UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2022 P 1245-5
Program	Prior Authorization/Notification
Medication	Ilumya™ (tildrakizumab-asmn)* *Ilumya is excluded from coverage for the majority of our benefits
P&T Approval Date	5/2018, 2/2019, 2/2020, 2/2021, 2/2022
Effective Date	5/1/2022; Oxford only: N/A

1. Background:

Ilumya (tildrakizumab-asmn) is an interleukin-23 antagonist indicated for the treatment of adults with moderate to severe plaque psoriasis who are candidates for systemic therapy or phototherapy.

2. Coverage Criteria:

A. Plaque Psoriasis

1. **Initial Authorization**

a. Ilumya will be approved based on **both** of the following criteria:

(1) Diagnosis of moderate to severe plaque psoriasis

-AND-

(2) Patient is not receiving Ilumya in combination with **any** of the following:

(a) Biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]
(b) Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
(c) Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

Authorization will be issued for 12 months.

2. **Reauthorization**

a. Ilumya will be approved based on **both** of the following criteria:

(1) Documentation of positive clinical response to Ilumya therapy

-AND-

(2) Patient is not receiving Ilumya in combination with **any** of the following:

(a) Biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]
(b) Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
(c) Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

Authorization will be issued for 12 months.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- *Ilumya is excluded from coverage for the majority of our benefits
- Supply limits, Step Therapy, and/or Medical Necessity may be in place.

4. Reference:

1. Ilumya [package insert]. Cranbury, NJ: Sun Pharmaceutical Industries, Inc.; July 2020.

Program	Prior Authorization/Notification - Ilumya (tildrakizumab)
Change Control	
5/2018	New program
2/2019	Annual review with no change to clinical criteria.
2/2020	Annual review. Added coverage exclusion statement.
2/2021	Annual review. Updated reauthorization duration.
2/2022	Annual review with no changes to coverage criteria. Updated reference.