Health Alliance™

Pharmacy Drug Policy Checklist

POLICY NAME	Plaque Psoriasis Immunomodulator Therapies	POLICY #	2750P

Criteria

Coverage Criteria of Preferred Products (Cimzia, covered adalimumab biosimilars, Enbrel, Otezla, covered ustekinumab biosimilars, Tremfya, Skyrizi)

- ☐ Diagnosis of moderate to severe plaque psoriasis
- ☐ Ordered by a Dermatologist (skin doctor)
- ☐ Age 18 years or older (age 6 years or older for ustekinumab/Otezla and age 4 years or older for Enbrel)
- ☐ Documented failure, intolerance, or contraindication to topical therapy (topical corticosteroids, vitamin D analogs, etc)

Coverage Criteria of Non-Preferred Products with Single Step Edit (Taltz)

- ☐ Diagnosis of moderate to severe plaque psoriasis
- ☐ Ordered by a Dermatologist (skin doctor)
- ☐ Age 6 years or older
- ☐ Documented failure, intolerance, or contraindication to topical therapy (topical corticosteroids, vitamin D analogs, etc)
- ☐ Documented failure to respond to a minimum 3 month trial, intolerance, or contraindication to any ONE of the following:
  - Cimzia
  - Covered adalimumab biosimilars
  - Enbrel
  - Covered ustekinumab biosimilars
  - Tremfya
  - Skyrizi

Coverage Criteria of Non-Preferred Products with Triple Step Edit (Bimzelx)

- ☐ Diagnosis of moderate to severe plaque psoriasis
- ☐ Ordered by a Dermatologist

- [ ] Age 6 years or older
- [ ] Documented failure, intolerance, or contraindication to topical therapy (topical corticosteroids, vitamin D analogs, etc)
- [ ] Documented failure to respond to a minimum 3 month trial, intolerance, or contraindication to Taltz and Pharmacy Drug Policy & Procedure any TWO of the following:
  - Cimzia
  - Enbrel
  - Otezla
  - Covered ustekinumab biosimilars
  - Tremfya
  - Skyrizi

Coverage Criteria of Non-Preferred Products with Quadruple Step Edit (Siliq, Cosentyx, Ilumya, Sotyku)

- [ ] Diagnosis of moderate to severe plaque psoriasis
- [ ] Ordered by a Dermatologist (skin doctor)
- [ ] Age 18 years or older (age 6 years or older for Cosentyx)
- [ ] Documented failure, intolerance, or contraindication to topical therapy (topical corticosteroids, vitamin D analogs, etc)
- [ ] Documented failure to respond to a minimum 3 month trial, intolerance, or contraindication to Taltz and THREE of the following:
  - Cimzia
  - Covered adalimumab biosimilars
  - Enbrel
  - Covered ustekinumab biosimilars
  - Tremfya
  - Skyrizi

Exclusion Criteria – Any of the following prevents coverage

- [ ] Allergic reaction to murine proteins or humanized monoclonal antibody
- [ ] Inadequate response to initial or previous therapy with requested immunomodulator
- [ ] Patients with active infections, latent tuberculosis, or symptomatic or deteriorating congestive heart failure
- [ ] Off-label (non FDA Approved) dosing frequencies
- [ ] Health Alliance Northwest does not cover more than one biologic immunomodulator at a time because of possible increased risk for infections and potential drug interactions

☐ Only certain NDCs of biosimilars will be considered for coverage, please reference most recent formulary file for covered NDCs