Clinical Policy: Tildrakizumab-asmn (Ilumya)

Reference Number: CP.PHAR.386
Effective Date: 05.01.18
Last Review Date: 08.26
Line of Business: Medicaid

Coding Implications
Revision Log

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

Description

Tildrakizumab-asmn (Ilumya™) is an interleukin-23 (IL-23) blocker.

FDA Approved Indication(s)

Ilumya is indicated for the treatment of adult patients with moderate-to-severe plaque psoriasis (PsO) who are candidates for systemic therapy or phototherapy.

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 Ilumya 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, unless previously failed a biologic agent for PsO (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 a ≥ 3 consecutive month trial of all* of the following, unless clinically significant adverse effects are experienced or all are contraindicated (a, b, and c):

a. One adalimumab product (e.g., *Hadlima™, Simlandi®, Yusimry™, adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, and adalimumab-fkjp are preferred*), unless the member has had a history of failure of two TNF blockers;
b. Otezla®/Otezla XR™;
c. One ustekinumab product (e.g., *Otulfi®, Pyzchiva® (branded), Selarsdi™, Steqeyma®, Yesintek™ are preferred*);

**Prior authorization may be required for adalimumab products, Otezla/Otezla XR, and ustekinumab products*

6. 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*);
7. Dose does not exceed 100 mg at weeks 0 and 4, followed by maintenance dose of 100 mg every 12 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.

II. Continued Therapy

A. Plaque Psoriasis (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 100 mg every 12 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 policies – 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, Remicade® and its biosimilars, Simponi®], interleukin agents [e.g., Actemra® (IL-6RA) and its biosimilars, Arcalyst® (IL-1 blocker), Bimzelx® (IL-17A and F antagonist), Cosentyx® (IL-17A inhibitor), Ilaris® (IL-1 blocker), Ilumya™ (IL-23 inhibitor), Kevzara® (IL-6RA), Kineret® (IL-1RA), Omvoh™ (IL-23 antagonist), Siliq™ (IL-17RA), Skyrizi™ (IL-23 inhibitor), Spevigo® (IL-36 antagonist), Stelara® (IL-12/23 inhibitor) and its biosimilars, Taltz® (IL-17A inhibitor), Tremfya® (IL-23 inhibitor)], Janus kinase inhibitors (JAKi) [e.g., Cibinqo™, Olumiant™, Rinvoq™, Xeljanz®/Xeljanz® XR,], anti-CD20 monoclonal antibodies [Rituxan® and its biosimilars], selective co-stimulation modulators [Orencia®], integrin receptor antagonists [Entyvio®], tyrosine kinase 2 inhibitors [Sotyktu™], and sphingosine 1-phosphate receptor modulator [Velsipity™] 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

FDA: Food and Drug Administration
IL-23: interleukin-23
JAKi: Janus kinase inhibitors
MTX: methotrexate
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 for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
acitretin (Soriatane®)	25 or 50 mg PO daily	50 mg/day
cyclosporine (Sandimmune®, Neoral®)	2.5 – 4 mg/kg/day PO divided BID	4 mg/kg/day
methotrexate (Trexall®, Otrexup™, Rasuvo®, RediTrex®, Rheumatrex®, Jylamvo®)	10 to 25 mg/week IM, SC or PO or 2.5 mg PO Q12 hr for 3 doses/week	30 mg/week
Hadlima (adalimumab-bwwd), Simlandi (adalimumab-ryvk), Yusimry (adalimumab-aqvh), adalimumab-aaty (Yuflyma®), adalimumab-adaz (Hyrimoz®), adalimumab-fkjp (Hulio®), adalimumab-adbm (Cyltezo®)	Initial dose: 80 mg SC Maintenance dose: 40 mg SC every other week starting one week after initial dose	40 mg every other week
Otezla®, Otezla XR™ (apremilast)	Initial dose: Otezla only: Day 1: 10 mg PO QAM Day 2: 10 mg PO QAM and 10 mg PO QPM Day 3: 10 mg PO QAM and 20 mg PO QPM Day 4: 20 mg PO QAM and 20 mg PO QPM Day 5: 20 mg PO QAM and 30 mg PO QPM Maintenance dose: Day 6 and thereafter: • Otezla: 30 mg PO BID • Otezla XR: 75 mg PO QD	Otezla: 60 mg/day Otezla XR: 75 mg/day
Otulfi® (ustekinumab-aauz), Pyzchiva®	Weight based dosing SC at weeks 0 and 4, followed by maintenance dose every 12 weeks	90 every 12 weeks

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
(ustekinumab-ttwe), Selarsdi™ (ustekinumab-aekn), Steqeyma® (ustekinumab-stba), Yesintek™ (ustekinumab-kfce)	*Adult:* Weight ≤ 100 kg: 45 mg Weight > 100 kg: 90 mg *Pediatrics (age 6 years to 17 years):* **Otulfi, Pyzchiva, Yesintek:** Weight < 60 kg: 0.75 mg/kg **Otulfi, Pyzchiva, Selarsdi, Steqeyma, Yesintek:** Weight 60 to 100 kg: 45 mg Weight > 100 kg: 90 mg	

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): serious hypersensitivity reaction to tildrakizumab 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.
- TNF blockers:
  - Etanercept (Enbrel®), adalimumab (Humira®) and its biosimilars, infliximab (Remicade®) and its biosimilars (Avsola™, Renflexis™, Inflectra®), certolizumab pegol (Cimzia®), and golimumab (Simponi®, Simponi Aria®).

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
PsO	Initial dose: 100 mg SC at weeks 0 and 4 Maintenance dose: 100 mg SC every 12 weeks	100 mg every 12 weeks

Indication	Dosing Regimen	Maximum Dose
	Ilumya should only be administered by a healthcare professional.	

VI. Product Availability

Single-dose prefilled syringe: 100 mg/1 mL

VII. References

1. Ilumya Prescribing Information. Whitehouse Station, NJ: Merck & Co., Inc.; December 2025. Available at: https://www.ilumyapro.com/content/dam/ilumya-pro/Sun-Pharma_ILUMYA_US_Prescribing-Info-and-Medication-Guide_combined.pdf. Accessed January 20, 2026.
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.

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
J3245	Injection, tildrakizumab, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2022 annual review: for PsO, allowed phototherapy as alternative to systemic conventional DMARD if contraindicated or clinically significant adverse effects are experienced; WCG.CP.PHAR.386 to be retired; reiterated requirement against combination use with a bDMARD or JAKi from Section III to Sections I and II; references reviewed and updated.	02.19.22	05.22
Template changes applied to other diagnoses/indications and continued therapy section.	09.23.22	
2Q 2023 annual review: added HCPCS code; for PsO, added TNFi criteria to allow bypass if member has had history of failure of two TNF blockers; references reviewed and updated.	02.10.23	05.23
Per July SDC: removed criteria requiring use of Enbrel; added criteria requiring use of of one adalimumab product and stating Yusimry, Hadlima, unbranded adalimumab-fkjp, and unbranded adalimumab-adaz as preferred; updated Appendix B with relevant therapeutic alternatives.	07.25.23	
Per December SDC, added adalimumab-adbm to listed examples of preferred adalimumab products.	12.06.23	02.24

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2024 annual review: added Bimzelx, Zymfentra, Omvoh, Wezlana, Sotyktu, Tofidence, and Velsipity to section III.B; references reviewed and updated.	01.23.24	05.24
Per June SDC, added Simlandi to listed examples of preferred adalimumab products. Per SDC, added unbranded adalimumab-aaty to listed examples of preferred adalimumab products.	07.23.24	08.24
2Q 2025 annual review: no significant changes; updated section III.B with Spevigo and biosimilar verbiage; references reviewed and updated.	01.23.25	05.25
Per April SDC: added criteria requiring use of one preferred Stelara biosimilar (Otulfi, Pyzchiva (branded), Selarsdi, Yesintek, and Steqeyma are preferred).	04.23.25	06.25
Added bypass of conventional therapies if a member has failed a biologic agent to clarify intention of not stepping back from biologic agent to conventional therapy. Extended initial approval durations to 12 months for chronic conditions.	09.08.25	11.25
2Q 2026 annual review: no significant changes; references reviewed and updated. RT4: For PsA, allowed Otezla XR to be used in place of Otezla.	03.30.26	05.26
Per June SDC: removed criteria requiring use of Taltz.	06.09.26	08.26

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.

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