MEDICATION POLICY

Generic Name: Ixekizumab

Therapeutic Class or Brand Name: Taltz®

Applicable Drugs (if Therapeutic Class)**:** N/A

Date of Origin: 8/25/16 **Date Last Reviewed/Revised:** 12/2/16

GPI Code: 9025055400

Prior Authorization Criteria (may be considered medically necessary when criteria I through VIII are met):

I. Documented diagnosis of moderate to severe plaque psoriasis.

II. History of treatment failure, intolerance, or contraindication with phototherapy or photochemotherapy.

III. History of treatment failure, intolerance, or contraindication with at least one systemic non-biologic agent (i.e. cyclosporine, methotrexate, acitretin, etc.).

IV. Documented failure, intolerance, or contraindication to at least one preferred tumor necrosis factor (TNF) inhibitor (refer to plan document for the list of preferred products).

V. Diagnosis must be established by a dermatologist or a rheumatologist.

VI. Minimum age requirement: 18 years old.

VII. Absence of active serious infection or sepsis.

VIII. Negative TB skin test within the previous 12 months or history of treatment for latent TB infection.

Exclusion Criteria:

- Coadministration of Taltz® with another biologic DMARD, Otezla® (apremilast), or Xeljanz®/ XR (tofacitinib). Examples of biologic DMARDs include the following:
  - Actemra® (tocilizumab)
  - Cosentyx® (secukinumab)
  - Entyvio® (vedolizumab)
  - Kineret® (anakinra)
  - Orencia® (abatacept)
  - Rituxan® (rituximab)
  - Stelara® (ustekinumab)

- TNF inhibitors [Cimzia® (certolizumab pegol), Enbrel® (etanercept), Humira® (adalimumab), Remicade® (infliximab), Simponi®/Simponi® Aria® (golimumab)]
- Tysabri® (natalizumab)

Other Criteria:

- N/A

Quantity/Days Supply Restrictions:

- Quantities of up to 4 syringes or autoinjectors for the first 28 days, then in quantities of up to 2 syringes or autoinjectors every 28 days for the next 56 days, then in quantities of 1 syringe every 28 days thereafter.

Approval Length:

- **Authorization:** 1 year.
- **Re-Authorization:** An updated letter of medical necessity or progress notes showing current medical necessity criteria are met and that the medication is effective.

Appendix:

N/A

References:

1. http://uspl.lilly.com/taltz/taltz.html#pi.
2. Medi-Span.

MEDICATION POLICY

Historical Tracking Of Changes Made To Policy	
12/2/2016	1. **Changed** "III. History of treatment failure, intolerance, or contraindication with at least one appropriate systemic agent (i.e. cyclosporine, methotrexate, acitretin, etc.)" **to** "III. History of treatment failure, intolerance, or contraindication with at least one systemic non-biologic agent (i.e. cyclosporine, methotrexate, acitretin, etc.)" **under Prior Authorization Criteria**. 2. **Changed** "IV. Documented failure, intolerance, or contraindication to two preferred biologic products (refer to plan document for the list of preferred products)" **to** "IV. Documented failure, intolerance, or contraindication to at least one preferred tumor necrosis factor (TNF) inhibitor (refer to plan document for the list of preferred products)" **under Prior Authorization Criteria**.