Clinical Policy: Risankizumab-rzaa (Skyrizi)

Reference Number: MDN.CP.PHAR.426
Effective Date: 06.04.19
Last Review Date: 4.17.25
Line of Business: Meridian IL Medicaid

Revision Log

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

Description

Risankizumab-rzaa (Skyrizi™) is an interleukin-23 (IL-23) blocker.

FDA Approved Indication(s)

Skyrizi is indicated for the treatment of:

- Moderate-to-severe plaque psoriasis (PsO) in adults who are candidates for systemic therapy or phototherapy
- Active psoriatic arthritis (PsA) in adults
- Moderately to severely active Crohn's disease (CD) in adults

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 Skyrizi is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Plaque Psoriasis (must meet all)**:**

1. Diagnosis of moderate-to-severe PsO as evidenced by involvement of one of the following (a or b):
   a. ≥ 3% of total body surface area;
   b. Hands, feet, scalp, face, or genital area;
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):
   a. Failure of a ≥ 3 consecutive month trial of methotrexate (MTX) at up to maximally indicated doses;
   b. Member has intolerance or contraindication to MTX (*see Appendix D*), and failure of a ≥ 3 consecutive month trial of cyclosporine or acitretin at up to maximally indicated doses, unless clinically significant adverse effects are experienced or both are contraindicated;
   c. Member has intolerance or contraindication to MTX, cyclosporine, and acitretin and failure of phototherapy, unless contraindicated or clinically significant adverse effects are experienced;

5. Failure of TWO of the following, each used for ≥ 3 consecutive months, unless the member has had a history of failure of two TNF blockers, contraindicated or clinically significant adverse effects are experienced: Cimzia®, Enbrel®, adalimumab-adbm or adalimumab-ryvk (Simlandi) ;
   **Prior authorization may be required for Cimzia, Enbrel, and adalimumab products*
6. Failure of the following used for ≥ 3 consecutive months: Cosentyx®;
   **Prior authorization may be required for Cosentyx*
7. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (see Section III: Diagnoses/Indications for which coverage is NOT authorized);
8. Dose does not exceed 150 mg at weeks 0 and 4, then every 12 weeks thereafter.

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 ALL of the following, each used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated (a, b, and c):
   a. Enbrel®, Cimzia®, and adalimumab-adbm or adalimumab-ryvk (Simlandi) unless the member has had a history of failure of two TNF blockers;
   b. If member has not responded or is intolerant to one or more TNF blockers, Xeljanz®/Xeljanz XR®, unless member has cardiovascular risk and benefits do not outweigh the risk of treatment;
   c. Cosentyx, unless clinically significant adverse effects are experienced or all are contraindicated.
   *Prior authorization may be required for adalimumab products, Cosentyx®, Enbrel, Xeljanz/Xeljanz XR;
5. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (see Section III: Diagnoses/Indications for which coverage is NOT authorized);
6. Dose does not exceed 150 mg at weeks 0 and 4, then every 12 weeks thereafter.

Approval duration: 6 months

C. Crohn's Disease (must meet all):

1. Diagnosis of CD;
2. Prescribed by or in consultation with a gastroenterologist;
3. Age ≥ 18 years;
4. Member meets one of the following (a or b):
   a. Failure of a ≥ 3 consecutive month trial of at least ONE immunomodulator (e.g., azathioprine, 6-mercaptopurine [6-MP], MTX) at up to maximally

indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated;
   b. Medical justification supports inability to use immunomodulators (see Appendix E);
5. Failure of a ≥ 3 consecutive month trial of adalimumab-adbm or adalimumab-ryvk (Simlandi) AND one other TNF blocker (e.g., Cimzia®), unless the member has had a history of failure of two TNF blockers clinically significant adverse effects are experienced or all are contraindicated; *Prior authorization may be required for adalimumab and TNF blockers
6. Member does not have combination use of biological disease-modifying antirheumatic drugs or JAK inhibitors (see Section III: Diagnoses/Indications for which coverage is NOT authorized);

7. Dose does not exceed all of the following (a, b, and c):
   a. Inducton: 600 mg at weeks 0, 4, and 8;
   b. Maintenance: 360 mg at week 12 and every 8 weeks thereafter;
   c. Quantity does not exceed one single dose vial or pre-filled cartridge per dose.

Approval duration: 6 months

D. Ulcerative Colitis (must meet all)**:**
1. Diagnosis of UC;
2. Prescribed by or in consultation with a gastroenterologist;
3. Age ≥ 18 years;
4. Documentation of a Mayo Score ≥ 6 (*see Appendix F*);
5. Failure of an 8-week trial of systemic corticosteroids, unless contraindicated or clinically significant adverse effects are experienced;
6. Member meets the following, used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or contraindicated (*see Appendix D*):
   a. Failure of adalimumab-adbm or adalimumab-ryvk (Simlandi
   **Prior authorization may be required for Humira*
7. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);

1. Dose does not exceed both of the following (a and b):
   a. Induction: 1,200 mg at weeks 0, 4, and 8;
   b. Maintenance (both i and ii):
      i. 360 mg at week 12 and every 8 weeks thereafter;
      ii. Quantity does not exceed one pre-filled cartridge per dose.

   Approval duration: 6 months

E. Other diagnoses/indications
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):

a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all):

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy;
3. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (see Section III: Diagnoses/Indications for which coverage is NOT authorized);
4. If request is for a dose increase, new dose does not exceed one of the following (a or b):
   a. For PsA or PsO: 150 mg every 12 weeks;
   b. For CD: both (i and ii):
      i. 360 mg every 8 weeks;
      ii. 1 pre-filled cartridge every 8 weeks.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2):

1. This this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

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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 or evidence of coverage documents;

B. Combination use of biological disease-modifying antirheumatic drugs (bDMARDs), including any tumor necrosis factor (TNF) antagonists [Cimzia®, Enbrel®, Simponi®, Avsola™, Inflectra™, Remicade®, Renflexis™], interleukin agents [Arcalyst® (IL-1 blocker), Ilaris® (IL-1 blocker), Kineret® (IL-1RA), Actemra® (IL-6RA), Kevzara® (IL-6RA), Stelara® (IL-12/23 inhibitor), Cosentyx® (IL-17A inhibitor), Taltz® (IL-17A inhibitor), Siliq™ (IL-17RA), Ilumya™ (IL-23 inhibitor), Skyrizi™ (IL-23 inhibitor), Tremfya® (IL-23 inhibitor)], janus kinase inhibitors (JAKi) [Xeljanz®/Xeljanz® XR, Rinvoq™], anti-CD20 monoclonal antibodies [Rituxan®, Riabni™, Ruxience™, Truxima®, and Rituxan Hycela®], selective co-stimulation modulators [Orencia®], or integrin receptor antagonists [Entyvio®] because of the possibility of increased immunosuppression, neutropenia and increased risk of infection.

C. Asthma.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CD: Crohn's disease
FDA: Food and Drug Administration
IL-23: interleukin-23
JAKi: Janus kinase inhibitors
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 daily	50 mg/day
azathioprine (Azasan®, Imuran®)	CD* 1.5 – 2.5 mg/kg/day PO	3 mg/kg/day
cyclosporine (Sandimmune®, Neoral®)	**PsO** 2.5 – 4 mg/kg/day PO divided BID	4 mg/kg/day
6-mercaptopurine (Purixan®)	CD* 50 mg PO QD or 0.75 – 1.5 mg/kg/	2 mg/kg/day
methotrexate (Trexall®, Otrexup™, Rasuvo®, RediTrex®,	**CD*** 15 – 25 mg/week IM or SC **PsO** 10 to 25 mg/week IM, SC or PO or 2.5 mg PO Q12 hr for 3 doses/week	30 mg/week

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Jylamvo® Rheumatrex®)		
Enbrel® (etanercept)	PsA 25 mg SC twice weekly or 50 mg SC once weekly	50 mg/week
Cimzia® (certolizumab)	CD Initial dose: 400 mg SC at 0, 2, and 4 weeks Maintenance dose: 400 mg SC every 4 weeks	400 mg every 4 weeks
Humira® Amjevita™ (adalimumab)	CD Initial dose: 160 mg SC on Day 1, then 80 mg SC on Day 15 Maintenance dose: 40 mg SC every other week starting on Day 29	40 mg 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.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): history of serious hypersensitivity reaction to risankizumab-rzaa or 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.
- In a phase 2a, multicenter, randomized, double-blind, placebo-controlled, 24-week, parallel-group trial, Skyrizi was shown to be not beneficial in treatment of severe asthma. The time to the first asthma worsening was shorter and the annualized rate of asthma worsening was higher with risankizumab than with placebo.
- TNF blockers:
  - Etanercept (Enbrel®), adalimumab (Humira®), adalimumab-atto (Amjevita™), infliximab (Remicade®) and infliximab biosimilars (Avsola™, Renflexis™, Inflectra®), certolizumab pegol (Cimzia®), and golimumab (Simponi®, Simponi Aria®).

Appendix E: CD and Immunomodulator Medical Justification

- The following may be considered for medical justification supporting inability to use an immunomodulator for CD:

- Inability to induce short-term symptomatic remission with a 3-month trial of systemic glucocorticoids
- High-risk factors for intestinal complications may include:
  - Initial extensive ileal, ileocolonic, or proximal GI involvement
  - Initial extensive perianal/severe rectal disease
  - Fistulizing disease (e.g., perianal, enterocutaneous, and rectovaginal fistulas)
  - Deep ulcerations
  - Penetrating, stricturing or stenosis disease and/or phenotype
  - Intestinal obstruction or abscess
- For TNF-inhibitors, high risk factors for postoperative recurrence may include:
  - Less than 10 years duration between time of diagnosis and surgery
  - Disease location in the ileum and colon
  - Perianal fistula
  - Prior history of surgical resection

Use of corticosteroids prior to surgery

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
PsA, PsO	150 mg SC at Week 0, Week 4 and every 12 weeks thereafter	150 mg every 12 weeks
CD	Induction: 600 mg IV at Week 0, Week 4 and Week 8 Maintenance: 180 mg or 360 mg SC at Week 12 and every 8 weeks thereafter	IV: 600 mg/dose SC: 360 mg every 8 weeks

VI. Product Availability

- Subcutaneous injection:
  - Single-dose prefilled syringes: 75 mg/0.83 mL, 150 mg/mL
  - Single-dose prefilled pen: 150 mg/mL
  - Single-dose prefilled cartridge: 180mg/1.2mL, 360 mg/2.4 mL
- Intravenous infusion:
  - Single-dose vial: 600 mg/10 mL

VII. References

1. Skyrizi Prescribing Information. North Chicago, IL: Abbvie Inc. September 2022. Available at: https://www.rxabbvie.com/pdf/skyrizi_pi.pdf. Accessed February 10, 2023.
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;80:1029-72. doi:10.1016/j.aad.201811.057.
3. Gossec L, Baraliakos X, Kerschbaumer A, et al. EULAR recommendations for the management of psoriatic arthritis with pharmacological therapies: 2019 update. Ann Rheum Dis. 2020;79:700–712. doi:10.1136/annrheumdis-2020-217159.

4. Singh JA, Guyatt G, Ogdie A, et al. 2018 American College of Rheumatology/National Psoriasis Foundation Guideline for the treatment of psoriatic arthritis. American College of Rheumatology. 2019; 71(1):5-32. doi: 10.1002/art.40726.
5. Brightling CE, Nair P, Cousins DJ, Louis R, and Sign D. Risankizumab in Severe Asthma — A Phase 2a, Placebo-Controlled Trial. N Engl J Med 2021; 385:1669-1679. DOI: 10.1056/NEJMoa2030880.
6. Feuerstein JD, Ho EY, Shmidt E, et al. AGA Clinical practice guidelines on the medical management of moderate to severe luminal and perianal fistulizing Crohn's disease. Gastroenterology 2021; 160:2496-2508. https://doi.org/10.1053/j.gastro.2021.04.022.
7. Feuerstein JD, Isaacs KL, Schneider Y, et al. AGA Clinical practice guidelines on the management of moderate to severe ulcerative colitis. Gastroenterology 2020;158:1450–1461. https://doi.org/10.1053/j.gastro.2020.01.006.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Code	Description
J2327	Injection, risankizumab-rzaa, intravenous, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created.	06.04.19	08.19
Removed HIM TBD line of business; updated preferred redirections based on SDC recommendation and prior clinical guidance: for PsO, removed redirection to adalimumab and added redirection to Taltz.	12.13.19	
2Q 2020 annual review: no significant changes; references reviewed and updated.	03.02.20	05.20
2Q 2021 annual review: added additional criteria related to diagnosis of moderate-to-severe PsO per 2019 AAD/NPF guidelines specifying at least 3% BSA involvement or involvement of areas that severely impact daily function; added combination of bDMARDs under Section III; references reviewed and updated.	02.23.21	05.21
RT4: added new 150 mg/mL prefilled pen and syringe formulations.	05.13.21	
Added newly FDAapproved indication for PsA; added asthma as a diagnosis not covered; reiterated requirement against combination use with a bDMARD or JAKi from Section III to Sections I and II; updated policy with Crohn's disease indication, new vial and prefilled cartridge formulations, new contraindication, and addition of Appendix E; references reviewed and updated.	08.12.22	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
RT4: added new 180 mg/1.2 mL single-dose prefilled cartridge dosage form and quantity limit stating that only one single dose vial or pre-filled cartridge is allowed per dose for CD; Template changes applied to other diagnostics/indications and continued therapy section; references reviewed and updated	11.30.22	
Added HCPCS code: [J2327].	2.27.23	
2Q 2023 annual review: updated off-label dosing in Appendix B; for PsA and CD, added TNFi criteria to allow bypass if member has had history of failure of two TNF blockers; added; references reviewed and updated.	4.22.23	
1Q 2024 annual review: updated t/f agents with preferred options; references reviewed.	3.26.24	
Clarified Psoriatic Arthritis section	7.1.24	
RT4: added new Ulcerative colitis criteria	11.6.24	
2Q2025 annual review: updated preferred adalimumab products	4.17.25	

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.

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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.