# Clinical Policy: Ixekizumab (Taltz)

Reference Number: MDN.CP.PHAR.257
Effective Date: 04.01.22
Last Review Date: 5.16.23
Line of Business: Meridian IL Medicaid

Coding Implications
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:

- Patients aged 6 years or older with moderate-to-severe plaque psoriasis (PsO) who are candidates for systemic therapy or phototherapy
- Adults with active psoriatic arthritis (PsA)
- Adults with active ankylosing spondylitis (AS)
- Adults with active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation

## 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. Axial Spondyloarthritis** (must meet all)**:**

1. Diagnosis of AS or nr-axSpA;
2. Prescribed by or in consultation with a rheumatologist;
3. Age ≥ 18 years;
4. Failure of at least TWO non-steroidal anti-inflammatory drugs (NSAIDs) at up to maximally indicated doses, each used for ≥ 4 weeks unless clinically significant adverse effects are experienced or all are contraindicated;
5. Failure of TWO of the following, each used for ≥ 3 consecutive months, unless contraindicated or clinically significant adverse effects are experienced: Cimzia®, Enbrel®, Humira®, Xeljanz/Xeljanz XR®;
   **Prior authorization may be required for Cimzia, Enbrel, Humira, and Xeljanz/Xeljanz XR*
6. Dose does not exceed one of the following (a or b):
   a. For AS: 160 mg at week 0, followed by maintenance dose of 80 mg every 4 weeks;
   b. For nr-axSpA: 80 mg every 4 weeks.

**Approval duration: 6 months**

**B. 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 ≥ 6 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;
   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;
5. Member meets one of the following (a or b):
   a. Adults ≥18 years old: Failure of the following, each used for ≥ 3 consecutive months, unless contraindicated or clinically significant adverse effects are experienced: Cimzia®, Enbrel®, Humira®;
   b. Pediatrics <18 years old: Failure of the following, used for ≥ 3 consecutive months, unless contraindicated or clinically significant adverse effects are experienced: Enbrel®;
   **Prior authorization may be required for Cimzia, Enbrel, and Humira*
6. Dose does not exceed one of the following (a – d):
   a. For adults: 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;
   b. For pediatric members weighing < 25 kg: 40 mg at week 0, followed by 20 mg every 4 weeks;
   c. For pediatric members weighing 25 – 50 kg: 80 mg at week 0, followed by 40 mg every 4 weeks;
   d. For pediatric members weighing > 50 kg: 160 mg (two 80 mg injections) at week 0, followed by 80 mg every 4 weeks.

**Approval duration: 6 months**

**C. 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 TWO of the following, each used for ≥ 3 consecutive months, unless contraindicated or clinically significant adverse effects are experienced: Cimzia®, Enbrel®, Humira®, Xeljanz/Xeljanz XR®;
   **Prior authorization may be required for Cimzia, Enbrel, Humira, and Xeljanz/Xeljanz XR*
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**

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

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. 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. 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.

**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 with biological disease-modifying antirheumatic drugs (bDMARDs) or potent immunosuppressants, including but not limited to any tumor necrosis factor (TNF) antagonists [e.g., Cimzia®, Enbrel®, Humira® and its biosimilars, Simponi®, Avsola™, Inflectra™, Remicade®, Renflexis™], interleukin agents [e.g., 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) [e.g., Xeljanz®/Xeljanz® XR, Cibinqo™, Olumiant™, Rinvoq™], anti-CD20 monoclonal antibodies [Rituxan®, Riabni™, Ruxience™, Truxima®, Rituxan Hycela®], selective co-stimulation modulators [Orencia®], and integrin receptor antagonists [Entyvio®] because of the additive immunosuppression, increased risk of neutropenia, as well as increased risk of serious infections.

## IV. Appendices/General Information

*Appendix A: Abbreviation/Acronym Key*

ACR: American College of Rheumatology
AS: ankylosing spondylitis
FDA: Food and Drug Administration
IL-17A: interleukin-17A
MTX: methotrexate
nr-axSpA: non-radiographic axial spondyloarthritis
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 |
|---|---|---|
| cyclosporine (Sandimmune®, Neoral®) | **PsO**<br>2.5 – 4 mg/kg/day PO divided BID | PsO: 4 mg/kg/day |
| methotrexate (Trexall®, Otrexup™, Rasuvo®, RediTrex®, Xatmep™, Rheumatrex®) | **PsO**<br>**10 – 25 mg/week PO, IM, or SC or** 2.5 mg PO Q12 hr for 3 doses/week | 30 mg/week |
| Enbrel® (etanercept) | **PsA**<br>50 mg SC once weekly | 50 mg/week |
| Humira® (adalimumab) | **PsO**<br>Initial dose:<br>80 mg SC<br>Maintenance dose:<br>40 mg SC every other week starting one week after initial dose<br><br>**PsA**<br>40 mg SC every other week | 40 mg every other week |
| Xeljanz® (tofacitinib) | **PsA**<br>5 mg PO BID | 10 mg/day |
| Xeljanz XR® (tofacitinib extended-release) | **PsA**<br>11 mg PO QD | 11 mg/day |
| Cimzia® (certolizumab) | **AS, PsA**<br>Initial dose: 400 mg SC at 0, 2, and 4 weeks<br>Maintenance dose: 200 mg SC every other week (or 400 mg SC every 4 weeks)<br><br>**PsO**<br>400 mg SC every other week. For some patients (with body weight ≤ 90 kg), a dose of 400 mg SC at 0, 2 and 4 weeks, followed by 200 mg SC every other week may be considered. | AS, PsA: 400 mg every 4 weeks<br><br>PsO: 400 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.*
**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
- PsA: According to the 2018 American College of Rheumatology (ACR) 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.

- AS and nr-axSpA: Although the 2019 ACR guidelines for AS recommend the use of TNF inhibitors over IL-17A antagonists such as Taltz or Cosentyx, this recommendation was based on "greater experience with TNF inhibitors and familiarity with their long-term safety and toxicity" rather than differences in efficacy.

## V. Dosage and Administration

<table>
<tr><th>Indication</th><th colspan="3">Dosing Regimen</th><th>Maximum Dose</th></tr>
<tr><td rowspan="7">PsO (with or without coexistent PsA)</td><td colspan="3">Adults:</td><td rowspan="7">80 mg every 4 weeks</td></tr>
<tr><td colspan="3">Initial dose: 160 mg (two 80 mg injections)</td></tr>
<tr><td colspan="3">SC at week 0, then 80 mg SC at weeks 2, 4, 6, 8, 10, and 12<br>Maintenance dose:</td></tr>
<tr><td colspan="3">80 mg SC every 4 weeks<br><br>Pediatrics between ages of 6 and 18 years:</td></tr>
<tr><td>Pediatric Patient's Weight</td><td>Starting Dose (Week 0)</td><td>Dose every 4 weeks (Q4W) Thereafter</td></tr>
<tr><td>> 50 kg</td><td>160 mg (two 80 mg injections)</td><td>80 mg</td></tr>
<tr><td>25 to 50 kg</td><td>80 mg</td><td>40 mg</td></tr>
<tr><td>< 25 kg</td><td>40 mg</td><td>20 mg</td></tr>
<tr><td rowspan="3">PsA, AS</td><td colspan="3">Initial dose: 160 mg (two 80 mg injections)</td><td rowspan="3">80 mg every 4 weeks</td></tr>
<tr><td colspan="3">SC at week 0<br>Maintenance dose:</td></tr>
<tr><td colspan="3">80 mg SC every 4 weeks</td></tr>
<tr><td>nr-axSpA</td><td colspan="3">80 mg SC every 4 weeks</td><td>80 mg every 4 weeks</td></tr>
</table>

## 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; July 2022. Available at http://www.taltz.com. Accessed February 10, 2023.
2. Pariser DM, Bagel J, Gelfand JM et al. National psoriasis foundation clinical consensus on disease severity. *Arch Dermatol*. 2007 Feb; 143: 239-242.
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; 58(5):826-50.

4. 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; 61(3):451-85.
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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
7. van der Heijde D, Ramiro S, Landewe R, et al. 2016 update of the ASAS-EULAR management recommendations for axial spondyloarthritis. *Ann Rheum Dis*. 2017;76:978-991. doi:10.1136/annrheumdis-2016-210770.
8. 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.
9. 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.
10. Ward MM, Deodhar A, Gensler LS, et al. 2019 Update of the American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network recommendations for the treatment of ankylosing spondylitis and nonradiographic axial spondyloarthritis. *Arthritis Care & Research*. 2019. Available at: https://www.rheumatology.org/Practice-Quality/Clinical-Support/Clinical-Practice-Guidelines/Axial-Spondyloarthritis. Accessed June 24, 2020.
11. Deodhar A, van der Heijde D, Gensler LS, et al. Ixekizumab for patients with non-radiographic axial spondyloarthritis (COAST-X): a randomised, placebo-controlled trial. *Lancet* 2020; 395: 53-64.

**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 Codes | Description |
|---|---|
| J3590 | Injection, ixekizumab, 80 mg/mL |

| Reviews, Revisions, and Approvals | Date | P&T Approval Date |
|---|---|---|
| Policy created, adapted from CP.PHAR.257 | 04.01.22 | 04.22 |
| 2Q 2023 annual review: no significant changes; updated off-label dosing for Appendix B; template changes applied to other diagnoses/indications and continued therapy section; Clarified pediatric vs Adult indications for plaque psoriasis references reviewed and updated | 5.12.23 | |

**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.