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# Subject: Ixekizumab (Taltz®) Injection

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## DESCRIPTION:

Ixekizumab (Taltz) was approved by the US Food and Drug Administration (FDA) in March 2016 for moderate to severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy. In December 2017, the FDA-approved indications for use were expanded to include the treatment of adults with active psoriatic arthritis (PsA). In August 2019, the FDA granted approval for the treatment of adult patients with active ankylosing spondylitis. In March 2020, the indication for plaque psoriasis was expanded to include pediatric patients 6 to less than 18 years of age. In May 2020, the FDA granted approval for the treatment of adult patients with active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation. In May 2022, a new, citrate-free formulation of ixekizumab injection was FDA-approved and then released in August 2022. The new formulation reduced injection site pain experienced by some people immediately following injection. The original formulation will only remain on the market until it is replaced by the citrate-free formulation (timing unknown); both products share the same NDC. Ixekizumab is a humanized IgG4 monoclonal antibody that selectively binds to the interleukin-17A (IL-17A) cytokine and inhibits its interaction with the IL-17 receptor. Secukinumab (Cosentyx), approved by the FDA in January 2015 for moderate to severe plaque psoriasis, was the first-in-class biologic agent to target IL-17. Interleukin-17A is a naturally occurring cytokine that is involved in normal inflammatory and immune responses. Elevated concentrations of IL-17A are found in psoriatic plaques. Ixekizumab inhibits the release of proinflammatory cytokines and chemokines.

**RHEUMATOID DISORDERS**

**Ankylosing spondylitis (AS)**

Ankylosing spondylitis (AS) is a form of chronic inflammatory arthritis characterized by sacroiliitis, enthesitis, and a marked propensity for sacroiliac joint and spinal fusion. AS is distinguished by universal

involvement with sacroiliac joint inflammation or fusion and more prevalent spinal ankylosis. Goals of treatment for AS are to reduce symptoms, maintain spinal flexibility and normal posture, reduce functional limitations, maintain work ability, and decrease disease complications. The mainstays of treatment have been nonsteroidal anti-inflammatory drugs (NSAIDs) and exercise/physical therapy.

NSAIDs are used as first line therapy for patients with active AS, with continuous treatment with NSAIDs being preferred. In patients with stable disease, NSAIDs may be used on-demand to decrease the risk of adverse effects with long term use. No particular NSAID is recommended as a preferred option. Biologics should be used in patients who continue to have persistently high disease activity despite NSAIDs. Failure of standard treatment with NSAIDs can be defined as a lack of response (or intolerance) to at least 2 NSAIDs after at least a 4-week duration of therapy in total.

Tumor necrosis factor (TNF) inhibitors or interleukin (IL)-17 inhibitors are recommended as initial biologic therapy. Other present comorbidities (e.g., inflammatory bowel disease, psoriasis, uveitis) can help guide selection of the initial biologic agent/drug class. Patients who have an inadequate response to a TNF inhibitor or IL-17 inhibitor may switch to a biologic of the other drug class, or switch to a Janus kinase (JAK) inhibitor. Patients with secondary failure to a biologic (presence of antidrug antibodies) may switch to another biologic of the same or different mode of action.

Systemic glucocorticoids should generally not be used in the treatment of AS. Short-term glucocorticoid injections may be used in select patients with peripheral signs and symptoms. Conventional disease-modifying antirheumatic drugs (cDMARDs) (e.g., methotrexate, sulfasalazine, leflunomide) are not recommended as treatment due to their lack of efficacy. However, sulfasalazine may be considered in patients with peripheral arthritis.

**Nonradiographic Axial Spondyloarthritis (nr-axSpA)**

Nonradiographic axial spondyloarthritis (nr-axSpA) falls under the same spondyloarthritis family as ankylosing spondylitis (AS). Nr-axSpA is characterized by chronic back pain and features suggestive of spondyloarthritis (SpA), although advanced sacroiliac joint damage and spine ankylosis are absent. The goals of treatment are to reduce symptoms, maintain spinal flexibility and normal posture, reduce functional limitations, maintain work ability, and decrease disease complications. The mainstays of treatment have been NSAIDs and exercise/physical therapy.

NSAIDs are used as first line therapy for patients with active nr-axSpA, with continuous treatment with NSAIDs being preferred. In patients with stable disease, NSAIDs may be used on-demand to decrease the risk of adverse effects with long term use. No particular NSAID is recommended as a preferred option.(64) Biologics should be used in patients who continue to have persistently high disease activity despite NSAIDs. Failure of standard treatment with NSAIDs can be defined as a lack of response (or intolerance) to at least 2 NSAIDs after at least a 4-week duration of therapy in total.

Tumor necrosis factor (TNF) inhibitors or interleukin (IL)-17 inhibitors are recommended as initial biologic therapy. Other present comorbidities (e.g., inflammatory bowel disease, psoriasis, uveitis) can help guide selection of the initial biologic agent/drug class. Patients who have an inadequate response to a TNF inhibitor or IL-17 inhibitor may switch to a biologic of the other drug class, or switch to a Janus kinase (JAK) inhibitor. Patients with secondary failure to a biologic (presence of antidrug antibodies) may switch to another biologic of the same or different mode of action.

Systemic glucocorticoids should generally not be used in the treatment of nr-axSpA. Short-term glucocorticoid injections may be used in select patients with peripheral signs and symptoms. Conventional disease-modifying antirheumatic drugs (cDMARDs) (e.g., methotrexate, sulfasalazine, leflunomide) are not recommended as treatment due to their lack of efficacy. However, sulfasalazine may be considered in patients with peripheral arthritis.

**Psoriatic Arthritis (PsA)**

Psoriatic arthritis (PsA) is a chronic inflammatory musculoskeletal disease associated with psoriasis (PS), most commonly presenting with peripheral arthritis, dactylitis, enthesitis, and spondylitis. Active PsA is defined as symptoms at an unacceptably bothersome level as reported by the patient due to one of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, active skin and/or nail involvement, and/or extraarticular manifestations such as uveitis or inflammatory bowel disease (IBD). Disease severity is based on the assessment of the level of disease activity at a given point in time, and the presence/absence of poor prognostic factors and long-term damage. Severe PsA is defined in the American College of Rheumatology (ACR) and the National Psoriasis Foundation (NPF) guidelines for PsA and includes the presence of one or more of the following:

- Erosive disease
- Elevated markers of inflammation (e.g., erythrocyte sedimentation rate [ESR], C-reactive protein [CRP]) attributable to PsA
- Long-term damage that interferes with function (e.g., joint deformities, vision loss)
- Highly active disease that causes a major impairment in quality of life, such as:
    - Active PsA at many sites including dactylitis and enthesitis
    - Function-limiting PsA at a few sites
- Rapidly progressive disease

Treatment involves the use of a variety of interventions, including many agents used for the treatment of other inflammatory arthritis disorders, particularly spondyloarthritis and rheumatoid arthritis, and other management strategies of the cutaneous manifestations of psoriasis. Symptomatic treatments include nonsteroidal anti-inflammatory drugs (NSAIDs), glucocorticoids, and local glucocorticoid injections. Only patients with very mild peripheral disease may sufficiently benefit from NSAIDs as monotherapy, and instead patients are typically treated with disease-modifying antirheumatic drugs (DMARDs) and/or biologics. Efficacy of DMARD and biologic therapies should be assessed 3 months after initiation, and if adequate improvement is not seen then the treatment regimen should be updated or changed. The ACR-NPF guidelines for PsA recommend a treat-to-target approach in therapy, regardless of disease activity, and treatment recommendations for active disease are as follows:

- Treatment naïve patients:
    - First line options include oral small molecules (OSM), tumor necrosis factor (TNF) inhibitors, interleukin (IL)-17 inhibitors, and IL-12/23 inhibitors
        - OSM (i.e., methotrexate [MTX], sulfasalazine, cyclosporine, leflunomide, apremilast) should be considered if the patient does not have severe PsA, does not have severe PS, prefers oral therapy, has concern over starting a biologic, or has contraindications to TNF inhibitors

        - Biologics (e.g., TNF inhibitor, IL-17 inhibitor, IL-12/23 inhibitor) are recommended as a first line option in patients with severe PsA and/or severe PS
- Previous treatment with OSM and continued active disease:
    - Switch to a biologic (i.e., TNF inhibitor, IL-17 inhibitor, IL-12/23 inhibitor); recommended over switching to a different OSM
        - Biologic monotherapy is conditionally recommended over biologic plus MTX combination therapy
    - Switch to a different OSM (except apremilast) OR add on apremilast to current OSM therapy; recommended over adding another OSM
    - Add another OSM (except apremilast) to current OSM therapy; may consider for patients that have exhibited partial response to current OSM
    - Switch to apremilast monotherapy; may be considered instead of adding apremilast to current OSM therapy if the patient has intolerable side effects with the current OSM
- Previous treatment with a biologic and continued active disease:
    - Switch to another biologic (e.g., TNF inhibitor, IL-17 inhibitor, IL-12/23 inhibitor, abatacept, or tofacitinib) as monotherapy
    - Add MTX to the current biologic; may consider adding MTX in patients with a partial response to current biologic therapy

The European Alliance of Associations for Rheumatology (EULAR) guidelines for PsA (2023 update) also recommend a treat-to-target approach in therapy. MTX (preferred) or another conventional synthetic disease-modifying antirheumatic drug (csDMARD) (e.g., sulfasalazine, leflunomide) should be used for initial therapy. If the treatment target is not achieved with a csDMARD, a biologic should be initiated with preference of product being based on patient specific disease characteristics. Biologics include TNF inhibitors, IL-12/23 inhibitors, IL-17A inhibitors, IL-17A/F inhibitors, IL-23 inhibitors, and cytotoxic T-lymphocyte–associated antigen 4 (CTLA4) analogs. No order of preference of biologics is provided since none have demonstrated superiority for joint involvement, however, CTLA4 analogs are least preferred due to limited efficacy in clinical trials. The use of a Janus kinase (JAK) inhibitor (e.g., tofacitinib, upadacitinib) may be used after failure of a biologic or if biologics are not clinically appropriate for the patient. However, careful consideration should be applied prior to using a JAK inhibitor due to the increased risk of cardiovascular and malignancy events in older patients with RA and cardiovascular risk factors. A phosphodiesterase-4 (PDE4) inhibitor (i.e., apremilast) may be considered in patients with mild disease and an inadequate response to at least one csDMARD, in whom neither a biologic nor a JAK inhibitor is appropriate. Patients with an inadequate response to a biologic or JAK inhibitor may switch to a different drug within the same class or switch to a different mode of action. Adding MTX to a biologic may increase drug survival by limiting the development of antidrug antibodies, especially for TNF inhibitors.

**DERMATOLOGICAL DISORDERS**

**Psoriasis (PS)**

Psoriasis (PS) is a chronic inflammatory skin and systemic disorder. It is a complex disease that affects the skin and joints and is associated with numerous comorbidities, including obesity and inflammatory bowel disease. Psoriasis vulgaris, or plaque psoriasis, is a cutaneous form that often presents with pink plaques with silvery scale on the scalp, elbows, knees, or presacral region, but any area of the skin may be involved. Plaque psoriasis is the most common form (affecting 90% of adults with psoriasis), but others include guttate, erythrodermic, pustular, inverse, nail, and psoriatic arthritis (PsA). PS is clinically diagnosed based on the presence of cutaneous and systemic symptoms, and treatment is similar for most forms but is guided by the body surface area (BSA) involved. The American Academy of Dermatology (AAD) and National Psoriasis Foundation (NPF) categorize psoriasis severity as mild (less than 3% of BSA), moderate (3% to 10% of BSA), or severe (greater than 10% of BSA). The AAD/NPF guidelines also note that psoriasis can be considered severe irrespective of BSA when it causes serious emotional consequences, occurs in select locations (e.g., hands, feet, scalp, face, or genital area), or when it causes intractable pruritus.

Topical therapies are most commonly used to treat mild to moderate PS, but they may be used in combination with phototherapy, systemic, or biologic therapies for the treatment of moderate to severe PS. Topical therapies alone can be sufficient for managing limited disease and also have fewer significant adverse effects compared to systemic treatment options. However, topical therapies may be inadequate to obtain and maintain skin clearance, and systemic therapies may be warranted. Conventional systemic agents are widely used as monotherapy or in combination with biologics for moderate to severe disease, and they are beneficial for widespread disease and ease of administration. Biologics are routinely used when one or more conventional agents fail to produce an adequate response but are considered first line in patients with severe PS or patients with concomitant severe PsA. The NPF medical board recommends a treat-to-target approach to therapy for psoriasis that includes the following:

- The preferred assessment instrument for determining treatment response is BSA
- The preferred time to perform initial evaluation of treatment response is after 3 months
- Target response after treatment initiation should be BSA less than or equal to 1% after 3 months
- Acceptable response is either a BSA less than or equal to 3% or a BSA improvement greater than or equal to 75% from baseline at 3 months after treatment initiation

Selection of treatment is based on several factors including benefit-risk assessment, clinical presentation, disease severity, and comorbidities. The AAD/NPF psoriasis treatment guidelines support the following treatment options:

- Topical therapies:
    - Topical corticosteroids (TCS)
    - Topical calcineurin inhibitors (TCIs), such as tacrolimus and pimecrolimus
    - Vitamin D analogues (e.g., calcipotriene and calcitriol)
    - Tazarotene (topical retinoid)
    - Coal tar preparations
    - Topical anthralin
- Psoralen plus ultraviolet light (PUVA) phototherapy

- Systemic non-biologic therapies:
  - Methotrexate (MTX)
  - Cyclosporine
  - Acitretin
  - Apremilast
- Biologic therapies:
  - Tumor necrosis factor (TNF)-α inhibitors (e.g., adalimumab, certolizumab, etanercept, infliximab)
  - Interleukin (IL)-17 inhibitors (e.g., brodalumab, ixekizumab, secukinumab)
  - IL-23 inhibitors (e.g., guselkumab, risankizumab, tildrakizumab)
  - IL-12/IL-23 Inhibitors (e.g., ustekinumab)

    *Note: Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics was published in 2019. No specific biologic drug/class is recommended as first-line for all patients with psoriasis, and instead choice of therapy should be individualized based on patient specific factors. Additional biologic drugs have since received FDA approval for psoriasis that are not discussed.

Primary failure for biologics is defined as initial nonresponse to treatment. Primary failure to a tumor necrosis factor (TNF)-α inhibitor does not preclude successful response to a different TNF-α inhibitor, and failure of another biologic therapy does not preclude successful response to ustekinumab. All biologics may lose efficacy in a patient who initially responds favorably to the medication (secondary failure), and loss of efficacy may be attributed to the presence of antidrug antibodies. The concomitant use of MTX with a biologic may increase drug survival by limiting antibody formation.

For the treatment of PS in the pediatric patient population, topical corticosteroids are the mainstay option based on extensive clinical experience that supports efficacy. Topical calcineurin inhibitors are also a treatment option and may be preferred for psoriasis of the face, genitalia, and body folds. Vitamin D analogues are recommended as a treatment option for childhood plaque psoriasis and are considered safe, effective, and generally well tolerated. Other topical therapies that may be used for the treatment of pediatric psoriasis include tazarotene, anthralin, and coal tar. Phototherapy may be efficacious and well tolerated for pediatric patients with generalized psoriasis or localized psoriasis refractory to topical agents. Systemic non-biologic therapies, such as methotrexate, cyclosporine, and acitretin, are options for moderate to severe psoriasis. Biologic therapies (e.g., adalimumab, etanercept, infliximab, ustekinumab) have also shown efficacy in moderate to severe plaque psoriasis in this patient population.

## POSITION STATEMENT:

**Comparative Effectiveness**

The Food and Drug Administration has deemed the drug(s) or biological product(s) in this coverage policy to be appropriate for self-administration or administration by a caregiver (i.e., not a healthcare

professional). Therefore, coverage (i.e., administration) in a provider-administered setting such as an outpatient hospital, ambulatory surgical suite, physician office, or emergency facility is not considered medically necessary.

**NOTE**: The list of self-administered products with prerequisites for certain indications can be found at Preferred Agents and Drug List.

Initiation of ixekizumab (Taltz) **meets the definition of medical necessity** when **ALL** of the following are met ("1" to "5"):

1. **ONE** of the following ("a", "b", or "c"):
    a. The member has been treated with ixekizumab (starting on samples is not approvable) within the past 90 days
    b. The prescriber states the member has been treated with ixekizumab (starting on samples is not approvable) within the past 90 days **AND** is at risk if therapy is changed
    c. **BOTH** of the following ('i" and "ii"):
        i. Ixekizumab will be used for the treatment of an indication listed in Table 1, and **ALL** of the indication-specific criteria are met
        ii. **EITHER** of the following if the member has an FDA-approved indication ("I" or "II")
            I. The member's age is within FDA labeling for the requested indication for ixekizumab
            II. The prescriber has provided information in support of using ixekizumab for the member's age for the requested indication
2. The prescriber is a specialist in the area of the member's diagnosis (e.g., rheumatologist for PsA, dermatologist for PS) or the prescriber has consulted with a specialist in the area of the member's diagnosis
3. Member does **NOT** have any FDA labeled contraindications to ixekizumab
4. Member will **NOT** be using subcutaneous abatacept in combination with another biologic immunomodulator agent (full list in "Other" section); Janus kinase (JAK) inhibitor [Cibinqo (abrocitinib), Leqselvi (deuruxolitinib), Litfulo (ritlecitinib), Olumiant (baricitinib), Opzelura (ruxolitinib), Rinvoq/Rinvoq LQ (upadacitinib), and Xeljanz/Xeljanz XR (tofacitinib)]; Otezla/Otezla XR (apremilast); Sotyktu (deucravacitinib); or sphingosine-1-phosphate (S1P) modulator [Velsipity (etrasimod) and Zeposia (ozanimod)]
5. **ANY** of the following ("a", "b", "c", or "d"):
    a. The dosage does not exceed
        i. Loading dose
            - AS and PsA: Initial dose of 160 mg (2 x 80 mg) at week 0, then maintenance doses starting 4 weeks later (i.e., week 4)
            - Adult PS (18 years and older) and PS with PsA: Initial dose of 160 mg (2 x 80 mg) at week 0, followed by 80 mg at weeks 2, 4, 6, 8, 10, and 12, then maintenance doses starting 4 weeks later (i.e., week 16)

- Pediatric PS (6 to 17 years):
    - Greater than 50 kg - 80 mg every 4 weeks (28 days) - Initial dose of 160 mg (2 x 80 mg) at week 0 then maintenance dosing starting 4 weeks later
    - 25 to 50 kg - 40 mg every 4 weeks (28 days) - Initial dose of 80 mg at week 0 then maintenance dosing starting 4 weeks later
    - Less than 25 kg - 20 mg every 4 weeks (28 days) - Initial dose of 40 mg at week 0 then maintenance dosing starting 4 weeks later
- nr-axSpA: No loading dose

ii. Maintenance dose – **EITHER** of the following:

- PS in adults (18 years and older), PsA, AS, and nr-axSpA - 80 mg every 4 weeks (28 days)
    - QL: 80 mg/mL autoinjector - 1 syringe/28 days
    - QL: 80 mg/mL syringe - 1 syringe/28 days
- PS in pediatrics (6 to 17 years old):
    - Greater than 50 kg - 80 mg every 4 weeks (28 days)
        - QL: 80 mg/mL autoinjector - 1 pen/28 days
        - QL: 80 mg/mL syringe - 1 syringe/28 days
    - 25 to 50 kg - 40 mg every 4 weeks (28 days)
        - QL: 40 mg/0.5 mL syringe - 1 syringe/28 days
    - Less than 25 kg - 20 mg every 4 weeks (28 days)
        - QL: 20 mg/0.25 mL syringe - 1 syringe/28 days

b. The member has an FDA labeled indication for the requested agent, **AND EITHER** of the following ("i" or "ii"):

i. The requested quantity (dose) does **NOT** exceed the maximum FDA labeled dose for the requested indication, AND the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength and/or package size that does not exceed the program quantity limit

ii. **ALL** of the following ("1", "2", and "3"):

1. The requested quantity (dose) exceeds the FDA maximum labeled dose for the requested indication
2. The member has tried and had an inadequate response to at least a 3-month trial of the maximum FDA labeled dose for the requested indication (medical records required)
3. **EITHER** of the following ("a" or "b"):
    a. The requested quantity (dose) does **NOT** exceed the maximum compendia supported dose for the requested indication, **AND** the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength/and or package size that does not exceed the program quantity limit

b. The requested quantity (dose) exceeds the maximum FDA labeled dose **AND** the maximum compendia supported dose for the requested indication, **AND** there is support for therapy with a higher dose or shortened dosing interval for the requested indication (submitted copy of clinical trials, phase III studies, guidelines required)

c. The member has a compendia supported indication for the requested agent, **AND EITHER** of the following ("i" or "ii"):

   i. The requested quantity (dose) does **NOT** exceed the maximum compendia supported dose for the requested indication, **AND** the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength/and or package size that does not exceed the program quantity limit

   ii. The requested quantity (dose) exceeds the maximum compendia supported dose for the requested indication, **AND** there is support for therapy with a higher dose or shortened dosing interval for the requested indication (submitted copy of clinical trials, phase III studies, guidelines required)

d. The member does **NOT** have an FDA labeled indication **NOR** a compendia supported indication for the requested agent, **AND BOTH** of the following ("i" and "ii"):

   i. The requested quantity (dose) cannot be achieved with a lower quantity of a higher strength and/or package size that does not exceed the program quantity limit

   ii. There is support for therapy with a higher dose or shortened dosing interval for the requested indication (submitted copy of clinical trials, phase III studies, guidelines required)

Compendia Allowed: AHFS, DrugDex 1 or 2a level of evidence, or NCCN 1 or 2a recommended use

**Approval duration**:

- AS and PsA - Loading dose (doses on week 0) for 1 month, then maintenance dose for 11 additional months [12 months for total duration of approval]
- Adult PS and Adult PS with PsA - Loading dose (doses on week weeks 0, 2, 4, 6, 8, 10, and 12) for 4 months, then maintenance dose for 8 additional months [12 months for total duration of approval]
- nr-axSpA and other indications – 12 months

## Table 1

| Diagnosis | Criteria |
|---|---|
| Active psoriatic arthritis (PsA) | **BOTH** of the following:<br>1. **ONE** of the following:<br>a. The member has tried and had an inadequate response to **ONE** conventional agent (i.e., cyclosporine, leflunomide, methotrexate, sulfasalazine) used in the treatment of PsA after at least a 3-month duration of therapy<br>**OR** |

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|---|---|
| | b. The member has an intolerance or hypersensitivity to **ONE** conventional agents used in the treatment of PsA<br><br>**OR**<br><br>c. The member has an FDA labeled contraindication to **ALL** conventional agents used in the treatment of PsA<br><br>**OR**<br><br>d. The member has severe active PsA (e.g., erosive disease, elevated markers of inflammation [e.g., ESR, CRP] attributable to PsA, long-term damage that interferes with function [i.e., joint deformities, vision loss], rapidly progressive)<br><br>**OR**<br><br>e. The member has concomitant severe psoriasis (PS) (e.g., greater than 10% body surface area involvement, occurring on select locations [i.e., hands, feet, scalp, face, or genitals], intractable pruritus, serious emotional consequences)<br><br>**OR**<br><br>f. The member's medication history indicates use of another biologic immunomodulator agent **OR** Otezla/Otezla XR that is FDA labeled or supported in DrugDex with 1 or 2a level of evidence or AHFS for the treatment of PsA<br><br>**AND**<br><br>2. **ANY** of the following (submitted medical records/chart notes are required for confirmation):<br><br>a. The member has tried and had an inadequate response to at least **TWO** preferred products after at least a 3-month trial per product<br><br>**OR**<br><br>b. The member has tried and had an inadequate response to **ONE** preferred product after at least a 3-month duration of therapy, **AND** an intolerance (defined as an intolerance to the drug or its excipients, not to the route of administration) or hypersensitivity to **ONE** preferred product<br><br>**OR**<br><br>c. The member has an intolerance (defined as an intolerance to the drug or its excipients, not to the route of administration) or hypersensitivity to **TWO** preferred products<br><br>**OR** |

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| | d. The member has an FDA labeled contraindication to **ALL** preferred products<br><br>**OR**<br><br>e. **ALL** preferred products are not clinically appropriate for the member, **AND** the prescriber has provided a complete list of previously tried products for the requested indication<br><br>**The preferred PsA products are:**<br><br>• Adalimumab-aaty<br>• Adalimumab-adaz<br>• Cosentyx (secukinumab)<br>• Enbrel (etanercept)<br>• Hadlima (adalimumab-bwwd)<br>• Humira (adalimumab)<br>• Otezla/Otezla XR (apremilast)<br>• Rinvoq/Rinvoq LQ (upadacitinib)<br>• Selarsdi (ustekinumab-aekn)<br>• Simlandi (adalimumab-ryvk)<br>• Skyrizi (risankizumab-rzaa)<br>• Stelara (ustekinumab)<br>• Steqeyma (ustekinumab-stba)<br>• Tremfya (guselkumab)<br>• Xeljanz/Xeljanz XR (tofacitinib)<br>• Yesintek (ustekinumab-kfce) |
| Moderate to severe plaque psoriasis (PS) | **BOTH** of the following:<br><br>1. **ONE** of the following:<br><br>a. The member has tried and had an inadequate response to **ONE** conventional agent (i.e., acitretin, calcipotriene, calcitriol, coal tar, cyclosporine, methotrexate, pimecrolimus, PUVA [phototherapy], tacrolimus, tazarotene, topical corticosteroids) used in the treatment of PS after at least a 3-month duration of therapy<br><br>**OR** |

| | |
|---|---|
| | b. The member has an intolerance or hypersensitivity to **ONE** conventional agent used in the treatment of PS<br><br>**OR**<br><br>c. The member has an FDA labeled contraindication to **ALL** conventional agents used in the treatment of PS<br><br>**OR**<br><br>d. The member has severe active PS (e.g., greater than 10% body surface area involvement, occurring on select locations [i.e., hands, feet, scalp, face, or genitals], intractable pruritus, serious emotional consequences)<br><br>**OR**<br><br>e. The member has concomitant severe psoriatic arthritis (PsA) (e.g., erosive disease, elevated markers of inflammation [e.g., ESR, CRP] attributable to PsA, long-term damage that interferes with function [i.e., joint deformities, vision loss], rapidly progressive)<br><br>**OR**<br><br>f. The member's medication history indicates use of another biologic immunomodulator agent **OR** Otezla/Otezla XR that is FDA labeled or supported in DrugDex with 1 or 2a level of evidence or AHFS for the treatment of PS<br><br>**AND**<br><br>2. **ANY** of the following (submitted medical records/chart notes are required for confirmation):<br><br>a. The member has tried and had an inadequate response to at least **THREE** preferred products after at least a 3-month trial per product<br><br>**OR**<br><br>b. The member has tried and had an inadequate response to **TWO** preferred products after at least a 3-month duration of therapy per product, **AND** an intolerance or hypersensitivity to **ONE** preferred product<br><br>**OR**<br><br>c. The member has tried and had an inadequate response to **ONE** preferred product after at least a 3-month duration of therapy, **AND** an intolerance or hypersensitivity to **TWO** preferred products<br><br>**OR** |

| | |
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| | d. The member has an intolerance (defined as an intolerance to the drug or its excipients, not to the route of administration) or hypersensitivity to **THREE** preferred products<br><br>**OR**<br><br>e. The member has an FDA labeled contraindication to **ALL** preferred products<br><br>**OR**<br><br>f. **ALL** preferred products are not clinically appropriate for the member, **AND** the prescriber has provided a complete list of previously tried products for the requested indication<br><br>**The preferred PS products are:**<br><br>• Adalimumab-aaty<br>• Adalimumab-adaz<br>• Cosentyx (secukinumab)<br>• Enbrel (etanercept)<br>• Hadlima (adalimumab-bwwd)<br>• Humira (adalimumab)<br>• Otezla/Otezla XR (apremilast)<br>• Selarsdi (ustekinumab-aekn)<br>• Simlandi (adalimumab-ryvk)<br>• Skyrizi (risankizumab)<br>• Sotyktu (deucravacitinib)<br>• Stelara (ustekinumab)<br>• Steqeyma (ustekinumab-stba)<br>• Tremfya (guselkumab)<br>• Yesintek (ustekinumab-kfce) |
| Active ankylosing spondylitis (AS) | **BOTH** of the following:<br><br>1. **ONE** of the following:<br><br>a. The member has tried and had an inadequate response to **TWO** different NSAIDs used in the treatment of AS after at least a 4-week TOTAL duration of therapy<br><br>**OR**<br><br>b. The member has tried and had an inadequate response to **ONE** NSAID used in the treatment of AS after at least a 4-week duration |

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| | of therapy **AND** an intolerance or hypersensitivity to **ONE** additional NSAID used in the treatment of AS<br><br>**OR**<br><br>c. The member has an intolerance or hypersensitivity to **TWO** different NSAIDs used in the treatment of AS<br><br>**OR**<br><br>d. The member has an FDA labeled contraindication to **ALL** NSAIDs used in the treatment of AS<br><br>**OR**<br><br>**e.** The member's medication history indicates use of another biologic immunomodulator agent that is FDA labeled or supported in DrugDex with 1 or 2a level of evidence or AHFS for the treatment of AS<br><br>**AND**<br><br>2. **ANY** of the following (submitted medical records/chart notes are required for confirmation):<br><br>a. The member has tried and had an inadequate response to at least **TWO** preferred products after at least a 3-month trial per product<br><br>**OR**<br><br>b. The member has tried and had an inadequate response to **ONE** preferred product after at least a 3-month duration of therapy, **AND** an intolerance (defined as an intolerance to the drug or its excipients, not to the route of administration) or hypersensitivity to **ONE** preferred product<br><br>**OR**<br><br>c. The member has an intolerance (defined as an intolerance to the drug or its excipients, not to the route of administration) or hypersensitivity to **TWO** preferred products<br><br>**OR**<br><br>d. The member has an FDA labeled contraindication to **ALL** preferred products<br><br>**OR**<br><br>e. **ALL** preferred products are not clinically appropriate for the patient, **AND** the prescriber has provided a complete list of previously tried products for the requested indication<br><br>**The preferred AS products are:**<br><br>• Adalimumab-aaty |

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| | • Adalimumab-adaz<br>• Cosentyx (secukinumab)<br>• Enbrel (etanercept)<br>• Hadlima (adalimumab-bwwd)<br>• Humira (adalimumab)<br>• Rinvoq (upadacitinib)<br>• Simlandi (adalimumab-ryvk)<br>• Xeljanz/Xeljanz XR (tofacitinib) |
| Active non-radiographic axial spondyloarthritis (nr-axSpA) | **BOTH** of the following:<br>1. **ONE** of the following:<br>a. The member has tried and had an inadequate response to **TWO** different NSAIDs used in the treatment of nr-axSpA after at least a 4-week TOTAL duration of therapy<br>**OR**<br>b. The member has tried and had an inadequate response to **ONE** NSAID used in the treatment of nr-axSpA after at least a 4-week duration of therapy **AND** an intolerance or hypersensitivity to **ONE** additional NSAID used in the treatment of nr-axSpA<br>**OR**<br>c. The member has an intolerance or hypersensitivity to **TWO** different NSAIDs used in the treatment of nr-axSpA after<br>**OR**<br>d. The member has an FDA labeled contraindication to **ALL** NSAIDs used in the treatment of nr-axSpA<br>**OR**<br>e. The member's medication history indicates use of another biologic immunomodulator agent that is FDA labeled or supported in DrugDex with 1 or 2a level of evidence or AHFS for the treatment of nr-axSpA<br>**AND**<br>2. **ANY** of the following (submitted medical records/chart notes are required for confirmation):<br>a. The member has tried and had an inadequate response to at least **TWO** preferred products after at least a 3-month trial per product |

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| | **OR**<br><br>b. The member has tried and had an inadequate response to **ONE** preferred product after at least a 3-month duration of therapy, **AND** an intolerance (defined as an intolerance to the drug or its excipients, not to the route of administration) or hypersensitivity to **ONE** preferred product<br><br>**OR**<br><br>c. The member has an intolerance (defined as an intolerance to the drug or its excipients, not to the route of administration) to at least **TWO** preferred products<br><br>**OR**<br><br>c. The member has an FDA labeled contraindication to **ALL** preferred products<br><br>**OR**<br><br>**d.** **ALL** preferred products are not clinically appropriate for the member, **AND** the prescriber has provided a complete list of previously tried products for the requested indication:<br><br>**The preferred nr-axSpA products are:**<br><br>• Cimzia (certolizumab pegol)<br>• Cosentyx (secukinumab)<br>• Rinvoq (upadacitinib) |
| Other indications | The member has another FDA labeled indication or an indication supported in DrugDex with 1 or 2a level of evidence, AHFS, or NCCN compendium recommended use 1 or 2a |

Continuation of ixekizumab (Taltz) **meets the definition of medical necessity** when **ALL** of the following are met ("1" to "6"):

1. An authorization or reauthorization for ixekizumab has been previously approved by Florida Blue [Note: members not previously approved for the requested agent will require initial evaluation review]
2. Member has had clinical benefit with ixekizumab therapy
3. The prescriber is a specialist in the area of the member's diagnosis (e.g., rheumatologist for PsA, dermatologist for PS) or the prescriber has consulted with a specialist in the area of the member's diagnosis
4. Member does **NOT** have any FDA labeled contraindications to ixekizumab
5. Member will **NOT** be using subcutaneous abatacept in combination with another biologic immunomodulator agent (full list in "Other" section); Janus kinase (JAK) inhibitor [Cibinqo

(abrocitinib), Leqselvi (deuruxolitinib), Litfulo (ritlecitinib), Olumiant (baricitinib), Opzelura (ruxolitinib), Rinvoq/Rinvoq LQ (upadacitinib), and Xeljanz/Xeljanz XR (tofacitinib), and Xeljanz XR (tofacitinib extended release)]; Otezla (apremilast); Sotyktu (deucravacitinib); or sphingosine-1-phosphate (S1P) modulator [Velsipity (etrasimod) and Zeposia (ozanimod)]

6. **ANY** of the following ("a", "b", "c", or "d"):
    a. The dosage does not exceed the following:
        i. PS in adults (18 years and older), PsA, AS, and nr-axSpA - 80 mg every 4 weeks (28 days)
            - QL: 80 mg/mL autoinjector - 1 pen/28 days
            - QL: 80 mg/mL syringe - 1 syringe/28 days
        ii. PS in pediatrics (6 to 17 years old):
            - Greater than 50 kg - 80 mg every 4 weeks (28 days)
                - QL: 80 mg/mL autoinjector - 1 pen/28 days
                - QL: 80 mg/mL syringe - 1 syringe/28 days
            - 25 to 50 kg - 40 mg every 4 weeks (28 days)
                - QL: 40 mg/0.5 mL syringe - 1 syringe/28 days
            - Less than 25 kg - 20 mg every 4 weeks (28 days)
                - QL: 20 mg/0.25 mL syringe - 1 syringe/28 days
    b. The member has an FDA labeled indication for the requested agent, **AND EITHER** of the following ("i" or "ii"):
        i. The requested quantity (dose) does **NOT** exceed the maximum FDA labeled dose for the requested indication, **AND** the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength and/or package size that does not exceed the program quantity limit
        ii. **ALL** of the following ("1", "2", and "3"):
            1. The requested quantity (dose) exceeds the FDA maximum labeled dose for the requested indication
            2. The member has tried and had an inadequate response to at least a 3-month trial of the maximum FDA labeled dose for the requested indication (medical records required)
            3. **EITHER** of the following ("a" or "b"):
                a. The requested quantity (dose) does **NOT** exceed the maximum compendia supported dose for the requested indication, **AND** the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength/and or package size that does not exceed the program quantity limit
                b. The requested quantity (dose) exceeds the maximum FDA labeled dose **AND** the maximum compendia supported dose for the requested indication, **AND** there is support for therapy with a higher dose or shortened dosing interval for the requested indication (submitted copy of clinical trials, phase III studies, guidelines required)

c. The member has a compendia supported indication for the requested agent, **AND EITHER** of the following ("i" or "ii"):

   i. The requested quantity (dose) does **NOT** exceed the maximum compendia supported dose for the requested indication, **AND** the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength/and or package size that does not exceed the program quantity limit

   ii. The requested quantity (dose) exceeds the maximum compendia supported dose for the requested indication, AND there is support for therapy with a higher dose or shortened dosing interval for the requested indication (submitted copy of clinical trials, phase III studies, guidelines required)

d. The member does **NOT** have an FDA labeled indication **NOR** a compendia supported indication for the requested agent, **AND BOTH** of the following ("i" and "ii"):

   i. The requested quantity (dose) cannot be achieved with a lower quantity of a higher strength and/or package size that does not exceed the program quantity limit

   ii. There is support for therapy with a higher dose or shortened dosing interval for the requested indication (submitted copy of clinical trials, phase III studies, guidelines required)

Compendia Allowed: AHFS, DrugDex 1 or 2a level of evidence, or NCCN 1 or 2a recommended use

**Approval duration**: 12 months

## DOSAGE/ADMINISTRATION:

**THIS INFORMATION IS PROVIDED FOR INFORMATIONAL PURPOSES ONLY AND SHOULD NOT BE USED AS A SOURCE FOR MAKING PRESCRIBING OR OTHER MEDICAL DETERMINATIONS. PROVIDERS SHOULD REFER TO THE MANUFACTURER'S FULL PRESCRIBING INFORMATION FOR DOSAGE GUIDELINES AND OTHER INFORMATION RELATED TO THIS MEDICATION BEFORE MAKING ANY CLINICAL DECISIONS REGARDING ITS USAGE.**

**FDA-approved**

- Indicated for (1) the treatment of patients 6 years of age and older with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy, (2) the treatment of adult patients with active psoriatic arthritis (PsA), and (3) the treatment of adult patients with active ankylosing spondylitis (AS), and (4) the treatment of adult patients with active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation.
- Administered by subcutaneous injection. The recommended dose is for adult plaque psoriasis 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. Dosing for pediatric PS (6 to <18 years old) is weight based. Refer to the product labeling for the recommended loading and maintenance dosing. The recommended dose for PsA and AS is 160 mg by subcutaneous injection (two 80 mg injections) at week 0, followed by 80 mg every 4 weeks. For PsA patients with coexistent moderate-to-severe plaque psoriasis, use the dosing regimen for plaque psoriasis. For nr-axSpA the recommended dose is 80 mg every 4 weeks (no loading dose). For PsA patients, ixekizumab may be administered alone or in combination with a csDMARD (e.g., methotrexate).
- Ixekizumab is intended for use under the guidance and supervision of a physician. Patients may self-inject after training in subcutaneous injection technique using the autoinjector or prefilled syringe.

Administer each injection at a different anatomic location (such as upper arms, thighs or any quadrant of abdomen) than the previous injection, and not into areas where the skin is tender, bruised, erythematous, indurated or affected by psoriasis. Administration the upper, outer arm may be performed by a caregiver or healthcare provider. If the 20 and 40 mg prefilled syringes are unavailable, doses of 20 mg or 40 mg must be prepared and administered by a qualified healthcare professional. Use only the commercial 80 mg/1 mL prefilled syringe when preparing the prescribed 20 mg and 40 mg pediatric dose.

- Before injection, remove ixekizumab from the refrigerator and allow to reach room temperature (30 minutes) without removing the needle cap.

**Dose Adjustments**

- Specific guidelines for dosage adjustments in hepatic or renal impairment are not available; it appears no dosage adjustments are needed

**Drug Availability**

- Autoinjector - 80 mg/mL solution in a single-dose prefilled autoinjector (cartons of 1, 2, or 3)
- Prefilled Syringe - 80 mg/mL, 40 mg/0.5 mL, and 20 mg/0.25 mL solution in a single-dose prefilled syringe (carton of 1)

## PRECAUTIONS:

**Boxed Warning**

- None

**Contraindications**

- Patients with a previous serious hypersensitivity reaction, such as anaphylaxis, to ixekizumab or to any of the excipients

**Precautions/Warnings**

- **Infections**: Serious infections have occurred. Instruct patients to seek medical advice if signs or symptoms of clinically important chronic or acute infection occur. If a serious infection develops, discontinue ixekizumab until the infection resolves.
- **Tuberculosis (TB**): Evaluate for TB prior to initiating treatment. Do not administer to patients with active TB infection. Initiate treatment of latent TB prior to administering ixekizumab. Consider anti-TB therapy prior to initiating in patients with a history of latent or active TB in whom an adequate course of treatment cannot be confirmed. Patients receiving ixekizumab should be monitored closely for signs and symptoms of active TB during and after treatment.
- **Hypersensitivity**: Serious hypersensitivity reactions, including angioedema and urticaria (each ≤0.1%), occurred in clinical trials. Anaphylaxis, including cases leading to hospitalization, has been reported in post marketing use. If a serious allergic reaction occurs, discontinue ixekizumab immediately and initiate appropriate therapy.

- **Eczematous Eruptions**: In the postmarketing setting, cases of severe eczematous eruptions were reported in patients receiving ixekizumab. Treatment may need to be discontinued to resolve the eczematous eruption.
- **Inflammatory Bowel Disease**: Crohn's disease and ulcerative colitis, including exacerbations, occurred during clinical trials. Patients who are treated with ixekizumab and have inflammatory bowel disease should be monitored closely.
- **Adverse Reactions**: Most common (≥1%) adverse reactions associated with ixekizumab treatment are injection site reactions, upper respiratory tract infections, nausea, and tinea infections.
- **Immunizations:** Prior to initiating therapy with ixekizumab, consider completion of all age-appropriate immunizations according to current immunization guidelines. Avoid use of live vaccines in patients treated with ixekizumab. No data are available on the response to live or inactive vaccines.
- **Pregnancy:** There are no available data on ixekizumab use in pregnant women to inform any drug associated risks. Human IgG is known to cross the placental barrier; therefore, ixekizumab may be transmitted from the mother to the developing fetus. An embryofetal development study conducted in pregnant monkeys at doses up to 19 times the maximum recommended human dose (MRHD) revealed no evidence of harm to the developing fetus.
- **Pediatric Use:** The safety and effectiveness of ixekizumab in pediatric patients (<18 years of age) have not been evaluated.
- **Cytochrome P450 Substrates:** The formation of CYP450 enzymes can be altered by increased levels of certain cytokines (e.g., IL-1, IL-6, IL-10, TNFα, IFN) during chronic inflammation. Thus, ixekizumab, an antagonist of IL-17A, could normalize the formation of CYP450 enzymes. Therefore, upon initiation or discontinuation in patients who are receiving concomitant drugs which are CYP450 substrates, particularly those with a narrow therapeutic index, consider monitoring for effect (e.g., for warfarin) or drug concentration (e.g., for cyclosporine) and consider dosage modification of the CYP450 substrate.

## BILLING/CODING INFORMATION:

### HCPCS Coding

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| J3590 | Unclassified biologics |

### ICD-10 Diagnosis Codes That Support Medical Necessity

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|---|---|
| L40.0 | Psoriasis vulgaris |
| L40.50 | Arthropathic psoriasis, unspecified |
| L40.51 | Distal interphalangeal psoriatic arthropathy |
| L40.52 | Psoriatic arthritis mutilans |
| L40.53 | Psoriatic spondylitis |
| L40.59 | Other psoriatic arthropathy |
| M45.0 – M45.9 | Ankylosing spondylitis |
| M45.A0 – M45.AB | Non-radiographic axial spondyloarthritis |
| M46.81 – M46.89 | Other specified inflammatory spondylopathies |

## REIMBURSEMENT INFORMATION:

Refer to section entitled **POSITION STATEMENT**.

## PROGRAM EXCEPTIONS:

**Federal Employee Program (FEP):** Follow FEP guidelines.

**State Account Organization (SAO):** Follow SAO guidelines.

**Medicare Part D:** Florida Blue has delegated to Prime Therapeutics authority to make coverage determinations for the Medicare Part D services referenced in this guideline.

**Medicare Advantage:** No National Coverage Determination (NCD) and/or Local Coverage Determination (LCD) were found at the time of the last guideline review date.

If this Medical Coverage Guideline contains a step therapy requirement, in compliance with Florida law 627.42393, members or providers may request a step therapy protocol exemption to this requirement if based on medical necessity. The process for requesting a protocol exemption can be found at Coverage Protocol Exemption Request.

## DEFINITIONS:

**DMARDs:** An acronym for disease-modifying antirheumatic drugs. These are drugs that modify the rheumatic disease processes, and slow or inhibit structural damage to cartilage and bone. These drugs are unlike symptomatic treatments such as NSAIDs that do not alter disease progression. DMARDs can be further subcategorized. With the release of biologic agents (e.g., anti-TNF drugs), DMARDs were divided into either: (1) conventional, traditional, synthetic, or non-biological DMARDs; or as (2) biological DMARDs. However, with the release of newer targeted non-biologic drugs and biosimilars, DMARDs are now best categorized as: (1) conventional synthetic DMARDs (csDMARD) (e.g., MTX, sulfasalazine), (2) targeted synthetic DMARDs (tsDMARD) (e.g., baricitinib, tofacitinib, apremilast), and (3) biological DMARDs (bDMARD), which can be either a biosimilar DMARD (bsDMARD) or biological originator DMARD (boDMARD).

**Plaque psoriasis:** It is the most common form of psoriasis. It affects 80 to 90% of people with psoriasis. Plaque psoriasis typically appears as raised areas of inflamed skin covered with silvery white scaly skin. These areas are called plaques.

**Psoriatic arthritis (PsA):** joint inflammation that occurs in about 5% to 10% of people with psoriasis (a common skin disorder). It is a severe form of arthritis accompanied by inflammation, psoriasis of the skin or nails, and a negative test for rheumatoid factor. Enthesitis refers to inflammation of entheses, the site where ligaments or tendons insert into the bones. It is a distinctive feature of PsA and does not occur with other forms of arthritis. Common locations for enthesitis include the bottoms of the feet, the Achilles' tendons, and the places where ligaments attach to the ribs, spine, and pelvis.

## RELATED GUIDELINES:

**Adalimumab Products, 09-J0000-46**

**Apremilast (Otezla) Tablet, 09-J2000-19**
**Bimekizumab (Bimzelx), 09-J4000-70**
**Brodalumab (Siliq) Injection, 09-J2000-74**
**Certolizumab Pegol (Cimzia), 09-J0000-77**
**Deucravacitinib (Sotyktu), 09-J4000-37**
**Etanercept (Enbrel), 09-J0000-38**
**Golimumab (Simponi, Simponi Aria), 09-J1000-11**
**Guselkumab (Tremfya), 09-J2000-87**
**Infliximab Products, 09-J0000-39**
**Psoralens with Ultraviolet A (PUVA), 09-10000-16**
**Risankizumab (Skyrizi), 09-J3000-45**
**Secukinumab (Cosentyx), 09-J2000-30**
**Tildrakizumab-asmn (Ilumya), 09-J3000-04**
**Ustekinumab (Stelara), 09-J1000-16**

## OTHER:

**NOTE**: The list of biologic immunomodulator agents not permitted as concomitant therapy can be found at Biologic Immunomodulator Agents Not Permitted as Concomitant Therapy.

### . Table 2: Conventional Synthetic DMARDs

| Generic Name | Brand Name |
|---|---|
| Auranofin (oral gold) | Ridaura |
| Azathioprine | Imuran |
| Cyclosporine | Neoral, Sandimmune |
| Hydroxychloroquine | Plaquenil |
| Leflunomide | Arava |
| Methotrexate | Rheumatrex, Trexall |
| Sulfasalazine | Azulfidine, Azulfidine EN-Tabs |

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## COMMITTEE APPROVAL:

This Medical Coverage Guideline (MCG) was approved by the Florida Blue Pharmacy Policy Committee on 11/12/25.

## GUIDELINE UPDATE INFORMATION:

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| 06/15/16 | New Medical Coverage Guideline. |
| 10/15/17 | Review and revision to guideline consisting of updating description, position statement, dosage/administration, definitions, related guidelines, and references. |
| 01/01/18 | Revision to guideline consisting of updating the preferred self-administered biologic products according to indication for use. Secukinumab (Cosentyx) is now a preferred product for plaque psoriasis. |

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| 01/15/18 | Revision to guideline consisting of the description section, position statement, dosage/administration, billing/coding information, related guidelines, definitions, and referenced, based on the new FDA-approved indication for the treatment of adults with active psoriatic arthritis. |
| 07/01/18 | Revision to guideline consisting of updating the position statement. |
| 10/15/18 | Review and revision to guideline consisting of updating the position statement and references. |
| 07/01/19 | Revision to guideline consisting of updating the position statement. |
| 09/01/19 | Revision to guideline consisting of updating the position statement. |
| 10/15/19 | Review and revision to guideline consisting of updating the description, position statement, dosage/administration, billing/coding, definitions, other section, and references. |
| 01/01/20 | Revision to guideline consisting of updating the position statement due to changes in preferred and non-preferred products. |
| 07/01/20 | Revision to guideline consisting of updating the description, position statement, dosage/administration, definitions, other, and references. |
| 01/01/21 | Review and revision to guideline consisting of updating the position statement and references. |
| 03/15/21 | Revision to guideline consisting of updating Table 1 in the position statement. |
| 10/01/21 | Revision: Addition of new ICD-10 code range M45.A0 – M45.AB. |
| 11/15/21 | Revision to guideline consisting of updating the position statement. |
| 01/01/22 | Review and revision to guideline consisting of updating the position statement, other section, and references. |
| 02/15/22 | Update to Table 1 in Position Statement. |
| 03/15/22 | Revision to guideline consisting of updating the position statement and other section. |
| 05/15/22 | Update to Table 1 in Position Statement. |
| 07/15/22 | Revision to guideline consisting of updating the position statement. |
| 09/15/22 | Revision to guideline consisting of updating the description, position statement, and references. |
| 01/01/23 | Review and revision to guideline consisting of updating the position statement, other section, and references. Rinvoq was added as a preferred agent for nr-AxSpA. New drugs were added to the list of drugs that are not permitted for use in combination. |
| 04/15/23 | Revision to guideline consisting of updating the position statement and other section. |
| 07/01/23 | Revision to guideline consisting of updating the position statement and other section. Amjevita and Hadlima added as Step 1a agents. Humira biosimilar products aded to list of Biologic Immunomodulator Agents Not Permitted as Concomitant Therapy. |
| 01/01/24 | Review and revision to guideline consisting of updating the position statement, other section, and references. Amjevita low concentration [10 mg/0.2 mL, 20 mg/0.4 mL, and 40 mg/0.8 mL concentrations only] clarified as the preferred prerequisite product. Update to Table 1 in Position Statement. New drugs were added to the list of drugs that are not permitted for use in combination. |
| 07/01/24 | Revision to guideline consisting of updating the description, position statement, related guidelines, and other section. Amjevita low concentration removed as a required prerequisite agent. Updates to the positioning of agents in Table 1. Removal of latent TB testing requirement. New drugs added to the list of Biologic Immunomodulator Agents Not Permitted as Concomitant Therapy. |

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| 10/01/24 | Revision to guideline consisting of updating the position statement. Updates to Table 1. Simlandi added among the required prerequisite agents for Taltz for AS, PS, and PsA. Rinvoq LQ added among the required prerequisite agents for Taltz for PsA. |
| 01/01/25 | Review and revision to guideline consisting of updating the position statement, dosage/administration, precautions, other section, and references. Adalimumab-aaty and Adalimumab-adaz added among the prerequisite therapies for AS, PsA, and PS. Sotyktu added among the prerequisite therapies for PS. Update to original Table 1 which is now a link out from the Position Statement. Table titles update. Weight-based dosing for pediatric PS added to the Position Statement. Revised wording regarding maximum dosage exceptions. New drugs were added to the list of drugs that are not permitted for use in combination. |
| 07/01/25 | Revision: Added Selarsdi, Steqeyma and Yesintek among the preferred agents for PS and PsA. |
| 01/01/26 | Review and revision to guideline consisting of updating the description, position statement and references. |