Effective Date **2/1/2024**
Next Review Date… **2/1/2025**
Coverage Policy Number **IP0224**

Ixekizumab

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Related Coverage Resources

INSTRUCTIONS FOR USE
The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview

This policy supports medical necessity review for ixekizumab (Taltz®).

Receipt of sample product does not satisfy any criteria requirements for coverage.

Medical Necessity Criteria

Ixekizumab (Taltz) is considered medically necessary when ONE of the following is met:

1. **Ankylosing Spondylitis.** Individual meets **ALL** of the following criteria:
   A. Documentation of **ONE** of the following:
      i. Failure, contraindication, or intolerance to **ONE** non-steroidal anti-inflammatory drug (NSAID)
      ii. Already tried a biologic or targeted synthetic DMARD (tsDMARD) for Ankylosing Spondylitis
   B. Medication is prescribed by, or in consultation with, a rheumatologist or prescriber who specializes in Ankylosing Spondylitis
   C. Non-Preferred Product Criteria is met, refer to below table(s) [Individual and Family Plan]

2. **Non-Radiographic Axial Spondyloarthritis.** Individual meets **ALL** of the following criteria:
   A. Has objective signs of inflammation, defined as **ONE** of the following:
      i. C-reactive protein (CRP) elevated beyond the upper limit of normal for the reporting laboratory
      ii. Sacroiliitis reported on magnetic resonance imaging (MRI)
   B. Medication is being prescribed by, or in consultation with, a rheumatologist
   C. Non-Preferred Product Criteria is met, refer to below table(s) [Individual and Family Plan]

3. **Plaque Psoriasis.** Individual meets **ALL** of the following criteria:
   A. 6 years of age or older
   B. Body Surface Area (BSA) of greater than 5% OR BSA less than 5% and there is and there is involvement of the scalp, face, the palms and soles (i.e., palmoplantar disease), or genitals
   C. Documentation of **ONE** of the following:
      i. Failure to **ONE** of the following, unless contraindicated or intolerant to **ALL** of the following:
         a. Topical therapy (for example, topical corticosteroids, topical vitamin D analogs, Tazorac)
         b. Systemic therapy (for example, methotrexate, cyclosporine, acitretin)
         c. Phototherapy
      ii. Already tried a biologic or targeted synthetic DMARD (tsDMARD) for Plaque Psoriasis.
   D. Medication is being prescribed by, or in consultation with, a dermatologist
   E. Non-Preferred Product Criteria is met, refer to below table(s) [Individual and Family Plan]

4. **Psoriatic Arthritis.** Individual meets **ALL** of the following criteria:
   A. Documentation of **ONE** of the following:
      i. Failure to **ONE** disease-modifying anti-rheumatic drug (DMARD), unless contraindicated or intolerant
      ii. Already tried a biologic or targeted synthetic DMARD (tsDMARD) for Psoriatic Arthritis
   B. Medication is being prescribed by, or in consultation with, a rheumatologist or dermatologist
   C. Non-Preferred Product Criteria is met, refer to below table(s) [Individual and Family Plan]

Coverage varies across plans and may require the use of preferred products. Refer to the customer's benefit plan document for coverage details.

Employer Group Plans	
Condition	
Ankylosing Spondylitis	**Preferred** [requires prior authorization]
Non-Radiographic Axial Spondyloarthritis	
Plaque Psoriasis - Adult and Pediatric/Adolescent	
Psoriatic Arthritis	

Individual and Family Plan	
Condition	**Non-Preferred Product Criteria**
Ankylosing Spondylitis	Documentation of failure, contraindication, or intolerance to **TWO** of the following: A. **Adalimumab Product** (**adalimumab-adaz/Hyrimoz** [manufactured by Sandoz/Novartis], **adalimumab – adbm/Cyltezo**, **Hadlima**, or **Humira**) [requires prior authorization] B. **Cimzia** [requires prior authorization] C. **Cosentyx subcutaneous injection** [requires prior authorization] D. **Enbrel** [requires prior authorization] E. **Rinvoq** [requires prior authorization] F. **Xeljanz/XR** [requires prior authorization]
Non-Radiographic Axial Spondyloarthritis	Documentation of failure, contraindication, or intolerance to **BOTH** of the following: A. **Cimzia** [requires prior authorization] B. **Cosentyx subcutaneous injection** [requires prior authorization]
Plaque Psoriasis - Adult	Documentation of failure, contraindication, or intolerance to **THREE** of the following: A. **Adalimumab Product** (**adalimumab-adaz/Hyrimoz** [manufactured by Sandoz/Novartis], **adalimumab – adbm/Cyltezo**, **Hadlima**, or **Humira**) [requires prior authorization] B. **Cimzia** [requires prior authorization] C. **Cosentyx subcutaneous injection** [requires prior authorization] D. **Enbrel** [requires prior authorization] E. **Otezla** [requires prior authorization] F. **Skyrizi SC** [requires prior authorization] G. **Stelara SC** [requires prior authorization] H. **Tremfya** [requires prior authorization]
Plaque Psoriasis - Pediatric and Adolescent	Documentation of failure, contraindication, or intolerance to **TWO** of the following: A. **Cimzia** [requires prior authorization] B. **Cosentyx subcutaneous injection** [requires prior authorization] C. **Enbrel** [requires prior authorization] D. **Stelara SC** [requires prior authorization]
Psoriatic Arthritis - Adult	Documentation of failure, contraindication, or intolerance to **THREE** of the following: A. **Adalimumab Product** (**adalimumab-adaz/Hyrimoz** [manufactured by Sandoz/Novartis], **adalimumab – adbm/Cyltezo**, **Hadlima**, or **Humira**) [requires prior authorization] B. **Cimzia** [requires prior authorization] C. **Cosentyx subcutaneous injection** [requires prior authorization] D. **Enbrel** [requires prior authorization] E. **Otezla** [requires prior authorization] F. **Rinvoq** [requires prior authorization] G. **Skyrizi SC** [requires prior authorization] H. **Stelara SC** [requires prior authorization] I. **Tremfya** [requires prior authorization] J. **Xeljanz/XR** [requires prior authorization]

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Reauthorization Criteria

Continuation of ixekizumab (Taltz) is considered medically necessary for **ALL** covered diagnoses when initial criteria are met AND beneficial response is demonstrated.

Authorization Duration

Initial approval duration is up to 12 months.
Reauthorization approval duration is up to 12 months.

Conditions Not Covered

Any other use is considered experimental, investigational or unproven, including the following (this list may not be all inclusive):

1. **Concurrent Use with other Biologics or with Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs).** Taltz should not be administered in combination with a biologic used for an inflammatory condition (see APPENDIX for examples). Combination therapy with biologics and targeted synthetic DMRADs has a potential for a higher rate of adverse effects and lacks controlled trial data in support of additive efficacy.

   This does NOT exclude the use of methotrexate (a traditional systemic agent used to treat psoriasis) in combination with Taltz.

2. **Inflammatory Bowel Disease (i.e., Crohn's disease, ulcerative colitis).** Exacerbations of inflammatory bowel disease, in some cases serious, occurred in clinical trials with Taltz-treated patients.[1]

Background

OVERVIEW
Taltz, an interleukin (IL)-17A antagonist, is indicated for the following uses:[1]

- **Ankylosing spondylitis**, in adults with active disease.
- **Non-radiographic axial spondyloarthritis**, in adults with active disease and objective signs of inflammation.
- **Plaque psoriasis**, in patients ≥ 6 years of age with moderate to severe disease who are candidates for systemic therapy or phototherapy.
- **Psoriatic arthritis**, in adults with active disease.

In the pivotal trial for non-radiographic axial spondyloarthritis, patients were required to have objective signs of inflammation, indicated by elevated C-reactive protein and/or sacroiliitis on magnetic resonance imaging.

Guidelines

- **Spondyloarthritis:** Guidelines for ankylosing spondylitis and non-radiographic axial spondylitis are published by the American College of Rheumatology (ACR)/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network (2019).[2] Following primary non-response to a tumor necrosis factor inhibitor (TNFi), either Cosentyx® (secukinumab subcutaneous injection) or Taltz is recommended; however, if the patient is a secondary non-responder, a second TNFi is recommended over switching out of the class. In patients with a contraindication to a TNFi, use of an IL blocker is recommended over traditional oral agents such as methotrexate or sulfasalazine.

- **Plaque Psoriasis:** Joint guidelines from the American Academy of Dermatology and National Psoriasis Medical Board (2019) have been published for management of psoriasis with biologics.[3] These guidelines list Taltz as a monotherapy treatment option for patients with moderate to severe plaque psoriasis. Guidelines from the European Dermatology Forum (2015) recommend biologics (i.e., etanercept, adalimumab, infliximab, Stelara® (ustekinumab subcutaneous injection) as second-line

therapy for induction and long-term treatment if phototherapy and conventional systemic agents have failed, are contraindicated, or are not tolerated.[4]

- **Psoriatic Arthritis:** Guidelines from ACR (2019) recommend TNFis over other biologics for use in treatment-naïve patients with psoriatic arthritis and in those who were previously treated with an oral therapy.[5]

References

1. Taltz® subcutaneous injection [prescribing information]. Indianapolis, IN: Eli Lilly; March 2021.
2. Ward MM, Deodhar A, Gensler LS, et al. 2019 update of the American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network recommendations for the treatment of ankylosing spondylitis and nonradiographic axial spondyloarthritis. *Arthritis Rheumatol*. 2019;71(10):1599-1613.
3. 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.
4. Nast A, Gisondi P, Ormerod AD, et al. European S3-Guidelines on the systemic treatment of psoriasis vulgaris – Update 2015 – Short version – EDF in cooperation with EADV and IPC. *J Eur Acad Dermatol Venereol*. 2015;29(12):2277-2294.
5. Singh JA, Guyatt G, Ogdie A, et al. 2018 American College of Rheumatology/National Psoriasis Foundation Guideline for the treatment of psoriatic arthritis. *Arthritis Care Res (Hoboken)*. 2019;71(1):2-29.

APPENDIX

Table 1. Approved TNFis for Targeted Indications.

	Rheumatology					Dermatology	Gastroenterology	
	RA	**JIA**	**AS**	**nr-axSpA**	**PsA**	**PsO**	**CD**	**UC**
Tumor Necrosis Factor Inhibitors								
Cimzia	√	--	√	√	√	√	√	--
Enbrel	√	√	√	--	√	√	--	--
Humira	√	√	√	--	√	√	√	√
Infliximab Products	√	--	√	--	√	√	√	√
Simponi Subcutaneous	√	--	√	--	√	--	--	√
Simponi Aria	√	√	√	--	√	--	--	--

TNFis – Tumor necrosis factor inhibitors; RA – Rheumatoid arthritis; JIA – Juvenile idiopathic arthritis; AS – Ankylosing spondylitis; nr-axSpA – Non-radiographic spondyloarthritis; PsA – Psoriatic arthritis; PsO – Plaque psoriasis; CD – Crohn's disease; UC – Ulcerative colitis.

Table 2. Approved IL-17, IL-23, and IL-12/23 Blockers for Targeted Indications.

	Rheumatology			Dermatology	Gastroenterology	
	Ankylosing Spondylitis	**nr-axSpA**	**Psoriatic Arthritis**	**Plaque Psoriasis**	**Crohn's Disease**	**Ulcerative Colitis**
Interleukin-17 Blockers						
Cosentyx	√	√	√	√	--	--
Siliq	--	--	--	√	--	--
Taltz	√	√	√	√	--	--
Interleukin-23 Blockers						
Ilumya	--	--	--	√	√	--
Skyrizi Intravenous	--	--	--	--	√#	--
Skyrizi Subcutaneous	--	--	√	√	√^	--
Tremfya	--	--	√	√	--	--
Interleukin-12/23 Blockers						
Stelara Subcutaneous	--	--	√	√	√^	√^
Stelara Intravenous	--	--	--	--	√#	√#

IL – Interleukin; nr-axSpA – Non-radiographic spondyloarthritis; ^ Maintenance dosing only; # Induction dosing only.

Table 3. Approved Oral tsDMARDs for Targeted Indications.

	Rheumatology					Dermatology	Gastro-enterology
	Rheumatoid Arthritis	**Juvenile Idiopathic Arthritis**	**Ankylosing Spondylitis**	**nr-axSpA**	**Psoriatic Arthritis**	**Plaque Psoriasis**	**Ulcerative Colitis**
Janus Kinases Inhibitors							
Olumiant	√	--	--	--	--	--	--
Rinvoq	√	--	√	√	√	--	√
Xeljanz tablets	√	√#	√	--	√	--	√
Xeljanz oral solution	--	√#	--	--	--	--	--
Xeljanz XR	√	--	√	--	√	--	√
Phosphodiesterase Type 4 Inhibitor							
Otezla	--	--	--	--	√	√	--
Sphingosine 1-Phosphate Receptor Modulator							
Zeposia	--	--	--	--	--	--	√
Tyrosine Kinase 2 Inhibitor							
Sotyktu	--	--	--	--	--	√	--

tsDMARDs – Targeted synthetic disease-modifying antirheumatic drugs; # Indicated in polyarticular JIA.

Table 4. Other Approved Biologics for Targeted Indications.

	Rheumatology		
	Rheumatoid Arthritis	**Juvenile Idiopathic Arthritis**	**Psoriatic Arthritis**
Interleukin-6 Blockers			
Actemra Intravenous	√	√^	--
Actemra Subcutaneous	√	√^	--
Kevzara	√	--	--
Interleukin-1 Blocker			
Kineret	√	--	--
T-Cell Costimulation Modulator			
Orencia Intravenous	√	√#	√
Orencia Subcutaneous	√	√#	√
CD20-Directed Cytolytic Antibody			
Rituximab Intravenous Products	√	--	--

^ Indicated in polyarticular and systemic JIA; # Indicated in polyarticular JIA.