BlueCross BlueShield
Federal Employee Program

ILUMYA
(tildrakizumab-asmn)

Pre - PA Allowance

None

Prior-Approval Requirements

Age 18 years of age or older

Diagnosis

Patient must have the following:

Moderate to severe plaque psoriasis (PsO)

AND ALL of the following:

a. Inadequate treatment response, intolerance or contraindication to either conventional systemic therapy (see Appendix 1) or phototherapy
    i. If the patient is intolerant or contraindicated to one therapy then the patient must have an inadequate treatment response, intolerance, or contraindication to the other treatment option
b. Prescriber will not exceed the FDA labeled maintenance dose of 100 mg every 12 weeks
c. **NOT** to be used in combination with any other biologic DMARD or targeted synthetic DMARD (Appendix 3)
d. Result for latent TB infection is negative **OR** result was positive for latent TB and patient completed treatment (or is receiving treatment) for latent TB
e. Absence of active infection [including tuberculosis and hepatitis B virus (HBV)]
f. **NOT** given concurrently with live vaccines
g. Patient **MUST** have tried the preferred product(s) (see Appendix 4) if adjudicated through the pharmacy benefit unless the patient has a valid medical exception (e.g., inadequate treatment response, intolerance, contraindication)

Prior - Approval Limits

Quantity 6 syringes
(injection at Week 0, 4, then every 12 weeks)

Duration 12 months

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Prior – Approval *Renewal* Requirements

Age 18 years of age or older

Diagnosis

Patient must have the following:

Plaque psoriasis (PsO)

AND ALL of the following:

a. Condition has improved or stabilized with therapy
b. Prescriber will not exceed the FDA labeled maintenance dose of 100 mg every 12 weeks
c. **NOT** to be used in combination with any other biologic DMARD or targeted synthetic DMARD (Appendix 3)
d. Absence of active infection [including tuberculosis and hepatitis B virus (HBV)]
e. **NOT** given concurrently with live vaccines
f. Patient **MUST** have tried the preferred product(s) (see Appendix 4) if adjudicated through the pharmacy benefit unless the patient has a valid medical exception (e.g., inadequate treatment response, intolerance, contraindication)

Prior - Approval *Renewal* Limits

Quantity 8 syringes

Duration 18 months

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Appendix 1
Clinical Reasons to Avoid Pharmacological Treatment

Contraindications
Alcoholism, alcoholic liver disease, other chronic liver disease
Breastfeeding
Drug interaction
Cannot be used due to risk of treatment- related toxicity
Pregnancy or planning pregnancy (male or female)
Significant comorbidity prohibits the use of systemic agents (liver or kidney disease, blood dyscrasias, uncontrolled hypertension)

Appendix 2
Conventional Systemic Therapy for Plaque Psoriasis

Generic	Brand
Methotrexate	Rheumatrex/Trexall
Cyclosporine	Sandimmune
Acitretin	Soriatane
Dexamethasone	Decadron
Predisone	Deltasone
Prednisolone	Orapred
Leflunomide	Arava
Tacrolimus	Astagraf/Envarsus/Hecoria/Prograf
Azathioprine	Azasan/Imuran
Sulfasalazine	Azulfidine/Sulfazine
Mycophenolate mofetil	Cellcept
Hydroxyurea	Droxia/hydrea
Fumaric acid esters	fumaderm

Appendix 3
Biological disease-modifying antirheumatic drugs (DMARDs)

Generic Name	Brand Name
abatacept	Orencia
adalimumab	Humira
anakinra	Kineret
bimekizumab-bkzx	Bimzelx
brodalumab	Siliq
certolizumab	Cimzia
etanercept	Enbrel
golimumab	Simponi/Simponi Aria
guselkumab	Tremfya
infliximab	Remicade
ixekizumab	Taltz

risankizumab-rzaa	Skyrizi
rituximab	Rituxan
sarilumab	Kevzara
secukinumab	Cosentyx
spesolimab-sbzo	Spevigo
tildrakizumab-asmn	Ilumya
tocilizumab	Actemra
ustekinumab	Stelara
vedolizumab	Entyvio

Targeted synthetic disease-modifying antirheumatic drugs (DMARDs)

Generic Name	Brand Name
apremilast	Otezla
baricitinib	Olumiant
deucravacitinib	Sotyktu
tofacitinib	Xeljanz/XR
upadactinib	Rinvoq

Appendix 4 - List of Preferred Products

Diagnosis	Standard Option/Basic Option Preferred Products	Blue Focus Preferred Products
Plaque Psoriasis (PsO)	*must try **TWO** preferred products: Enbrel Humira** Otezla Skyrizi Stelara (SC) Taltz Tremfya	*must try ONE preferred product: Enbrel Humira**

**Including all preferred biosimilars (see reference product criteria)