use of MTX. MTX may only be contraindicated if patients choose to drink over 14 units of alcohol per week. However, excessive alcohol drinking can lead to worsening of the condition, so patients who are serious about clinical response to therapy should refrain from excessive alcohol consumption.
- In a phase 2a, multicenter, randomized, double-blind, placebo-controlled, 24-week, parallel-group trial, Skyrizi was shown to be not beneficial in treatment of severe asthma. The time to the first asthma worsening was shorter and the annualized rate of asthma worsening was higher with risankizumab than with placebo.

- TNF blockers:
 - Etanercept (Enbrel[®]), adalimumab (Humira[®]) and its biosimilars, infliximab (Remicade[®]) and its biosimilars (Avsola[™], Renflexis[™], Inflectra[®]), certolizumab pegol (Cimzia[®]), and golimumab (Simponi[®], Simponi Aria[®]).

Appendix E: CD and Immunomodulator Medical Justification

- The following may be considered for medical justification supporting inability to use an immunomodulator for CD:
 - Inability to induce short-term symptomatic remission with a 3-month trial of systemic glucocorticoids
 - High-risk factors for intestinal complications may include:
 - Initial extensive ileal, ileocolonic, or proximal GI involvement
 - Initial extensive perianal/severe rectal disease
 - Fistulizing disease (e.g., perianal, enterocutaneous, and rectovaginal fistulas)
 - Deep ulcerations
 - Penetrating, stricturing or stenosis disease and/or phenotype
 - Intestinal obstruction or abscess
 - For TNF-inhibitors, high risk factors for postoperative recurrence may include:
 - Less than 10 years duration between time of diagnosis and surgery
 - Disease location in the ileum and colon
 - Perianal fistula
 - Prior history of surgical resection
 - Use of corticosteroids prior to surgery

Appendix F: Mayo Score or Modified Mayo Score

- Mayo Score: evaluates ulcerative colitis stage, based on four parameters: stool frequency, rectal bleeding, endoscopic evaluation and Physician's global assessment. Each parameter of the score ranges from zero (normal or inactive disease) to 3 (severe activity) with an overall score of 12.

Score	Decoding
0 – 2	Remission
3 – 5	Mild activity
6 – 10	Moderate activity
>10	Severe activity

- Modified Mayo Score: developed from the full Mayo score and evaluates ulcerative colitis stage, based on three parameters: stool frequency, rectal bleeding, and endoscopic evaluation. The modified Mayo Score gives a maximum overall score of 9. The FDA currently accepts the modified Mayo Score for the assessment of disease activity in pivotal UC clinical trials.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
PsA, PsO	150 mg SC at Week 0, Week 4 and every 12 weeks thereafter	150 mg every 12 weeks
CD	<u>Induction</u> : 600 mg IV at Week 0, Week 4 and Week 8	IV: 600 mg/dose

Indication	Dosing Regimen	Maximum Dose
	<u>Maintenance</u> : 180 mg or 360 mg SC at Week 12 and every 8 weeks thereafter	SC: 360 mg every 8 weeks
UC	<u>Induction</u> : 1,200 mg IV at Week 0, Week 4 and Week 8 <u>Maintenance</u> : 180 mg or 360 mg SC at Week 12 and every 8 weeks thereafter	IV: 1,200 mg/dose SC: 360 mg every 8 weeks

VI. Product Availability

- Subcutaneous injection:
 - Single-dose prefilled syringes: 90 mg/mL, 150 mg/mL
 - Single-dose prefilled pen: 150 mg/mL
 - Single-dose prefilled cartridges: 180 mg/1.2 mL, 360 mg/2.4 mL
- Intravenous infusion:
 - Single-dose vial: 600 mg/10 mL

VII. References

1. Skyrizi Prescribing Information. North Chicago, IL: Abbvie Inc. June 2024. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/761105s029,761262s0071bl.pdf. Accessed February 28, 2025.
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10. Naegeli AN, Hunter T, Dong Y, et al. Full, Partial, and Modified Permutations of the Mayo Score: Characterizing Clinical and Patient-Reported Outcomes in Ulcerative Colitis Patients. *Crohn's Colitis* 360. 2021 Feb 23;3(1):otab007. doi: 10.1093/crocol/otab007. PMID: 36777063; PMCID: PMC9802037.
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Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J2327	Injection, Risankizumab-rzaa, intravenous, 1 mg
C9399	Unclassified drugs or biologicals
J3590	Unclassified biologics

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2021 annual review: added additional criteria related to diagnosis of moderate-to-severe PsO per 2019 AAD/NPF guidelines specifying at least 3% BSA involvement or involvement of areas that severely impact daily function; added combination of bDMARDs under Section III; references reviewed and updated.	02.23.21	05.21
RT4: added new 150 mg/mL prefilled pen and syringe formulations.	05.13.21	
2Q 2022 annual review: for PsO, allowed phototherapy as alternative to systemic conventional DMARD if contraindicated or clinically significant adverse effects are experienced; RT4: added newly FDA-approved indication for PsA; added asthma as a diagnosis not covered; reiterated requirement against combination use with a bDMARD or JAKi from Section III to Sections I and II; references reviewed and updated.	02.21.22	05.22
RT4: updated policy with Crohn's disease indication, new vial and prefilled cartridge formulations, new contraindication, and addition of Appendix E.	07.06.22	
Template changes applied to other diagnoses/indications and continued therapy section.	09.23.22	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
RT4: added new 180 mg/1.2 mL single-dose prefilled cartridge dosage form and quantity limit stating that only one single dose vial or pre-filled cartridge is allowed per dose for CD.	10.13.22	
Per February SDC, added Amjevita as an alternative option to Humira for CD. Added HCPCS code: [J2327].	02.13.23	
2Q 2023 annual review: updated off-label dosing in Appendix B; for PsA and CD, added TNFi criteria to allow bypass if member has had history of failure of two TNF blockers; references reviewed and updated.	02.28.23	05.23
Per July SDC: for PsA, removed criteria requiring use of Enbrel; for CD, removed criteria requiring use of Humira and Amjevita; added criteria requiring use of one adalimumab product and stating Yusimry, Hadlima, unbranded adalimumab-fkjp, and unbranded adalimumab-adaz as preferred; updated Appendix B with relevant therapeutic alternatives.	07.25.23	
Per December SDC, added adalimumab-adbm to listed examples of preferred adalimumab products.	12.06.23	02.24
2Q 2024 annual review: added Bimzelx, Zymfentra, Omvoh, Wezlana, Sotyktu, Tofidence, and Velsipity to section III.B; added HCPCS codes [C9399] and [J3590]; references reviewed and updated.	01.22.24	05.24
Per June SDC, added Simlandi to listed examples of preferred adalimumab products. RT4: added newly approved Ulcerative Colitis indication to criteria. Per SDC, added unbranded adalimumab-aaty to listed examples of preferred adalimumab products.	07.23.24	08.24
2Q 2025 annual review: for UC initial criteria, added option for documentation of modified Mayo Score ≥ 5 ; removed redirection to preferred adalimumab products as adalimumab is not recommended due to low efficacy per 2024 AGA guidelines; revised redirection to Zeposia with bypass allowance stating member must use Zeposia unless member has had history of failure of biological disease-modifying antirheumatic drug or Janus kinase inhibitor as supported by 2024 AGA guidelines; for Appendix F, added supplemental information on modified Mayo Score; updated section III.B with Spevigo and biosimilar verbiage; references reviewed and updated.	01.23.25	05.25
Per April SDC: for PsO, PsA, CD, and UC, added criteria requiring use of one preferred Stelara biosimilar (Otulfi, Pyzchiva (branded), Selarsdi, Yesintek, and Steqeyma are preferred); for UC, removed criteria requiring use of preferred agent Zeposia; for UC, revised requirement to include option for step through preferred adalimumab product or preferred ustekinumab product.	04.23.25	06.25

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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