



Drug Coverage Policy

Effective Date03/15/2026
Coverage Policy Number.....IP0689
Policy Title.....Tremfya Subcutaneous
Prior Authorization Policy

Inflammatory Conditions – Tremfya Subcutaneous Prior Authorization Policy

- Tremfya® (guselkumab subcutaneous injection – Janssen Biotech/Johnson & Johnson)

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. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. 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

Tremfya, an interleukin (IL)-23 blocker, is indicated for the following uses:¹

- **Crohn's disease**, in adults with moderate to severe active disease.
- **Plaque psoriasis**, in adults with moderate to severe disease who are candidates for systemic therapy or phototherapy.
- **Plaque psoriasis**, in pediatric patients ≥ 6 years of age and weighing ≥ 40 kg with moderate to severe disease who are candidates for phototherapy or systemic therapy.
- **Psoriatic arthritis**, in adults with active disease (given \pm a conventional synthetic disease-modifying antirheumatic drug).
- **Psoriatic arthritis**, in pediatric patients ≥ 6 years of age and weighing ≥ 40 kg with active disease (given \pm a conventional synthetic disease-modifying antirheumatic drug).
- **Ulcerative colitis**, in adults with moderate to severe active disease.

Guidelines

IL blockers are mentioned in guidelines for treatment of inflammatory conditions.

- **Crohn's Disease:** The American College of Gastroenterology (ACG) [2025] and the American Gastroenterological Association (AGA) [2025] have guidelines for the management of Crohn's disease in adults.^{7,8} Both guidelines recommend upfront use of advanced therapies, rather than step-up therapy after failure of corticosteroids and/or immunomodulators. Advanced therapies recommended include tumor necrosis factor (TNF) inhibitors, Entyvio® (vedolizumab intravenous infusion, subcutaneous injection), IL-23 inhibitors, IL-12/23 inhibitors, and Rinvoq® (upadacitinib extended-release tablets).
- **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.² These guidelines list Tremfya as a monotherapy treatment option for patients with moderate to severe plaque psoriasis. It is recommended that a response to therapy be ascertained after 12 weeks of continuous therapy. Guidelines from the European Dermatology Forum (2025) recommend biologics as second-line therapy for induction and long-term treatment if phototherapy and conventional systemic agents have failed, are contraindicated, or are not tolerated.³ Pediatric guidelines were published by the American Academy of Dermatology and the National Psoriasis Foundation (NPF) [2020].⁹ These guidelines list traditional systemic therapies (e.g., methotrexate, cyclosporine, acitretin) and biologics as options for treatment of moderate to severe plaque psoriasis.
- **Psoriatic Arthritis:** Guidelines from the American College of Rheumatology/National Psoriasis Foundation (2018) were published prior to approval of Tremfya for psoriatic arthritis. However, these guidelines generally recommend TNF inhibitors as the first-line treatment strategy over other biologics (e.g., IL-17 blockers, IL-12/23 inhibitor) with differing mechanisms of action.⁴
- **Ulcerative colitis:** The AGA (2024) and ACG (2025) have clinical practice guidelines on the management of moderate to severe ulcerative colitis in adults.^{5,6} In moderate to severe disease, systemic corticosteroids or advanced therapies may be utilized for induction of remission. Recommended advanced therapies include TNF inhibitors, Entyvio, IL-23 inhibitors, IL-12/23 inhibitors, sphingosine-1-phosphate (S1P) receptor modulators, and Janus kinase (JAK) inhibitors. If steroids are utilized for induction, efforts should be made to introduce steroid-sparing agents for maintenance therapy. Of note, guidelines state that corticosteroids may be avoided entirely when other effective induction strategies are planned.⁶ Both guidelines also recommend that any drug that effectively treats induction should be continued for maintenance.^{5,6}

Coverage Policy

Policy Statement

Prior Authorization is required for benefit coverage of Tremfya. All approvals are for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days. Because of the specialized skills required for evaluation and diagnosis of patients treated with Tremfya as well as the monitoring required for adverse events and long-term efficacy, initial approval requires Tremfya to be prescribed by or in consultation with a physician who specializes in the condition being treated.

Tremfya subcutaneous is considered medically necessary when ONE of the following is met (1, 2, 3, or 4):

FDA-Approved Indications

- 1. Crohn's Disease.** Approve for the duration noted if the patient meets ONE of the following (A or B):
 - A) Initial Therapy.** Approve for 6 months if the patient meets BOTH of the following (i and ii):
 - i.** Patient is ≥ 18 years of age; AND
 - ii.** The medication is prescribed by or in consultation with a gastroenterologist; OR
 - B) Patient is Currently Receiving Tremfya Subcutaneous.** Approve for 1 year if the patient meets BOTH of the following (i and ii):
 - i.** Patient has been established on therapy for at least 6 months; AND
Note: A patient who has received < 6 months of therapy or who is restarting therapy is reviewed under criterion A (Initial Therapy).
 - ii.** Patient meets at least ONE of the following (a or b):
 - a)** When assessed by at least one objective measure, patient experienced a beneficial clinical response from baseline (prior to initiating Tremfya); OR
Note: Examples of objective measures include fecal markers (e.g., fecal lactoferrin, fecal calprotectin), serum markers (e.g., C-reactive protein), imaging studies (magnetic resonance enterography, computed tomography enterography), endoscopic assessment, and/or reduced dose of corticosteroids.
 - b)** Compared with baseline (prior to initiating Tremfya), patient experienced an improvement in at least one symptom, such as decreased pain, fatigue, stool frequency, and/or blood in stool.
- 2. Plaque Psoriasis.** Approve for the duration noted if the patient meets ONE of the following (A or B):
 - A) Initial Therapy.** Approve for 3 months if the patient meets ALL of the following (i, ii, and iii):
 - i.** Patient meets ONE of the following (a or b):
 - a)** Patient meets BOTH of the following [(1) and (2)]:
 - (1)** Patient is ≥ 6 years to ≤ 17 years of age; AND
 - (2)** Patient weighs ≥ 40 kg; OR
 - b)** Patient is ≥ 18 years of age; AND
 - ii.** Patient meets ONE of the following (a or b):
 - a)** Patient has tried at least one traditional systemic agent for psoriasis for at least 3 months, unless intolerant; OR
Note: Examples include methotrexate, cyclosporine, or acitretin. A 3-month trial of psoralen plus ultraviolet A light (PUVA) also counts. An exception to the requirement for a trial of one traditional systemic agent for psoriasis can be made if the patient has already had a 3-month trial or previous intolerance to at least one biologic, Otezla (apremilast tablets)/Otezla XR (apremilast extended-release tablets) or Sotyktu (deucravacitinib tablets) Refer to [Appendix](#) for examples of biologics used for psoriasis. A patient who has already tried a biologic, Otezla (apremilast

tablets)/Otezla XR (apremilast extended-release tablets or Sotyktu (deucravacitinib tablets) for psoriasis is not required to “step back” and try a traditional systemic agent for psoriasis.

b) According to the prescriber, the patient has a contraindication to methotrexate; AND

iii. The requested agent is prescribed by or in consultation with a dermatologist; OR

B) Patient is Currently Receiving Tremfya. Approve for 1 year if the patient meets ALL of the following (i, ii, and iii):

i. Patient has been established on the requested drug for at least 3 months; AND

Note: A patient who has received < 3 months of therapy or who is restarting therapy with the requested drug is reviewed under criterion A (Initial Therapy).

ii. Patient experienced a beneficial clinical response, defined as improvement from baseline (prior to initiating the requested drug) in at least one of the following: estimated body surface area, erythema, induration/thickness, and/or scale of areas affected by psoriasis; AND

iii. Compared with baseline (prior to initiating the requested drug), patient experienced an improvement in at least one symptom, such as decreased pain, itching, and/or burning.

3. Psoriatic Arthritis. Approve for the duration noted if the patient meets ONE of the following (A or B):

A) Initial Therapy. Approve for 6 months if the patient meets BOTH of the following (i and ii):

i. Patient meets ONE of the following (a or b):

a) Patient meets BOTH of the following [(1) and (2)]:

(1) Patient is \geq 6 years to \leq 17 years of age; AND

(2) Patient weighs \geq 40 kg; OR

b) Patient is \geq 18 years of age; AND

ii. The medication is prescribed by or in consultation with a rheumatologist or a dermatologist; OR

B) Patient is Currently Receiving Tremfya. Approve for 1 year if the patient meets BOTH of the following (i and ii):

i. Patient has been established on the requested drug for at least 6 months; AND

Note: A patient who has received < 6 months of therapy or who is restarting therapy with the requested drug is reviewed under criterion A (Initial Therapy).

ii. Patient meets at least ONE of the following (a or b):

a) When assessed by at least one objective measure, patient experienced a beneficial clinical response from baseline (prior to initiating the requested drug); OR

Note: Examples of objective measures of disease activity include Disease Activity Index for Psoriatic Arthritis (DAPSA), Composite Psoriatic Disease Activity Index (CPDAI), Psoriatic Arthritis Disease Activity Score (PsA DAS), Grace Index, Leeds Enthesitis Score (LEI), Spondyloarthritis Consortium of Canada (SPARCC) enthesitis score, Leeds Dactylitis Instrument Score, Minimal Disease Activity (MDA), Psoriatic Arthritis Impact of Disease (PsAID-12), and/or serum markers (e.g., C-reactive protein, erythrocyte sedimentation rate).

b) Compared with baseline (prior to initiating the requested drug), patient experienced an improvement in at least one symptom, such as less joint pain, morning stiffness, or fatigue; improved function or activities of daily living; decreased soft tissue swelling in joints or tendon sheaths.

4. Ulcerative Colitis. Approve for the duration noted if the patient meets ONE of the following (A or B):

A) Initial Therapy. Approve for 6 months if the patient meets ALL of the following (i and ii):

i. Patient is \geq 18 years of age; AND

ii. The medication is prescribed by or in consultation with a gastroenterologist; OR

- B) Patient is Currently Receiving Tremfya Subcutaneous.** Approve for 1 year if the patient meets BOTH of the following (i and ii):
- i. Patient has been established on the requested drug for at least 6 months; AND
Note: A patient who has received < 6 months of therapy or who is restarting therapy with the requested drug is reviewed under criterion A (Initial Therapy).
 - ii. Patient meets at least ONE of the following (a or b):
 - a) When assessed by at least one objective measure, patient experienced a beneficial clinical response from baseline (prior to initiating the requested drug); OR
Note: Examples of assessment for inflammatory response include fecal markers (e.g., fecal calprotectin), serum markers (e.g., C-reactive protein), endoscopic assessment, and/or reduced dose of corticosteroids.
 - b) Compared with baseline (prior to initiating the requested drug), patient experienced an improvement in at least one symptom, such as decreased pain, fatigue, stool frequency, and/or decreased rectal bleeding.

Conditions Not Covered

Tremfya subcutaneous for any other use is considered not medically necessary, including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

- 1. Concurrent Use with a Biologic or with a Targeted Synthetic Oral Small Molecule Drug.** This medication should not be administered in combination with another biologic or with a targeted synthetic oral small molecule drug used for an inflammatory condition (see [Appendix](#) for examples). Combination therapy is generally not recommended due to a potentially higher rate of adverse events and lack of controlled clinical data supporting additive efficacy.
Note: This does NOT exclude the use of conventional synthetic disease-modifying antirheumatic drugs (e.g., methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine) in combination with this medication.

References

1. Tremfya® subcutaneous injection [prescribing information]. Horsham, PA: Janssen Biotech/Johnson & Johnson September 2025.
2. 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.
3. Nast A, Smith C, Spuls PI, et al. EuroGuiDerm Guideline on the systemic treatment of Psoriasis vulgaris - Part 1: treatment and monitoring recommendations. *J Eur Acad Dermatol Venereol.* 2020 Nov;34(11):2461-2498.
4. Singh JA, Guyatt G, Ogdie A, et al. 2018 American College of Rheumatology/National Psoriasis Foundation guideline for the treatment of psoriatic arthritis. *Arthritis Rheumatol.* 2019;71(1):5-32.
5. Singh S, Loftus EV Jr, Limketkai BN, et al. AGA Living Clinical Practice Guideline on Pharmacological Management of Moderate-to-Severe Ulcerative Colitis. *Gastroenterology.* 2024 Dec;167(7):1307-1343.
6. Rubin D, Ananthakrishnan A, Siegel C. ACG Clinical Guideline Update: Ulcerative Colitis in Adults. *Am J of Gastroenterol.* 2025 June;120(6):1187-1224
7. Lichtenstein, G, Loftus E, Afzali A, et al. ACG Clinical Guideline: Management of Crohn's Disease in Adults. *Am J Gastroenterol.* 2025 June;120(6):1225-1264.

8. Scott FI, Ananthakrishnan AN, Click B, et al. AGA Living Clinical Practice Guideline on the Pharmacologic Management of Moderate-to-Severe Crohn's Disease. *Gastroenterology*. 2025 Dec;169(7):1397-1448.
9. Menter A, Cordoro KM, Davis DMR, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management and treatment of psoriasis in pediatric patients. *J Am Acad Dermatol*. 2020 Jan;82(1):161-201.

Revision Details

Type of Revision	Summary of Changes	Date
New	New policy	11/1/2024
Selected Revision	Policy name was changed to as listed (previously was Inflammatory Conditions – Tremfya). Ulcerative Colitis: This new condition of approval was added to the policy.	01/01/2025
Selected Revision	Crohn's Disease: This new condition of approval was added to the policy.	05/15/2025
Selected Revision	Ulcerative Colitis: For initial therapy, removed the following options of approval: (1) the patient has tried one systemic therapy; (2) the patient has pouchitis and tried an antibiotic, probiotic, corticosteroid enema, or mesalamine enema.	09/01/2025
Annual Revision	Ulcerative Colitis: For initial therapy, removed the requirement the patient will receive three induction doses of Tremfya intravenous within three months of initiating therapy with Tremfya subcutaneous. Plaque Psoriasis: For Initial Therapy: an option of approval in a patient ≥ 6 years to ≤ 17 years of age and weighing ≥ 40 kg was added; in the Note, a 3-month trial or prior intolerance to Otezla (apremilast tablets), Otezla XR (apremilast extended-release tablets), or Sotyktu (deucravacitinib tablets) was added as an exception to the requirement for a trial of one traditional systemic agent for psoriasis; and "patient has a contraindication to methotrexate, as determined by the prescriber" was modified to "according to the prescriber, the patient has a contraindication to methotrexate". Psoriatic Arthritis: An option of approval in a patient ≥ 6 years to ≤ 17 years of age and weighing ≥ 40 kg was added.	11/01/2025
Selected Revision	Crohn's Disease: For initial therapy, the following options of approval were removed: The patient has tried or is currently taking systemic corticosteroids, or corticosteroids are contraindicated; patient has tried one conventional systemic therapy for Crohn's disease along with the associated Note; patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas; patient had ileocolonic	03/15/2026

	resection (to reduce the chance of Crohn's disease recurrence). Appendix: Otezla XR (apremilast extended-release tablets) was added.	
--	--	--

The policy effective date is in force until updated or retired.

APPENDIX

	Mechanism of Action	Examples of Indications*
Biologics		
Adalimumab SC Products (Humira®, biosimilars)	Inhibition of TNF	AS, CD, JIA, PsO, PsA, RA, UC
Cimzia® (certolizumab pegol SC injection)	Inhibition of TNF	AS, CD, nr-axSpA, PsO, PsA, RA
Etanercept SC Products (Enbrel®, biosimilars)	Inhibition of TNF	AS, JIA, PsO, PsA, RA
Infliximab IV Products (Remicade®, biosimilars)	Inhibition of TNF	AS, CD, PsO, PsA, RA, UC
Zymfentra® (infliximab-dyyb SC injection)	Inhibition of TNF	CD, UC
Simponi®, Simponi Aria® (golimumab SC injection, golimumab IV infusion)	Inhibition of TNF	SC formulation: AS, PsA, RA, UC
		IV formulation: AS, PJIA, PsA, RA
Tocilizumab Products (Actemra® IV, biosimilar; Actemra SC, biosimilar)	Inhibition of IL-6	SC formulation: PJIA, RA, SJIA
		IV formulation: PJIA, RA, SJIA
Kevzara® (sarilumab SC injection)	Inhibition of IL-6	RA
Orencia® (abatacept IV infusion, abatacept SC injection)	T-cell costimulation modulator	SC formulation: JIA, PSA, RA
		IV formulation: JIA, PsA, RA
Rituximab IV Products (Rituxan®, biosimilars)	CD20-directed cytolytic antibody	RA
Kineret® (anakinra SC injection)	Inhibition of IL-1	JIA [^] , RA
Omvo® (mirikizumab IV infusion, SC injection)	Inhibition of IL-23	CD, UC
Ustekinumab Products (Stelara® IV, biosimilars, Stelara SC, biosimilars)	Inhibition of IL-12/23	SC formulation: CD, PsO, PsA, UC
		IV formulation: CD, UC
Siliq® (brodalumab SC injection)	Inhibition of IL-17	PsO
Cosentyx® (secukinumab SC injection; secukinumab IV infusion)	Inhibition of IL-17A	SC formulation: AS, ERA, nr-axSpA, PsO, PsA
		IV formulation: AS, nr-axSpA, PsA
Taltz® (ixekizumab SC injection)	Inhibition of IL-17A	AS, nr-axSpA, PsO, PsA
Bimzelx® (bimekizumab-bkzx SC injection)	Inhibition of IL-17A/17F	AS, nr-axSpA, PsO, PsA
Ilumya® (tildrakizumab-asmn SC injection)	Inhibition of IL-23	PsO
Skyrizi® (risankizumab-rzaa SC injection, risankizumab-rzaa IV infusion)	Inhibition of IL-23	SC formulation: CD, PSA, PsO, UC
		IV formulation: CD, UC

Tremfya [®] (guselkumab SC injection, guselkumab IV infusion)	Inhibition of IL-23	SC formulation: CD, PsA, PsO, UC IV formulation: CD, UC
Entyvio [®] (vedolizumab IV infusion, vedolizumab SC injection)	Integrin receptor antagonist	CD, UC
Oral Therapies/Targeted Synthetic Oral Small Molecule Drugs		
Otezla [®] (apremilast tablets)	Inhibition of PDE4	PsO, PsA
Otezla XR [™] (apremilast extended-release tablets)	Inhibition of PDE4	PsO, PsA
Cibinqo [™] (abrocitinib tablets)	Inhibition of JAK pathways	AD
Olumiant [®] (baricitinib tablets)	Inhibition of JAK pathways	RA, AA
Litfulo [®] (ritlecitinib capsules)	Inhibition of JAK pathways	AA
Leqselvi [®] (deuruxolitinib tablets)	Inhibition of JAK pathways	AA
Rinvoq [®] (upadacitinib extended-release tablets)	Inhibition of JAK pathways	AD, AS, nr-axSpA, RA, PsA, CD, UC
Rinvoq [®] LQ (upadacitinib oral solution)	Inhibition of JAK pathways	PsA, PJIA
Sotyktu [®] (deucravacitinib tablets)	Inhibition of TYK2	PsO
Xeljanz [®] (tofacitinib tablets/oral solution)	Inhibition of JAK pathways	RA, PJIA, PsA, UC
Xeljanz [®] XR (tofacitinib extended-release tablets)	Inhibition of JAK pathways	RA, PsA, UC
Zeposia [®] (ozanimod tablets)	Sphingosine 1 phosphate receptor modulator	UC
Velsipity [®] (etrasimod tablets)	Sphingosine 1 phosphate receptor modulator	UC

* Not an all-inclusive list of indications. Refer to the prescribing information for the respective agent for FDA-approved indications; SC – Subcutaneous; TNF – Tumor necrosis factor; AS – Ankylosing spondylitis; CD – Crohn’s disease; JIA – Juvenile idiopathic arthritis; PsO – Plaque psoriasis; PsA – Psoriatic arthritis; RA – Rheumatoid arthritis; UC – Ulcerative colitis; nr-axSpA – Non-radiographic axial spondyloarthritis; IV – Intravenous, PJIA – Polyarticular juvenile idiopathic arthritis; IL – Interleukin; SJIA – Systemic juvenile idiopathic arthritis; ^ Off-label use of Kineret in JIA supported in guidelines; ERA – Enthesitis-related arthritis; DMARD – Disease-modifying antirheumatic drug; PDE4 – Phosphodiesterase 4; JAK – Janus kinase; AD – Atopic dermatitis; AA – Alopecia areata; TYK2 – Tyrosine kinase 2.

“Cigna Companies” refers to operating subsidiaries of The Cigna Group. All products and services are provided exclusively by or through such operating subsidiaries, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of The Cigna Group. © 2026 The Cigna Group.