BlueCross BlueShield Federal Employee Program

SILIQ
(brodalumab)

Pre - PA Allowance

None

Prior-Approval Requirements

Age 18 years of age or older

Diagnosis

Patient must have the following:

1. 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 agrees to monitor for onset or exacerbations of Crohn's disease and discontinue if necessary
c. Prescriber agrees to participate in Siliq REMS Program and to monitor for onset of suicidal ideation and behavior and discontinue if necessary
d. Patient's condition will be re-evaluated at week 12 - 16 to confirm if therapy with Siliq may continue
e. Prescriber will not exceed the FDA labeled maintenance dose of 210 mg every 2 weeks
f. **NOT** to be used in combination with any other biologic DMARD or targeted synthetic DMARD (see Appendix 1)
g. 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
h. Absence of active infection [including tuberculosis and hepatitis B virus (HBV)]
i. **NOT** given concurrently with live vaccines
j. Patient **MUST** have tried the preferred product(s) (see Appendix 2) if adjudicated through the pharmacy benefit unless the patient has a valid medical exception (e.g., inadequate treatment response, intolerance, contraindication)

BlueCross BlueShield Federal Employee Program

SILIQ
(brodalumab)

Prior - Approval Limits

Quantity 28 (210mg) syringes
(injection at Weeks 0, 1, 2 then every 2 weeks)

Duration 12 months

Prior – Approval *Renewal* Requirements

Age 18 years of age or older

Diagnosis

Patient must have the following:

1. Plaque Psoriasis (PsO)

AND ALL of the following:

a. Condition has shown improvement or stabilization
b. Prescriber agrees to monitor for onset or exacerbations of Crohn's disease and discontinue if necessary
c. Prescriber agrees to participate in Siliq REMS Program and to monitor for onset of suicidal ideation and behavior and discontinue if necessary
d. Prescriber will not exceed the FDA labeled maintenance dose of 210 mg every 2 weeks
e. **NOT** to be used in combination with any other biologic DMARD or targeted synthetic DMARD (see Appendix 1)
f. Absence of active infection [including tuberculosis and hepatitis B virus (HBV)]
g. **NOT** given concurrently with live vaccines
h. Patient **MUST** have tried the preferred product(s) (see Appendix 2) 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 6 (210mg) syringes per 84 days

Duration 18 months

Appendix 1 - List of DMARDs

Conventional disease-modifying antirheumatic drugs (DMARDs)

Generic Name	Brand Name
azathioprine	Azasan, Imuran
cyclophosphamide	Cytoxan
cyclosporine	Neoral, Gengraf, Sandimmune
hydroxychloroquine	Plaquenil
leflunomide	Arava
methotrexate	Rheumatrex, Trexall
mycophenolate	Cellcept
sulfasalazine	Azulfidine, Sulfazine

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 2 - 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)