Clinical Policy: Ixekizumab (Taltz)
Reference Number: CP.PHAR.257
Effective Date: 08.01.16
Last Review Date: 05.19
Line of Business: Medicaid, HIM-Medical Benefit

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Ixekizumab (Taltz®) is an interleukin-17A (IL-17A) antagonist.

FDA Approved Indication(s)
Taltz is indicated for the treatment of:
- Adults with moderate-to-severe plaque psoriasis (PsO) who are candidates for systemic therapy or phototherapy
- Adults with active psoriatic arthritis (PsA)

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Taltz is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Plaque Psoriasis (must meet all):
      1. Diagnosis of PsO;
      2. Prescribed by or in consultation with a dermatologist or rheumatologist;
      3. Age ≥ 18 years;
      4. Member meets one of the following (a or b):
         a. Failure of a ≥ 3 consecutive month trial of methotrexate (MTX) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
         b. If intolerance or contraindication to MTX (see Appendix D), failure of a ≥ 3 consecutive month trial of cyclosporine or acitretin at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
      5. Failure of a ≥ 3 consecutive month trial of adalimumab (Humira® is preferred), unless contraindicated or clinically significant adverse effects are experienced;
         *Prior authorization is required for adalimumab
      6. Dose does not exceed 160 mg at week 0, 80 mg at weeks 2, 4, 6, 8, 10, and 12, followed by maintenance dose of 80 mg every 4 weeks.

Approval duration: 6 months
B. **Psoriatic Arthritis** (must meet all):
   1. Diagnosis of PsA;
   2. Prescribed by or in consultation with a dermatologist or rheumatologist;
   3. Age ≥ 18 years;
   4. Failure of etanercept (*Enbrel® is preferred*) and adalimumab (*Humira is preferred*), each used for ≥ 3 consecutive months, unless contraindicated or clinically significant adverse effects are experienced;  
      *Prior authorization is required for etanercept and adalimumab*
   5. Dose does not exceed one of the following (a or b):
      a. PsA alone: 160 mg at weeks 0, followed by maintenance dose of 80 mg every 4 weeks;
      b. PsA with coexistent PsO: 160 mg at Week 0, 80 mg at weeks 2, 4, 6, 8, 10, and 12, followed by maintenance dose of 80 mg every 4 weeks.

   **Approval duration: 6 months**

C. **Other diagnoses/indications**
   1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid and HIM-Medical Benefit.

II. **Continued Therapy**
A. **All Indications in Section I** (must meet all):
   1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   2. Member is responding positively to therapy;
   3. If request is for a dose increase, new dose does not exceed 80 mg every 4 weeks.

   **Approval duration: 12 months**

B. **Other diagnoses/indications** (must meet 1 or 2):
   1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
      
      **Approval duration: Duration of request or 6 months (whichever is less); or**
   2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid and HIM-Medical Benefit.

III. **Diagnoses/Indications for which coverage is NOT authorized:**
A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 for Medicaid and HIM-Medical Benefit or evidence of coverage documents.

IV. **Appendices/General Information**
   
   **Appendix A: Abbreviation/Acronym Key**
   
   FDA: Food and Drug Administration  
   PsA: psoriatic arthritis  
   IL-17A: interleukin-17A  
   PsO: plaque psoriasis  
   MTX: methotrexate
Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>acitretin (Soriatane®)</td>
<td>PsO 25 or 50 mg PO QD</td>
<td>50 mg/day</td>
</tr>
<tr>
<td>cyclosporine (Sandimmune®, Neoral®)</td>
<td>PsO 2.5 – 4 mg/kg/day PO divided BID</td>
<td>PsO: 4 mg/kg/day</td>
</tr>
<tr>
<td>methotrexate (Rheumatrex®)</td>
<td>PsO 10 – 25 mg/week PO or 2.5 mg PO Q12 hr for 3 doses/week</td>
<td>30 mg/week</td>
</tr>
<tr>
<td>Enbrel® (etanercept)</td>
<td>PsA 50 mg SC once weekly</td>
<td>50 mg/week</td>
</tr>
<tr>
<td>Humira® (adalimumab)</td>
<td>PsO Initial dose: 80 mg SC Maintenance dose: 40 mg SC every other week starting one week after initial dose PsA 40 mg SC every other week</td>
<td>40 mg every other week</td>
</tr>
</tbody>
</table>

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

*Off-label

Appendix C: Contraindications/Boxed Warnings
- Contraindication(s): previous serious hypersensitivity reaction, such as anaphylaxis, to ixekizumab or to any of the excipients
- Boxed warning(s): none reported

Appendix D: General Information
- Definition of failure of MTX or DMARDs
  - Child-bearing age is not considered a contraindication for use of MTX. Each drug has risks in pregnancy. An educated patient and family planning would allow use of MTX in patients who have no intention of immediate pregnancy.
  - Social use of alcohol is not considered a contraindication for use of MTX. MTX may only be contraindicated if patients choose to drink over 14 units of alcohol per week. However, excessive alcohol drinking can lead to worsening of the condition, so patients who are serious about clinical response to therapy should refrain from excessive alcohol consumption.
• Examples of positive response to therapy may include, but are not limited to:
  o Reduction in joint pain/swelling/tenderness
  o Improvement in erythrocyte sedimentation rates/C-reactive protein (ESR/CRP) levels
  o Improvements in activities of daily living
• PsA: According to the 2018 American College of Rheumatology and National Psoriasis Foundation guidelines, TNF inhibitors or oral small molecules (e.g., methotrexate, sulfasalazine, cyclosporine, leflunomide, apremilast) are preferred over other biologics (e.g., interleukin-17 inhibitors or interleukin-12/23 inhibitors) for treatment-naïve disease. TNF inhibitors are also generally recommended over oral small molecules as first-line therapy unless disease is not severe, member prefers oral agents, or TNF inhibitor therapy is contraindicated.

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>PsO (with or without coexistent PsA)</td>
<td>Initial dose: 160 mg (two 80 mg injections) SC at week 0, then 80 mg SC at weeks 2, 4, 6, 8, 10, and 12 Maintenance dose: 80 mg SC every 4 weeks</td>
<td>80 mg every 4 weeks</td>
</tr>
<tr>
<td>PsA</td>
<td>Initial dose: 160 mg (two 80 mg injections) SC at week 0 Maintenance dose: 80 mg SC every 4 weeks</td>
<td>80 mg every 4 weeks</td>
</tr>
</tbody>
</table>

VI. Product Availability
- Single-dose prefilled autoinjector: 80 mg/mL
- Single-dose prefilled syringe: 80 mg/mL

VII. References

<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy created</td>
<td>06.16</td>
<td>08.16</td>
</tr>
<tr>
<td>Converted to new template.</td>
<td></td>
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</tr>
<tr>
<td>PsO: Preferencing requirement for Enbrel removed.</td>
<td>08.17</td>
<td>08.17</td>
</tr>
<tr>
<td>Trial requirement modified to require the concomitant use of oral and topical agent or phototherapy.</td>
<td></td>
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<tr>
<td>Safety criteria was applied according to the safety guidance discussed at CPAC and endorsed by Centene Medical Affairs.</td>
<td></td>
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</tr>
<tr>
<td>2Q 2018 annual review: criteria added for new FDA indication; psoriatic arthritis; removed specific diagnosis requirements for PsO; removed trial and failure of phototherapy and topical therapy for PsO; modified requirement for trial and failure of MTX (and if intolerance or contraindication to MTX, trial and failure of cyclosporine or acitretin) for PsO; removed TB testing for PsO; references reviewed and updated.</td>
<td>02.27.18</td>
<td>05.18</td>
</tr>
<tr>
<td>4Q 2018 annual review: allowed bypassing conventional DMARDs for axial PsA and required trial of NSAIDs; references reviewed and updated.</td>
<td>09.04.18</td>
<td>11.18</td>
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<tr>
<td>2Q 2019 annual review: removed trial and failure requirement of conventional DMARDs (e.g., MTX)/NSAIDs for PsA per ACR/NPF 2018 guidelines; added HIM-Medical Benefit; references reviewed and updated.</td>
<td>03.05.19</td>
<td>05.19</td>
</tr>
</tbody>
</table>

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and
limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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**Note: For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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