Clinical Policy: Ixekizumab (Taltz)

Reference Number: CP.PHAR.257
Effective Date: 08.01.16
Last Review Date: 11.18
Line of Business: Medicaid

Revision Log

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. Member meets one of the following (a, b, or c), unless contraindicated or clinically significant adverse effects are experienced:
   a. Failure of a ≥ 3 consecutive month trial of MTX at up to maximally indicated doses;
   b. If intolerance or contraindication to MTX (*see Appendix D*), failure of a ≥ 3 consecutive month trial of cyclosporine, sulfasalazine, or leflunomide at up to maximally indicated doses;
   c. For axial disease, failure of a ≥ 4 week-trial of non-steroidal anti-inflammatory drugs (NSAIDs) at up to maximally indicated doses;
5. 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*
6. 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 CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

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 CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

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 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration
IL-17A: interleukin-17A
MTX: methotrexate
PsA: psoriatic arthritis
PsO: plaque psoriasis

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.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
acitretin (Soriatane®)	**PsO** 25 or 50 mg PO QD	50 mg/day
cyclosporine (Sandimmune®, Neoral®)	**PsO** 2.5 – 4 mg/kg/day PO divided BID **PsA*** 2.5 to 3 mg/kg/day PO	PsO: 4 mg/kg/day PsA: 3 mg/kg/day
leflunomide (Arava®)	**PsA*** 100 mg/day PO loading dose for 3 days, followed by 20 mg/day PO QD	20 mg/day
methotrexate (Rheumatrex®)	**PsO** 10 – 25 mg/week PO or 2.5 mg PO Q12 hr for 3 doses/week **PsA*** 7.5 – 15 mg/week PO	30 mg/week
NSAIDs (e.g., indomethacin, ibuprofen, naproxen, celecoxib)	**PsA** Varies	Varies
sulfasalazine (Azulfidine®)	**PsA*** 2 g/day PO	5 g/day
Enbrel® (etanercept)	**PsA** 50 mg SC once weekly	50 mg/week
Humira® (adalimumab)	**PsO** Initial dose: 80 mg SC	40 mg every other week

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	Maintenance dose: 40 mg SC every other week starting one week after initial dose **PsA** 40 mg SC every other week	

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:
  - Reduction in joint pain/swelling/tenderness
  - Improvement in erythrocyte sedimentation rates/C-reactive protein (ESR/CRP) levels
  - Improvements in activities of daily living

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
PsO (with or without coexistent PsA)	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	80 mg every 4 weeks
PsA	Initial dose: 160 mg (two 80 mg injections) SC at week 0 Maintenance dose: 80 mg SC every 4 weeks	80 mg every 4 weeks

VI. Product Availability

- Single-dose prefilled autoinjector: 80 mg/mL
- Single-dose prefilled syringe: 80 mg/mL

VII. References

1. Taltz Prescribing Information. Indianapolis, IN: Eli Lilly and Company; May 2018. Available at http://pi.lilly.com/us/taltz-uspi.pdf. Accessed September 4, 2018.
2. Menter A, Korman NJ, Elmets CA, , et al. American Academy of Dermatology. Guidelines of care for the management of psoriasis and psoriatic arthritis: section 4. Guidelines of care for the management and treatment of psoriasis with traditional systemic agents. J Am Acad Dermatol. 2009 Sep; 61(3):451-85.
3. Menter A, Gottlieb A, Feldman SR, et al. American Academy of Dermatology. Guidelines of care for the management of psoriasis and psoriatic arthritis: Section 1. Overview of psoriasis and guidelines of care for the treatment of psoriasis with biologics. J Am Acad Dermatol 2008 May; 58(5):826-50.
4. Hsu S, Papp KA, Lebwohl MG et al. Consensus guidelines for the management of plaque psoriasis. Arch Dermatol. 2012 Jan; 148(1):95-102
5. Pariser DM, Bagel J, Gelfand JM et al. National psoriasis foundation clinical consensus on disease severity. Arch Dermatol. 2007 Feb; 143: 239-242.
6. Gossec L, Smolen JS, Ramiro S, et al. European League Against Rheumatism (EULAR) recommendations for the management of psoriatic arthritis with pharmacological therapies: 2015 update. Ann Rheum Dis 2015;0:1-12. doi:10.1136/annrheumdis-2015-208337

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	06.16	08.16
Converted to new template. PsO: Preferencing requirement for Enbrel removed. Trial requirement modified to require the concomitant use of oral and topical agent or phototherapy. Safety criteria was applied according to the safety guidance discussed at CPAC and endorsed by Centene Medical Affairs.	08.17	08.17
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.	02.27.18	05.18
4Q 2018 annual review: allowed bypassing conventional DMARDs for axial PsA and required trial of NSAIDs; references reviewed and updated.	09.04.18	11.18

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.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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.