AETNA BETTER HEALTH® Coverage Policy/Guideline				
Name:	Ilumya		Page:	1 of 4
Effective Date:	1/30/2025		Last Review Date:	7/2023; 12/2024
Applies to:	☒Illinois ☐New Jersey ☐Pennsylvania Kids	☐Florida ☐Maryland ☐Virginia	☐Florida Kids ☐Michigan ☐Kentucky PRMD	

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Ilumya under the patient's prescription drug benefit.

Description:

FDA-Approved Indication
Treatment of adult patients with moderate to severe plaque psoriasis (PsO) who are candidates for systemic therapy or phototherapy.

All other indications are considered experimental/investigational and not medically necessary.

Applicable Drug List:

Non-Preferred: Ilumya

Policy/Guideline:

Documentation for all indications:
The patient is unable to take THREE preferred products, where indicated, for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication. Documentation is required for approval.

Documentation:
Submission of the following information is necessary to initiate the prior authorization review:

A. Initial requests:
   1. Chart notes or medical record documentation of affected area(s) and body surface area (BSA) affected (if applicable).
   2. Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.

B. Continuation requests: Chart notes or medical record documentation of decreased body surface area (BSA) affected and/or improvement in signs and symptoms.

Prescriber Specialty:
This medication must be prescribed by or in consultation with a dermatologist.

Criteria for Initial Approval:
Plaque psoriasis (PsO)

A. Authorization of 12 months may be granted for adult members who have previously received a biologic or targeted synthetic drug indicated for treatment of moderate to severe plaque psoriasis.
B. Authorization of 12 months may be granted for adult members for treatment of moderate to severe plaque psoriasis when any of the following criteria is met:
    1. Crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected.
    2. At least 10% of body surface area (BSA) is affected.
    3. At least 3% of body surface area (BSA) is affected and the member meets any of the following criteria:
        i. Member has had an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin.
        ii. Member has a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin (see Appendix).

Continuation of Therapy:
Authorization of 12 months may be granted for all adult members (including new members) who are using the requested medication for moderate to severe plaque psoriasis and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when either of the following is met:

A. Reduction in body surface area (BSA) affected from baseline
B. Improvement in signs and symptoms from baseline (e.g., itching, redness, flaking, scaling, burning, cracking, pain)

Other Criteria:
Member has had a documented negative tuberculosis (TB) test (which can include a tuberculosis skin test [TST] or an interferon-release assay [IGRA])* within 6 months of initiating therapy for persons who are naïve to biologic drugs or targeted synthetic drugs associated with an increased risk of TB.

* If the screening testing for TB is positive, there must be further testing to confirm there is no active disease (e.g., chest x-ray). Do not administer the requested medication to members with active TB infection. If there is latent disease, TB treatment must be started before initiation of the requested medication.

Member cannot use the requested medication concomitantly with any other biologic drug or targeted synthetic drug for the same indication.

APPENDIX

Examples of Clinical Reasons to Avoid Pharmacologic Treatment with Methotrexate, Cyclosporine, or Acitretin

1. Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease
2. Drug interaction
3. Risk of treatment-related toxicity
4. Pregnancy or currently planning pregnancy
5. Breastfeeding
6. Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension)
7. Hypersensitivity
8. History of intolerance or adverse event

Approval Duration and Quantity Restrictions:

Approval:

Initial Approval: 12 months

Renewal Approval: 12 months

Quantity Level Limit:

Medication	Standard Limit	Exception Limit*
Ilumya 100 mg/mL single-dose prefilled syringe	1 syringe per 12 weeks	2 syringes per 28 days

*Exception limit applies to loading doses.

References:

1. Ilumya [package insert]. Cranbury, NJ: Sun Pharmaceutical Industries, Inc.; December 2022.
2. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Section 4: Guidelines of care for the management and treatment of psoriasis with traditional systemic agents. *J Am Acad Dermatol.* 2009;61(3):451-485.
3. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Section 6: Guidelines of care for the treatment of psoriasis and psoriatic arthritis:

case-based presentations and evidence-based conclusions. *J Am Acad Dermatol*. 2011;65(1):137-174.

4. Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. *J Am Acad Dermatol*. 2019;80(4):1029-1072.
5. Menter A, Gelfand JM, Connor C, et al. Joint AAD-NPF guidelines of care for the management of psoriasis with systemic nonbiologic therapies. *J Am Acad Dermatol.* 2020;82(6):1445-1486.
6. Testing for TB Infection. Centers for Disease Control and Prevention. Retrieved on January 4, 2024 from: https://www.cdc.gov/tb/topic/testing/tbtesttypes.htm.
7. Coates LC, Soriano ER, Corp N, et al. Group for Research and Assessment of Psoriasis and Psoriatic Arthritis (GRAPPA): updated treatment recommendations for psoriatic arthritis 2021. *Nat Rev Rheumatol.* 2022;18(8):465-479.