Taltz (ixekizumab) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

### PLAQUE PSORIASIS (PP)

For **initial** authorization:
1. Member must be 18 years of age or older; AND
2. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), an interferon-release assay (IGRA), or a chest x-ray) within 6 months prior to starting therapy; AND
3. Medication must be prescribed by a rheumatologist or dermatologist; AND
4. Member has PP for 6 months or longer; AND
5. Member has PP involves 10% or more of the member’s body surface area; AND
6. Member’s Psoriasis Area and Severity Index (PASI) score is greater than or equal to 12; AND
7. Member has tried and failed to respond to treatment with at least one of the following:
   a) At least 12 weeks of photochemotherapy (i.e., psoralen plus ultraviolet A therapy);
   b) At least 12 weeks of phototherapy (i.e. UVB light therapy, Excimer laser treatments) (tanning beds emit mostly UVA light and therefore would not meet this criteria).
   c) At least a 4 week trial with topical antipsoriatic agents (i.e. anthralin, calcipotriene, coal tar, corticosteroids, tazarotene); AND
8. Member has tried and failed to respond to treatment of an immunosuppressant (i.e., cyclosporine, methotrexate, acetretin) for at least a 12 week trial; AND
9. Member has tried and failed treatment with both Enbrel and Humira.
10. **Dosage allowed**: Recommended dose is 160 mg (two 80 mg injections) at Week 0, followed by 80 mg at Weeks 2, 4, 6, 8, 10, and 12, then 80 mg every 4 weeks.

**If member meets all the requirements listed above, the medication will be approved for 3 months.**

For **reauthorization**:
1. Must have been retested for TB with a negative result within the past 12 months; AND
2. Member must be in compliance with all other initial criteria; AND
3. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease; AND
4. Documented member’s PASI score improvement.

**If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.**
PSORIATIC ARTHRITIS (PsA)

For **initial** authorization:
1. Member must be 18 years of age or older; AND
2. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), an interferon-release assay (IGRA), or a chest x-ray) within 6 months prior to starting therapy; AND
3. Medication must be prescribed by a rheumatologist or dermatologist; AND
4. Member has tried and failed treatment with both Enbrel and Humira; AND
5. Member meets at least one of the following scenarios:
   a) Member has predominantly axial disease (i.e., sacroiliitis or spondylitis) as indicated by radiographic evidence; OR
   b) Member has shown symptoms of predominantly axial disease (i.e., sacroiliitis or spondylitis) for more than 3 months (i.e., limited spinal range of motion, spinal morning stiffness for more than 30 minutes) AND has tried and failed to respond to treatment with at least 2 prescription NSAIDs taken at the maximum recommended dosages. Treatment failure requires at least 4 weeks of therapy without an adequate response; OR
   c) Member has predominately non-axial disease and has tried and failed to respond to treatment with at least 8-week trial of methotrexate and NSAID.
6. **Dosage allowed:** Recommended dose is 160 mg by subcutaneous injection (two 80 mg injections) at Week 0, followed by 80 mg every 4 weeks.

**If member meets all the requirements listed above, the medication will be approved for 12 months.**

For **reauthorization**:
1. Must have been retested for TB with a negative result within the past 12 months; AND
2. Member must be in compliance with all other initial criteria; AND
3. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease.

**If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.**

CareSource considers Taltz (ixekizumab) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Active infections
- Asthma
- Cellulitis
- Crohn’s Disease
- Dissecting scalp cellulitis
- For use in combination with other TNF-inhibitors (i.e. Kineret, Enbrel, Remicade)
- Giant-cell arteritis
- Guttate psoriasis
- Infectious uveitis
- Lupus perino
- Osteoarthritis
- Recurrent pregnancy loss
- Relapsing polychondritis
- Sarcoidosis
- Sciatica
- Spondyloarthritis (other than ankylosing spondylitis)
- Takayasu’s arteritis
- Vogt-Koyanagi

<table>
<thead>
<tr>
<th>DATE</th>
<th>ACTION/DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/19/2017</td>
<td>New policy for Taltz created.</td>
</tr>
<tr>
<td>02/05/2018</td>
<td>New indication for Psoriatic Arthritis added.</td>
</tr>
</tbody>
</table>

References:

Effective date: 04/04/2018
Revised date: 02/05/2018