Commercial/Healthcare Exchange PA Criteria

Effective: July 22, 2019

Prior Authorization: Skyrizi

Products Affected: Skyrizi (risankizumab) subcutaneous injection

Medication Description: Skyrizi is indicated for the treatment of moderate-to-severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy. Efficacy was demonstrated based on 90% improvement in the Psoriasis Area Severity Index (PASI 90) and static Physician's Global Assessment (sPGA) score of 0 or 1 with Skyrizi compared with either ustekinumab or placebo in 2 large randomized studies.

Covered Uses: treatment of moderate-to-severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy.

Exclusion Criteria: N/A

Required Medical Information:

1. Diagnosis
2. Previous therapies tried

Age Restrictions: 18 years of age or older

Prescriber Restrictions: Must be prescribed by, or in consultation with, a dermatologist.

Coverage Duration:
Initial: 3 Months
Continuation: 3 years

Other Criteria:

Dosing Limitations: Only allow additional quantity for loading dose purposes.
The recommended dose is 150 mg (two 75 mg injections) administered by subcutaneous injection at Week 0, Week 4, and every 12 weeks thereafter.

Initiation
Plaque Psoriasis
*Note: Skyrizi is a preferred product for the diagnosis of Psoriasis

A. Patient has chronic (greater than or equal to 1 year) plaque psoriasis; **AND**
B. Patient has minimum body surface area involvement with plaque psoriasis of ≥ 10%; **AND**
C. Patient has a documented failure of, or intolerance to, or contraindication to at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant. *Women of childbearing age may*

be given special consideration for approval without systemic therapy when topical and phototherapy options have been tried and failed.

Continuation

A. Patient meets all initial authorization criteria; **AND**
B. Patient achieves or maintains a positive clinical response after at least 3 months of therapy with Skyrizi as evidenced by low disease activity or improvement in signs and symptoms of the condition.

*ConnectiCare does not consider alcohol use to be a clinical reason to use Skyrizi over methotrexate.
*ConnectiCare does not consider needle-phobia to be a clinical reason to use Skyrizi over injectable medications.

Note: Clinical criteria incorporated into the Skyrizi quantity limit edit, approve additional quantity (to allow for loading doses at week 0 and week 4 then every 12 weeks thereafter).

References:

1. Product Information: SKYRIZI(TM) subcutaneous injection, risankizumab-rzaa subcutaneous injection. AbbVie Inc (per FDA), North Chicago, IL, 2019.

Policy Revision history

Rev #	Type of Change	Summary of Change	Sections Affected	Date
1	New Policy	New Policy	All	7/22/2019
2	Update	Added Dosing Limitations according to FDA label	Other Criteria	5/4/2020