UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2021 P 1183-7
Program	Prior Authorization/Notification
Medication	Taltz® (ixekizumab)* * Taltz is excluded from coverage for the majority of our benefits
P&T Approval Date	5/2016, 3/2017, 2/2018, 2/2019, 9/2019, 7/2020, 7/2021
Effective Date	10/1/2021; Oxford: N/A

1. Background:

Taltz (ixekizumab) is a humanized interleukin-17A antagonist indicated for the treatment of patients aged 6 years or older with moderate to severe plaque psoriasis who are candidates for systemic therapy or phototherapy. It is also indicated for the treatment of adult patients with active psoriatic arthritis, active ankylosing spondylitis or non-radiographic axial spondyloarthritis with objective signs of inflammation.

2. Coverage Criteria:

A. Plaque Psoriasis

1. **Initial Authorization**

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

      (1) Diagnosis of moderate to severe plaque psoriasis

      -AND-

      (2) Patient is not receiving **Taltz** 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. **Taltz** will be approved based on **both** of the following criteria:

      (1) Documentation of positive clinical response to Taltz therapy

      -AND-

      (2) Patient is not receiving **Taltz** 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.

B. Psoriatic Arthritis

1. **Initial Authorization**

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

(1) Diagnosis of active psoriatic arthritis

-AND-

(2) Patient is not receiving **Taltz** 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. **Taltz** will be approved based on **both** of the following criteria:

(1) Documentation of positive clinical response to Taltz therapy

-AND-

(2) Patient is not receiving **Taltz** 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.

C. Ankylosing Spondylitis or Non-radiographic Axial Spondyloarthritis

1. **Initial Authorization**

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

(1) Diagnosis of active ankylosing spondylitis or active non-radiographic axial spondyloarthritis

-AND-

(2) Patient is not receiving **Taltz** in combination with **either** of the following:

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

Authorization will be issued for 12 months.

2. **Reauthorization**

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

(1) Documentation of positive clinical response to Taltz therapy

-AND-

(2) Patient is not receiving **Taltz** in combination with **either** of the following:

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

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.
- Exclusion: Taltz is excluded from coverage for the majority of our benefits
- Medical Necessity, Supply limits and/or Step Therapy may be in place.

4. Reference:

1. Taltz [package insert]. Indianapolis, IN: Eli Lilly and Co.; May 2020.

Program	Prior Authorization/Notification - Taltz (ixekizumab)
Change Control	
5/2016	New program
3/2017	Annual review with no change to criteria. Updated reference.
2/2018	Updated background and added criteria for new indication of psoriatic arthritis. Updated reference.
2/2019	Annual review with no change to criteria. Updated reference.
9/2019	Updated background and criteria to include new indication for active ankylosing spondylitis. Added coverage exclusion statement. Updated reference.
7/2020	Updated background and criteria to include new indication for active non-radiographic axial spondyloarthritis. Changed reauthorization duration to 12 months. Updated reference.
7/2021	Annual review with no changes to criteria.