| Tildrakizumab-asmn (Ilumya®) | Place of Service<br>Office Administration<br>Infusion Center Administration<br>Home Infusion Administration<br>Outpatient Facility Administration*<br>[*Prior authorization required – see section (1)]<br><br>HCPCS: J3245 per 1 mg |
|---|---|

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

- Plaque psoriasis

**AHFS therapeutic class:** Antipsoriatic agent, systemic

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

## (1) Special Instructions and pertinent Information

**Covered 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 tildrakizumab-asmn (Ilumya®) must be sent for clinical review and receive authorization prior to drug administration or claim payment.**

Plaque psoriasis

1. Disease is moderate to severe, **AND**
2. Age ≥ 18 years of age, **AND**
3. Prescribed or recommended or by a dermatologist or rheumatologist, **AND**
4. One of the following:
    a. Baseline PASI score is 10 or more prior to starting biological therapy, OR
    b. Baseline BSA (body surface area) affected is 3% or more prior to starting biological therapy, OR
    c. Sensitive area is involved (i.e., groin, face, etc.), OR
    d. Disease is otherwise debilitating

    **AND**
5. Inadequate response, intolerable side effect, or contraindication to one of the following:
    a. Methotrexate, cyclosporine (Neoral), acitretin (Soriatane), OR
    b. PUVA or UVB treatment

    **AND**
6. Not used with Otezla or another targeted immunomodulator, **AND**
7. Inadequate response or intolerable side effect with preferred infliximab (Avsola, Inflectra or Renflexis), or contraindication to all infliximab products

**Covered Doses**

Up to 100 mg SC at Weeks 0, 4, and every twelve weeks thereafter.

**Coverage Period**

Initial: 24 weeks

Reauthorization: Yearly if meets the following:

1. Not being used in combination with other targeted biologics, AND
2. One of the following:
    a. Improvement in PASI score from baseline, OR
    b. Improvement in BSA from baseline, OR
    c. Decrease in sensitive area disease severity, OR
    d. Decrease in debilitating disease severity

**ICD-10:**
L40.0-L40.4

**(3) The following condition(s) DO NOT require Prior Authorization/Preservice**
**All requests for tildrakizumab-asmn (Ilumya™) 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:
100 mg/mL solution in a single-dose prefilled syringe

**(6) References**

- AHFS®. Available by subscription at http://www.lexi.com
- DrugDex®. Available by subscription at http://www.micromedexsolutions.com/home/dispatch
- Ilumya® (tildrakizumab-asmn) [Prescribing information]. Cranbury, NJ: Sun Pharmaceutical Industries, Inc.; 7/2020.
- Menter A, Gottlieb A, Feldman SR, Van Voorhees AS, Leonardi CL, Gordon KB,et al. Guidelines of care for the management of psoriasis and psoriatic arthritis: Section 1. Overview of psoriasis and guidelines of care for the treatment of psoriasis with biologics. J Am Acad Dermatol. 2008 May;58(5):826-50.
- Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. J Am Acad Dermatol 2019;80:1029-72.


**(7) Policy Update**
Date of last revision: 4Q2023
Date of next review: 2Q2024
Changes from previous policy version:

- No clinical change to policy following revision.

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