



Montana Healthcare Programs
Physicians Administered Drug Coverage Interim Criteria

ILUMYA® (tildrakizumab-asmn)

I. Medication Description

Ilumya® is an interleukin-23 antagonist indicated for the treatment of moderate to severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy

II. Position Statement

Coverage is determined through a prior authorization process **that must include** supporting clinical documentation for each request.

III. Initial Coverage Criteria

Member must meet all the following criteria:

- Must be 18 years of age or older
- Must have a diagnosis of moderate to severe plaque psoriasis
- Must be prescribed by or in consult with an appropriate specialist (dermatologist, rheumatologist)
- If not prescribed by an appropriate specialist, a copy of the specialty consult is required; annual consult required for yearly reauthorization
- Must have a trial and inadequate response or contraindication to a preferred drug with the same indication from the Montana Healthcare Programs Preferred Drug List
- Prescriber attests to the following:
 - Member has been screened for TB prior to initiating treatment
 - Provider will monitor for active infection
- Provider attests that member **will not** use Ilumya® concomitantly with other biologics

IV. Renewal Coverage Criteria

Member must meet all the following criteria:

- Member has documentation of positive clinical response to therapy (reduction in the frequency and/or severity of symptoms and exacerbations)
- Annual specialist consult provided if prescriber not a specialist
- Provider attests that member **will not** use Ilumya® concomitantly with other biologics

V. Quantity Limitations

100mg subcutaneous injection at week 0, week 4 and every 12 weeks thereafter

VI. Coverage Duration

Initial approval: 3 doses (weeks 0, 4 and 16); update required prior to dose at 28 weeks

Renewal approval duration: 1 year