blue california
Promise Health Plan

risankizumab-rzaa (Skyrizi IV)

Medical Benefit Drug Policy

Place of Service

Home Infusion
Infusion Center Administration
Office Administration
Outpatient Facility Infusion Administration

Drug Details

USP Category: IMMUNOLOGICAL AGENTS
Mechanism of Action: an interleukin-23 antagonist
HCPCS:
J2327:Injection, risankizumab-rzaa, intravenous, 1 mg
How Supplied:

- IV Infusion 600 mg/10 mL (60 mg/mL)

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

- Crohn's Disease (CD), moderate to severe
- Ulcerative Colitis (UC), moderate to severe

Any condition not listed in this policy requires a review to confirm it is medically necessary. For conditions that have not been approved for intended use by the Food and Drug Administration (i.e., off-label use), the criteria outlined in the California Code of Regulations (CCR), Title 22, Section 51303 and 51313 must be met.

Special Instructions and Pertinent Information

Provider must submit documentation (such as office chart notes, lab results or other clinical information) to ensure the member has met all medical necessity requirements.

The member's specific benefit may impact drug coverage. Other utilization management processes, and/or legal restrictions may take precedence over the application of this clinical criteria.

Coverage Criteria
The following condition(s) require Prior Authorization/Preservice.

Crohn's Disease (CD), moderate to severe

Meets medical necessity if all the following are met:

1. Age consistent with the FDA-approved indication
2. ***Effective 2/1/2026 and after:*** Prescribed by or in consultation with a gastroenterologist
3. Not being used in combination with other targeted immunomodulators

Covered Doses:
Induction: 600 mg given intravenously at Week 0, Week 4, and Week 8.

Maintenance: Up to 360 mg given subcutaneously 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

Ulcerative Colitis (UC), moderate to severe
Meets medical necessity if all the following are met:
1. Age consistent with the FDA-approved indication
2. ***Effective 2/1/2026 and after:*** Prescribed by or in consultation with a gastroenterologist
3. Not being used in combination with other targeted immunomodulators

Covered Doses:
Induction: 1,200 mg given intravenously at Week 0, Week 4, and Week 8
Maintenance: 360 mg given subcutaneously 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:
K51.0-K51.319, K51.5-K51.519, K51.80-K51.919

References

1. AHFS. Available by subscription at http://www.lexi.com
   DrugDex. Available by subscription at
   http://www.micromedexsolutions.com/home/dispatch
2. Skyrizi (risankizumab-rzaa). Prescribing Information. AbbVie Inc.; North Chicago, IL. May 2025.

Review History

Date of Last Annual Review: 4Q2025
Changes from previous policy version:

- Added specialist requirement for Crohn's disease and ulcerative colitis. (Rationale: Ensure appropriate use)

Blue Shield of California Medication Policy to Determine Medical Necessity
Reviewed by P&T Committee