| Risankizumab-rzaa IV (Skyrizi® IV) | Place of Service<br>Office Administration<br>Home Infusion Administration<br>Infusion Center Administration<br>Outpatient Facility Infusion Administration<br>Self-Administration *(The subcutaneous formulation may be covered under the pharmacy benefit)*<br><br>HCPCS: J2327 per 1 mg |
|---|---|

**Condition listed in policy (*see criteria for details*)**

- Crohn's disease

**AHFS therapeutic class:** Skin and mucous membrane agents, miscellaneous

**Mechanism of action**: Interleukin-23 antagonist

## (1) Special Instructions and pertinent Information

**Skyrizi, given subcutaneously, is managed under the outpatient Pharmacy Benefit for self-administration.** Please contact the member's Pharmacy Benefit for information on how to obtain this drug.

**Skyrizi, given intravenously, is managed under the Medical Benefit.** Please submit clinical information for prior authorization review.

## (2) Prior Authorization/Medical Review is required for the following condition(s)

**All requests for Skyrizi® (risankizumab-rzaa) must be sent for clinical review and receive authorization prior to drug administration or claim payment.**

Crohn's disease

1. Age ≥ 18 years of age, **AND**
2. Not being used in combination with another targeted immunomodulator

**Covered Dose**

Induction: Up to 600 mg IV at Week 0, Week 4, and Week 8

Maintenance: Up to 360 mg SC at Week 12, and every 8 weeks thereafter. Maintenance with the subcutaneous formulation can be requested from your pharmacy benefit.

**Coverage Period**

Induction: 3 months

Maintenance: Yearly based upon continued response to therapy. Maintenance with the subcutaneous formulation can be requested from your pharmacy benefit.

**ICD-10:**

K50.00-K50.119, K50.80-K50.919

## (3) The following condition(s) DO NOT require Prior Authorization/Preservice

**All requests for Skyrizi® (risankizumab-rzaa) must be sent for clinical review and receive authorization prior to drug administration or claim payment.**

## (4) This Medication is NOT medically necessary for the following condition(s)

Coverage for a Non-FDA approved indication, requires that criteria outlined in Health and Safety Code § 1367.21, including objective evidence of efficacy and safety are met for the proposed indication.

Please refer to the Provider Manual and User Guide for more information.

## (5) Additional Information

How supplied:

- Intravenous: 600 mg/10 mL (60 mg/mL) single-dose vial

## (6) References


- AHFS®. Available by subscription at http://www.lexi.com
- DrugDex®. Available by subscription at http://www.micromedexsolutions.com/home/dispatch
- Skyrizi® (risankizumab-rzaa) [Prescribing information]. North Chicago, IL: AbbVie Inc.; 1/2024.


## (7) Policy Update

Date of last review: 3Q2023
Date of next review: 3Q2024
Changes from previous policy version:

- No clinical change to policy following routine annual review.

*BSC Drug Coverage Criteria to Determine Medical Necessity*
*Reviewed by P&T Committee*