# INTERLEUKIN-17 AND 23 ANTAGONISTS

**Included Products:** Cosentyx (Secukinumab), Ilumya (tildrakizumab-asmn), Omvoh (mirikizumab-mrkz), Siliq (brodalumab), Skyrizi (risankizumab), Stelara (ustekinumab), Taltz (ixekizumab), Tremfya (guselkumab)

*Created:* 03/10/2022 *Revised:* 11/14/2024 *Reviewed:* 11/14/2024 *Updated:* 12/1/2024

*Ilumya is nonformulary for outpatient benefit. Prior authorization required on medical benefit.*

| All Diagnoses | | | |
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| **Initial Criteria: All Diagnoses** | | **If yes** | **If no** |
| **1.** | Is the requested agent indicated for or supported for use in the submitted diagnosis for the member's age? | Continue to #2. | Do not approve. |
| **2.** | Is the request for maintenance of remission in a patient who already achieved remission with the requested product or has already initiated therapy? | Continue to renewal criteria for the submitted diagnosis. | Continue to #3. |
| **3.** | Has the risk of infections been addressed by the following?<br>a. Initial testing for latent TB and treatment, if necessary, before starting therapy.<br>b. No current active infection at initiation of therapy.<br>c. Risks and benefits documented in cases of chronic or recurrent infection. | Continue to #4. | Do not approve. |
| **4.** | Has the treatment been initiated by or is an appropriate specialist currently supervising it?<br>a. Ankylosing Spondylitis and Axial Spondyloarthritis: | Continue to #5 | Do not approve. |

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| | Rheumatologist<br>b. Crohn's Disease: Gastroenterologist<br>c. Juvenile Idiopathic Arthritis: Rheumatologist<br>d. Plaque Psoriasis: Dermatologist<br>e. Psoriatic Arthritis: Dermatologist or Rheumatologist<br>f. Ulcerative Colitis: Gastroenterologist | | |
| **5.** | Is the requested agent to be used in combination with another biologic or Otezla? | Do not approve. | Continue to #6. |
| **6.** | Has the member failed or have contraindications to infliximab? | Continue to #8. | Continue to #7. |
| **7.** | Is the member under 21 years old? | Continue to #8. | Do not approve. |
| **8.** | Has the member failed a TNF inhibitor or have or have contraindications to all TNF inhibitors? | Continue to #9. | Do not approve. |
| **9.** | Proceed to specific criteria for the submitted indication. | | |

# Crohn's Disease

| Initial Criteria | | If yes | If no |
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| **1.** | Is the member transitioning to the requested treatment from a different biologic product? | Continue to #3. | Continue to #2. |
| **2.** | Does the member have moderate to severe Crohn's disease? | Continue to #3. | Do not approve. |
| **3.** | Has the member tried and failed ALL of the following biologics?<br>a. Infliximab, AND<br>b. Adalimumab, AND<br>c. Entyvio or a JAK inhibitor (Rinvoq) | Continue to #4. | Do not approve. |
| **4.** | Approve for 6 months. | | |
| **Renewal Criteria** | | **If yes** | **If no** |
| **1.** | Has the member experienced a decrease in symptoms, reduction in enterocutaneous fistulas or clinical remission? | Continue to #2. | Do not approve. |
| **2.** | Approve for 12 months. | | |

# Juvenile Idiopathic Arthritis

| Initial Criteria | | If yes | If no |
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| **1.** | Does the member have juvenile idiopathic arthritis with active systemic features of JIA, with a physician global assessment of 5 or higher (or any systemic activity in the absence of active joint involvement)? | Continue to #3. | Continue to #2. |
| **2.** | Does the member have juvenile idiopathic arthritis without active systemic features of JIA? | Continue to #4. | Do not approve. |
| **3.** | Has the member tried and failed systemic corticosteroids? | Continue to #4. | Do not approve. |
| **4.** | Has the member tried and failed methotrexate or leflunomide for at least 3 months (or have a contraindication to both)? | Continue to #5. | Do not approve. |
| **5.** | Has the member tried and failed Actemra/Tyenne? | Continue to #6 | Do not approve. |
| **6.** | Is the dose appropriate for the member's age and weight? | Continue to #7 | Do not approve. |
| **7.** | Approve for 6 months. | | |
| **Renewal Criteria** | | **If yes** | **If no** |
| **1.** | Has the member experienced 20% or greater improvement in tender joint count and swollen joint count or stabilization of active systemic activity? | Continue to #2. | Do not approve. |
| **2.** | Approve for 12 months. | | |

# Plaque Psoriasis

| Initial Criteria | | If yes | If no |
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| **1.** | Does the member have chronic, moderate to severe plaque psoriasis at baseline with functional impairment and one or more of the following?<br>a. At least 10% body surface area involved<br>b. Hand, foot, face, or mucous membrane | Continue to #4. | Continue to #2. |

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| | involvement | | |
| **2.** | Is the member under the age of 21? | Continue to #3. | Do not approve. Plaque psoriasis without functional impairment and hand, foot, face, or mucous membrane involvement or affecting 10% or more of body surface area is not covered for treatment by the Oregon Health Plan. |
| **3.** | Is it medically necessary or medically appropriate to treat the psoriasis due to contributing factors to a comorbid condition or impact on growth, learning, or development? | Continue to #4. | Do not approve based on medical necessity or appropriateness. |
| **4.** | Is the member transitioning to the requested treatment from a different biologic product? | Continue to #7. | Continue to #5. |
| **5.** | Has the member tried and failed high-potency topical corticosteroids, such as augmented betamethasone cream 0.05%, desoximetasone 0.25% cream, or clobetasol AND a non-steroid topical? | Continue to #6. | Do not approve. |
| **6.** | Has the member tried and failed ONE of the following?:<br>a. An oral DMARD (methotrexate, cyclosporine, or acitretin) OR<br>b. Phototherapy<br>. | Continue to #7. | Do not approve. |
| **7.** | Is the dosing within plan quantity limits (in criteria below)? | Continue to #7. | Do not approve. |
| **8.** | Is the request for Stelara or Skyrizi? | Continue to #8. | Continue to #9. |
| **9.** | Has the member failed Cosentyx Ilumya or Siliq? | Continue to #9. | Do not approve. |

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| **10.** | Is the dose appropriate for age and weight? | Continue to #10 | Do not approve. |
| **11.** | Approve for 3 months. | | |
| Renewal Criteria | | If yes | If no |
| **1.** | Has the member experienced a clinically significant response, such as PASI-75 (75% improvement) and/or is there evidence of functional improvement? | Continue to #2. | Do not approve. |
| **2.** | Approve for 12 months. | | |

# Psoriatic Arthritis

| Initial Criteria | | If yes | If no |
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| **1.** | Does the member have psoriatic arthritis based on at least 3 out of 5 of the following?<br>a. Psoriasis (1 point for personal or family history, 2 points for current)<br>b. Psoriatic nail dystrophy<br>c. Negative test result for RF<br>d. Dactylitis (current or history)<br>e. Radiological evidence of juxta-articular new bone formation | Continue to #2. | Do not approve. |
| **2.** | Is the member transitioning to the requested treatment from a different biologic product? | Continue to #4. | Continue to #3. |
| **3.** | Has the member failed or have contraindications to conventional management with all of the following?<br>a. NSAIDs, and<br>b. Methotrexate or other DMARD such as leflunomide, sulfasalazine, or cyclosporine. | Continue to #4. | Do not approve.. |
| **4.** | Is the request for Cosentyx? | Continue to #5. | Continue to #6. |
| **5.** | Has the provider requested a loading dose? (induction dosing 150 mg at weeks 0, 1, 2, 3, and 4.) | Do not approve. | Continue to #8. |
| **6.** | Is the request for Stelara or Skyrizi? | Continue to #7. | Continue to #8. |

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| **7.** | Has the member failed another IL-17/23 inhibitor (Cosentyx, Tremfya, Taltz) OR a JAK inhibitor (Xeljanz or Rinvoq)? | Continue to #8. | Do not approve. |
| **8.** | Is the dose appropriate for age and weight? | Continue to #9. | Do not approve. |
| **9.** | Approve for 6 months. | | |
| Renewal Criteria | | If yes | If no |
| **1.** | Has the member experienced 20% or greater improvement in tender joint count and swollen joint count? | Continue to #2. | Do not approve. |
| **2.** | Approve for 12 months. | | |

# Ulcerative Colitis

| Initial Criteria | | If yes | If no |
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| **1.** | Is the member transitioning to the requested treatment from a different biologic product? | Continue to #3. | Continue to #2. |
| **2.** | Does the member have a diagnosis of moderate to severe ulcerative colitis defined by the following criteria?<br>a. Moderate = greater than or equal to 4 stools daily.<br>b. Severe = greater than or equal to 6 bloody stools daily and evidence of toxicity such as fever, anemia, elevated ESR, or tachycardia. | Continue to #3. | Do not approve. |
| **3.** | Has the member tried and failed or have a contraindication to ALL of the following?<br>a. Infliximab, AND<br>b. Adalimumab, AND<br>c. Entyvio OR a JAK inhibitor (Xeljanz or Rinvoq) | Continue to #4. | Do not approve. |
| **4.** | Approve for 6 months. | | |
| Renewal Criteria | | If yes | If no |
| **1.** | Has the member demonstrated a significant response including the following?<br>a. Decrease in bloody stools per day and/or<br>b. Elimination of signs of toxicity | Continue to #2. | Do not approve. |
| **2.** | Approve for 12 months. | | |