Original Effective Date: 06/01/2019
Current Effective Date: 10/25/2023
Last P&T Approval/Version: 10/26/2022
Next Review Due By: 10/2023
Policy Number: C17336-A

Skyrizi (risankizumab-rzaa)

PRODUCTS AFFECTED

Skyrizi (risankizumab-rzaa)

COVERAGE POLICY

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Coverage Guideline must be read in its entirety to determine coverage eligibility, if any. This Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide Molina Healthcare complete medical rationale when requesting any exceptions to these guidelines.

Documentation Requirements:
Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational, or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

DIAGNOSIS:
Moderate-to-severe Plaque Psoriasis, Psoriatic Arthritis, Crohn’s Disease

REQUIRED MEDICAL INFORMATION:
This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. If a drug within this policy receives an updated FDA label within the last 180 days, medical necessity for the member will be reviewed using the updated FDA label information along with state and federal requirements, benefit being administered and formulary preferencing. Coverage will be determined on a case-by case basis until the criteria can be updated through Molina Healthcare, Inc. clinical governance. Additional information may be required on a case-by-case basis to allow for adequate review. When the requested drug product for coverage is dosed by weight, body surface area or other member specific measurement, this data element is required as part of the medical necessity review. The Pharmacy and Therapeutics Committee has determined that the drug benefit shall be a mandatory generic and that generic drugs will be dispensed whenever available.

FOR ALL INDICATIONS

1. (a) Prescriber attests, or clinical reviewer has found, member has had a negative TB screening* or TB test** (if indicated) result within the last 12 months for initial and continuation of therapy requests

*MOLINA REVIEWER NOTE: TB SCREENING assesses patient for future or ongoing TB exposure or risk and includes reviewing if they have been exposed to tuberculosis, if they have resided or traveled to areas of endemic tuberculosis, if patient resides or works in a congregate setting (e.g., correctional facilities, long-term care facilities, homeless shelters), etc.
**MOLINA REVIEWER NOTE: TB SKIN TEST (TST, PPD) AND TB BLOOD TEST (QuantiFERON TB Gold, T-Spot) are not required or recommended in those without risk factors for tuberculosis
OR
(b) For members who have a positive test for latent TB, provider documents member has completed a treatment course (a negative chest x-ray is also required every 12 months) OR that member has been cleared by an infectious disease specialist to begin treatment
AND

2. Member is not on concurrent treatment or will not be used in combination with TNF-inhibitor, biologic response modifier or other biologic DMARDs, Janus kinase Inhibitors, or Phosphodiesterase 4 inhibitor (i.e., apremilast, tofacitinib, baricitinib) as verified by prescriber attestation, member medication fill history, or submitted documentation
AND
3. Prescriber attests member does not have an active infection, including clinically important localized infections
AND
4. IF THIS IS A NON-FORMULARY/NON-PREFERRED PRODUCT: Documentation of trial/failure of or serious side effects to a majority (not more than 3) of the preferred formulary/PDL alternatives for the given diagnosis. Submit documentation including medication(s) tried, dates of trial(s) and reason for treatment failure(s).

A. PLAQUE PSORIASIS:

1. Documented diagnosis of moderate to severe psoriasis (BSA ≥ 3) OR < 3% body surface area with plaque psoriasis that involves sensitive areas of the body or areas that would significantly impact daily function (e.g., face, neck, hands, feet, genitals)
AND
2. (a) Documentation of treatment failure, serious side effects, or clinical contraindication to TWO of the following systemic therapies for ≥ 3 months: Methotrexate (oral or IM at a minimum dose of 15 mg/week), cyclosporine, acitretin, azathioprine, hydroxyurea, leflunomide, mycophenolate mofetil, or tacrolimus
OR
(b) Documentation of treatment failure to Phototherapy for ≥3 months with either psoralens with ultraviolet A (PUVA) or ultraviolet B (UVB) radiation (provider to submit documentation of duration of treatment, dates of treatment, and number of sessions; contraindications include type 1 or type 2 skin, history of photosensitivity, treatment of facial lesions, presence of premalignant lesions, history of melanoma or squamous cell carcinoma, or physical inability to stand for the required exposure time)
AND
3. Documentation of prescriber baseline disease activity evaluation and goals for treatment to be used to evaluate efficacy of therapy at renewal [DOCUMENTATION REQUIRED]

B. PSORIATIC ARTHRITIS (PsA):

1. Documentation of active psoriatic arthritis
AND
2. Documentation of prescriber baseline disease activity evaluation and goals for treatment to be used to evaluate efficacy of therapy [DOCUMENTATION REQUIRED]
AND
3. (a) Documented treatment failure, serious side effects or clinical contraindication to a minimum 3- month trial of ONE of the following: Leflunomide, Methotrexate, Sulfasalazine, Cyclosporine
OR

(b) Documentation member has severe psoriatic arthritis [erosive disease, elevated markers of inflammation, long term damage that interferes with function, highly active disease that causes a major impairment in quality of life, active PsA at many sites including dactylitis, enthesitis, function-limiting PsA at a few sites or rapidly progressive disease]
OR
(c) Documentation member has severe psoriasis [PASI ≥12, BSA of >5-10%, significant involvement in specific areas (e.g., face, hands or feet, nails, intertriginous areas, scalp), impairment of physical or mental functioning with lower amount of surface area of skin involved]

C. MODERATE TO SEVERE ACTIVE CROHN'S DISEASE:

1. Documentation of a diagnosis of Crohn's Disease
   AND
2. Prescriber attests that members liver enzymes and bilirubin levels have been obtained and reviewed prior to initiating therapy with Skyrizi (risankizumab)
   NOTE: For the treatment of Crohn's disease, evaluate liver enzymes and bilirubin at baseline, and during induction at least up to 12 weeks of treatment. Monitor thereafter according to routine patient management.
   AND
3. Member has one or more high risk feature:
   i. Diagnosis at a younger age (<30 years old)
   ii. History of active or recent tobacco use
   iii. Elevated C-reactive protein and/or fecal calprotectin levels
   iv. Deep ulcers on colonoscopy
   v. Long segments of small and/or large bowel involvement
   vi. Perianal disease
   vii. Extra-intestinal manifestations
   viii. History of bowel resections
   AND
4. (a) Documentation of treatment failure, serious side effects or clinical contraindication to an adequate trial (> 3 months) of ONE immunomodulator (e.g., azathioprine, 6-mercaptopurine, methotrexate) up to maximally indicated doses
   OR
   (b) Prescriber provides documented medical justification that supports the inability to use immunomodulators
      i. Inability to induce short-term symptomatic remission with a 3-month trial of systemic glucocorticoids
      ii. High-risk factors for intestinal complications may include: Initial extensive ileal, ileocolonic, or proximal GI involvement, Initial extensive perianal/severe rectal disease, Fistulizing disease (e.g., perianal, enterocutaneous, and rectovaginal fistulas), Deep ulcerations, Penetrating, stricturing or stenosis disease and/or phenotype, Intestinal obstruction or abscess
      iii. High risk factors for postoperative recurrence may include: Less than 10 years duration between time of diagnosis and surgery, Disease location in the ileum and colon, Perianal fistula, Prior history of surgical resection, Use of corticosteroids prior to surgery
   AND
5. Documentation of prescriber baseline disease activity evaluation and goals for treatment to be used to evaluate efficacy of therapy at renewal [DOCUMENTATION REQUIRED]

CONTINUATION OF THERAPY:

A. ALL INDICATIONS:

1. Adherence to therapy at least 85% of the time as verified by the prescriber or member medication fill history OR adherence less than 85% of the time due to the need for surgery or treatment of an infection, causing temporary discontinuation
   AND
2. Prescriber attests to or clinical reviewer has found no evidence of intolerable adverse effects or

drug toxicity (e.g., drug-induced liver injury in Crohn's Disease)
AND

3. Documentation of positive clinical response as demonstrated by low disease activity and/or improvements in the condition's signs and symptoms. [DOCUMENTATION REQUIRED]
AND
4. (a) Prescriber attests, or clinical reviewer has found, member has had a negative TB screening* or TB test (if indicated)** result within the last 12 months for initial and continuation of therapy requests
*MOLINA REVIEWER NOTE: TB SCREENING assesses patient for future or ongoing TB exposure or risk and includes reviewing if they have been exposed to tuberculosis, if they have resided or traveled to areas of endemic tuberculosis, if patient resides or works in a congregate setting (e.g., correctional facilities, long-term care facilities, homeless shelters), etc.
**MOLINA REVIEWER NOTE: TB SKIN TEST (TST, PPD) AND TB BLOOD TEST (QuantiFERON TB Gold, T-Spot) are not required or recommended in those without risk factors for tuberculosis
OR
(b) For members who have a positive test for latent TB, provider documents member has completed a treatment course (a negative chest x-ray is also required every 12 months) OR that member has been cleared by an infectious disease specialist to begin treatment

DURATION OF APPROVAL:
Initial authorization: 6 months, Continuation of therapy: 12 months.

PRESCRIBER REQUIREMENTS:
Prescribed by or in consultation with a board-certified dermatologist, rheumatologist or gastroenterologist. [If prescribed in consultation, consultation notes must be submitted with initial request and reauthorization requests]

AGE RESTRICTIONS:
18 years of age and older

QUANTITY:
Plaque Psoriasis and Psoriatic Arthritis:150 mg administered by subcutaneous injection at Week 0, Week 4 and every 12 weeks thereafter.

Crohn's Disease:
Initial dosing: 600 mg administered by intravenous infusion over at least one hour at Week 0, Week 4, and Week 8.
Maintenance dosage: max 360 mg administered by subcutaneous injection at Week 12, and every 8 weeks thereafter

PLACE OF ADMINISTRATION:
The recommendation is that subcutaneous injectable medications in this policy will be for pharmacy benefit coverage and patient self-administered.

The recommendation is that infused medications in this policy will be for pharmacy or medical benefit coverage administered in a place of service that is a non-inpatient hospital facility-based location as per the Molina Health Care Site of Care program.

Note: Site of Care Utilization Management Policy applies for Skyrizi (risankizumab-rzaa) to channel to the prescription drug benefit for member self-administration as appropriate. For information on site of care, see Specialty Medication Administration Site of Care Coverage Criteria (molinamarketplace.com)

DRUG INFORMATION

ROUTE OF ADMINISTRATION:
Intravenous, Subcutaneous

DRUG CLASS:
Antipsoriatics - Systemic/Interleukin Antagonists

FDA-APPROVED USES:
Indicated for the treatment of:

- moderate-to-severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy
- active psoriatic arthritis in adults
- moderately to severely active Crohn's disease in adults

COMPENDIAL APPROVED OFF-LABELED USES:
None

APPENDIX

APPENDIX:
None

BACKGROUND AND OTHER CONSIDERATIONS

BACKGROUND:
Psoriasis is a cell-mediated autoimmune and inflammatory disease that affects about 3% of the population. Plaque psoriasis accounts for about 80% to 90% of all patients with psoriasis. Patients are considered to have a “moderate-to-severe” degree of plaque psoriasis when the disease affects more than 5% to 10% of a patient’s body surface. Roughly 70% to 80% of patients with plaque psoriasis have mild disease that can be adequately managed with topical therapy.
Skyrizi, an interleukin (IL)-23 blocker, is indicated for treatment of adults with moderate to severe plaque psoriasis who are candidates for systemic therapy or phototherapy. Skyrizi selectively binds to the p19 subunit of the IL-23 cytokine and inhibits interaction with the IL-23 receptor. IL-23, a key cytokine involved in inflammatory and immune responses, is thought to be linked to several chronic immune-mediated diseases such as plaque psoriasis. The recommended dose of Skyrizi is 150 mg(two 75 mg injections) administered subcutaneously (SC) at Weeks 0 and 4 and then once every 12 weeks (Q12W) thereafter. Administer each dose at a different anatomic location such as the thighs or abdomen.
Efficacy:
Four multicenter, randomized, double-blind studies ULTIMMA-1, ULTIMMA-2, IMMHANCE, and IMMVENT enrolled 2109 subjects 18 years of age and older with moderate -to-severe plaque psoriasis who had a body surface area (BSA) involvement of ≥10%, a static Physician’s Global Assessment (sPGA) score of ≥3 (“moderate”) in the overall assessment (plaque thickness/induration, erythema, and scaling) of psoriasis on a severity scale of 0 to 4, and a Psoriasis Area and Severity Index (PASI) score ≥12. Overall, subjects had a median baseline PASI score of 17.8 and a median BSA of 20.0%. Baseline sPGA score was 4 (“severe”) in 19% of subjects. A total of 10% of study subjects had a history of diagnosed psoriatic arthritis. Across all studies, 38% of subjects had received prior phototherapy, 48% had received prior nonbiologic systemic therapy, and 42% had received prior biologic therapy for the treatment of psoriasis. In ULTIMMA-1 and ULTIMMA-2, 997 subjects were enrolled (including 598 subjects randomized to the SKYRIZI 150 mg group, 200 subjects randomized to the placebo group, and 199 to the biologic active control group). Subjects received treatment at Weeks 0, 4, and every 12 weeks thereafter.
Both studies assessed the responses at Week 16 compared to placebo for two co-primary endpoints:
▪ the proportion of subjects who achieved an sPGA score of 0 (“clear”) or 1 (“almost clear”)
▪ the proportion of subjects who achieved at least a 90% reduction from baseline PASI (PASI 90)

Secondary endpoints included the proportion of subjects who achieved PASI 100, sPGA 0, and PSS0 at Week 16.

Examination of age, gender, race, body weight, baseline PASI score and previous treatment with systemic or biologic agents did not identify differences in response to Skyrizi among these subgroups at Week 16. In ULTIMMA-1 and ULTIMMA-2 at Week 52, subjects receiving Skyrizi achieved sPGA 0 (58% and 60%, respectively), PASI 90 (82% and 81%, respectively), and PASI 100 (56% and 60%, respectively). IMMHANCE enrolled 507 subjects (407 randomized to Skyrizi 150 mg and 100 to placebo). Subjects received treatment at Weeks 0, 4, and every 12 weeks thereafter. At Week 16, Skyrizi was superior to placebo on the co-primary endpoints of sPGA 0 or 1 (84% SKYRIZI and 7% placebo) and PASI 90 (73% Skyrizi and 2% placebo). The respective response rates for Skyrizi and placebo at Week 16 were: sPGA 0 (46% Skyrizi and 1% placebo); PASI 100 (47% Skyrizi and 1% placebo); and PASI 75 (89% Skyrizi and 8% placebo). In ULTIMMA-1 and ULTIMMA-2, among the subjects who received Skyrizi and had PASI 100 at Week 16, 80% (206/258) of the subjects who continued on Skyrizi had PASI 100 at Week 52. For PASI 90 responders at Week 16, 88% (398/450) of the subjects had PASI 90 at Week 52. In IMMHANCE, subjects who were originally on Skyrizi and had sPGA 0 or 1 at Week 28 were re- randomized to continue Skyrizi every 12 weeks or withdrawal of therapy. At Week 52, 87% (97/111) of the subjects re-randomized to continue treatment with Skyrizi had sPGA 0 or 1 compared to 61% (138/225) who were re-randomized to withdrawal of Skyrizi.

Adverse Effects

A total of 2234 subjects were treated with Skyrizi in clinical development studies in plaque psoriasis. Of these, 1208 subjects with psoriasis were exposed to Skyrizi for at least one year. Data from placebo- and active-controlled studies were pooled to evaluate the safety of Skyrizi for up to 16 weeks. In total, 1306 subjects were evaluated in the Skyrizi 150 mg group. Table 1 summarizes the adverse drug reactions that occurred at a rate of at least 1% and at a higher rate in the Skyrizi group than the placebo group during the 16-week controlled period of pooled clinical studies. Adverse drug reactions that occurred in < 1% but > 0.1% of subjects in the Skyrizi group and at a higher rate than in the placebo group through Week 16 were folliculitis and urticaria. In the first 16 weeks, infections occurred in 22.1% of the Skyrizi group (90.8 events per 100 subject- years) compared to 14.7% of the placebo group (56.5 events per 100 subject-years) and did not lead to discontinuation of Skyrizi. The rates of serious infections for the Skyrizi group and the placebo group were ≤0.4%. Serious infections in the Skyrizi group included cellulitis, osteomyelitis, sepsis and herpes zoster. In ULTIMMA-1 and ULTIMMA-2, through Week 52, the rate of infections (73.9 events per 100 subject- years) was similar to the rate observed during the first 16 weeks of treatment. Through Week 52, no new adverse reactions were identified, and the rates of the adverse reactions were similar to those observed during the first 16 weeks of treatment. During this period, serious infections that led to study discontinuation included pneumonia.

CONTRAINDICATIONS/EXCLUSIONS/DISCONTINUATION:

All other uses of Skyrizi (risankizumab-rzaa) are considered experimental/investigational and therefore, will follow Molina's Off-Label policy. Contraindications to Skyrizi (risankizumab-rzaa) include: a history of serious hypersensitivity reaction to risankizumab-rzaa or any of the excipients, use with live vaccines.

OTHER SPECIAL CONSIDERATIONS:

None

CODING/BILLING INFORMATION

Note: 1) This list of codes may not be all-inclusive. 2) Deleted codes and codes which are not

HCPCS CODE	DESCRIPTION
J2327	Injection, Risankizumab-rzaa, intravenous, 1mg

AVAILABLE DOSAGE FORMS:
Skyrizi (150 MG Dose) PSKT 75MG/0.83ML (2 x 75 MG/0.83ML Prefilled syringe Kit)
Skyrizi Pen SOAJ 150MG/ML Auto-injector
Skyrizi SOCT 180MG/1.2ML
Skyrizi SOCT 360MG/2.4ML
Skyrizi SOSY 150MG/ML Prefilled syringe
Skyrizi SOLN 600MG/10ML

REFERENCES

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SUMMARY OF REVIEW/REVISIONS	DATE
REVISION- Notable revisions: Required Medical Information Continuation of Therapy Drug Class Contraindications/Exclusions/Discontinuation Other Special Considerations Coding/Billing Information Available Dosage Forms References	Q4 2023
REVISION- Notable revisions: Required Medical Information Continuation of Therapy	Q4 2022
REVISION- Notable revisions: Diagnosis Required Medical Information Prescriber Requirements Quantity Place of administration Route of Administration FDA-Approved Uses Coding/Billing Information Available Dosage Forms References	Q3 2022
Q2 2022 Established tracking in new format	Historical changes on file