Pharmacy Drug Policy Checklist

POLICY NAME	Plaque Psoriasis Immunomodulator Therapies	POLICY #	2750P

Criteria

Exclusion Criteria – Any of the following prevents coverage

- ☐ **5.1** Allergic reaction to murine proteins or humanized monoclonal antibody
- ☐ **5.2** Inadequate response to initial or previous therapy with requested immunomodulator
- ☐ **5.3** Patients with active infections, latent tuberculosis, or symptomatic or deteriorating congestive heart failure
- ☐ **5.4** Off-label (non FDA Approved) dosing frequencies
- ☐ **5.5** 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
- ☐ **5.6** Only certain NDCs of biosimilars will be considered for coverage, please reference most recent formulary file for covered NDCs

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

- ☐ **1.1** Diagnosis of moderate to severe plaque psoriasis
- ☐ **1.2** Ordered by a Dermatologist (skin doctor)
- ☐ **1.3** Age 18 years or older (age 6 years or older for ustekinumab/Otezla and age 4 years or older for Enbrel)
- ☐ **1.4** 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)

- ☐ **2.1** Diagnosis of moderate to severe plaque psoriasis
- ☐ **2.2** Ordered by a Dermatologist (skin doctor)
- ☐ **2.3** Age 6 years or older
- ☐ **2.4** Documented failure, intolerance, or contraindication to topical therapy (topical corticosteroids, vitamin D analogs, etc)
- ☐ **2.5** 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)

- ☐ **3.1** Diagnosis of moderate to severe plaque psoriasis
- ☐ **3.2** Ordered by a Dermatologist
- ☐ **3.3** Age 6 years or older
- ☐ **3.4** Documented failure, intolerance, or contraindication to topical therapy (topical corticosteroids, vitamin D analogs, etc)
- ☐ **3.5** 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)

- ☐ **4.1** Diagnosis of moderate to severe plaque psoriasis
- ☐ **4.2** Ordered by a Dermatologist (skin doctor)
- ☐ **4.3** Age 18 years or older (age 6 years or older for Cosentyx)
- ☐ **4.4** Documented failure, intolerance, or contraindication to topical therapy (topical corticosteroids, vitamin D analogs, etc)
- ☐ **4.5** 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