09-J2000-79

Original Effective Date: 06/15/17

Reviewed: 11/12/25

Revised: 01/01/26

Subject: Brodalumab (Siliq®) Injection

THIS MEDICAL COVERAGE GUIDELINE IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS MEDICAL COVERAGE GUIDELINE APPLIES TO ALL LINES OF BUSINESS UNLESS OTHERWISE NOTED IN THE PROGRAM EXCEPTIONS SECTION.

DESCRIPTION:

Brodalumab (Siliq) is an injectable human monoclonal IgG2κ antibody directed against interleukin-17 receptor A (IL-17RA). Blocking IL-17RA inhibits IL-17 cytokine-induced responses including the release of pro-inflammatory cytokines and chemokines. Brodalumab was approved by the US Food and Drug Administration (FDA) in February 2017 for "the treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy or phototherapy and have failed to respond or have lost response to other systemic therapies." Because of an observed risk of suicidal ideation and behavior during clinical trials, the labeling includes a Boxed Warning and the drug is only available through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS), the SILIQ REMS Program. Brodalumab is the third biologic agent that specifically targets the IL-17 pathway to be approved by the FDA for treatment of psoriasis. Secukinumab (Cosentyx), approved in January 2015, was the first followed by ixekizumab (Taltz) approved in March 2016. In October 2022, brodalumab was granted orphan drug designation by the FDA for the treatment of systemic sclerosis.

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 FDA 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 brodalumab (Siliq) 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 brodalumab (starting on samples is not approvable) within the past 90 days

b. The prescriber states the member has been treated with brodalumab (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. Brodalumab 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 brodalumab

II. The prescriber has provided information in support of using brodalumab 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., 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 brodalumab

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:

- Loading dose - 210 mg at weeks 0, 1, and 2
- Maintenance dose - 210 mg every 2 weeks, starting 2 weeks after week 2 (i.e., on week 4):
  - QL: 210 mg/1.5 mL syringe - 2 syringes (3 mL)/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: Loading dose (doses on week 0, 1, and 2) for 4 weeks, then maintenance dose for 12 additional weeks [16 weeks for total duration of approval]

Table 1

Diagnosis	Criteria
Moderate to severe plaque psoriasis (PS)	**BOTH** of the following: 1. **ONE** of the following: 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 **OR**

	b. The member has an intolerance or hypersensitivity to **ONE** conventional agent used in the treatment of PS **OR** c. The member has an FDA labeled contraindication to **ALL** conventional agents used in the treatment of PS **OR** 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) **OR** 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) **OR** 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 **AND** 2. **ANY** of the following (submitted medical records/chart notes are required for confirmation): a. The member has tried and had an inadequate response to **THREE** preferred products after at least a 3-month trial per product **OR** b. The member has tried and had an inadequate response to **TWO** preferred products after at least a 3-month duration of therapy per products, **AND** an intolerance or hypersensitivity to **ONE** preferred product **OR** 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 **OR** 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.

	OR e. The member has an FDA labeled contraindication to **ALL** preferred products **OR** f. **ALL** preferred products are not clinically appropriate for the member, **AND** the prescriber has provided a complete list of previously tried agents for the requested indication **The preferred PS products are:** • Adalimumab-aaty • Adalimumab-adaz • Cosentyx (secukinumab) • Enbrel (etanercept) • Hadlima (adalimumab-bwwd) • Humira (adalimumab) • Otezla/Otezla XR (apremilast) • Selarsdi (ustekinumab-aekn) • Simlandi (adalimumab-ryvk) • Skyrizi (risankizumab) • Sotyktu (deucravacitinib) • Stelara (ustekinumab) • Steqeyma (ustekinumab-stba) • Tremfya (guselkumab) • Yesintek (ustekinumab-kfce)
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 brodalumab (Siliq) **meets the definition of medical necessity** when **ALL** of the following are met ("1" to "6"):

1. An authorization or reauthorization for brodalumab 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 brodalumab therapy

3. The prescriber is a specialist in the area of the member's diagnosis (e.g., 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 brodalumab
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)]; Otezla/Otezla XR (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 210 mg every 2 weeks
        - QL: 210 mg/1.5 mL syringe - 2 syringes (3 mL)/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 the treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy or phototherapy and have failed to respond or have lost response to other systemic therapies.
- The recommended dose is 210 mg administered by subcutaneous injection at Weeks 0, 1, and 2 followed by 210 mg every 2 weeks. If an adequate response has not been achieved after 12 to 16 weeks of treatment, consider discontinuing therapy. Continued treatment beyond 16 weeks in patients who have not achieved an adequate response is not likely to result in greater success.
- Brodalumab is intended for use under the guidance and supervision of a healthcare professional. Patients may self-inject when deemed appropriate by a healthcare professional and after proper training in subcutaneous injection technique using the prefilled syringe.

Dose Adjustments

- No specific guidelines for dosage adjustments for renal or hepatic impairment are available. It appears that no dosage adjustments are needed.

Drug Availability

- Injection: 210 mg/1.5 mL solution in a single-dose prefilled syringe. Each prefilled syringe is for single-dose only.

PRECAUTIONS:

Boxed Warning

- Suicidal ideation and behavior, including completed suicides, have occurred in patients treated with brodalumab. Prior to prescribing brodalumab, weigh the potential risks and benefits in patients with a history of depression and/or suicidal ideation or behavior. Patients with new or worsening suicidal ideation and behavior should be referred to a mental health professional, as appropriate. Advise patients and caregivers to seek medical attention for manifestations of suicidal ideation or behavior, new onset or worsening depression, anxiety, or other mood changes.
- Because of the observed suicidal behavior in subjects treated with brodalumab, brodalumab is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the SILIQ REMS Program.

Contraindications

- Patients with Crohn's disease because brodalumab may cause worsening of disease
- Patient with clinically significant hypersensitivity to brodalumab or to any of the excipients in Siliq or component of the container.

Precautions/Warnings

- **SILIQ REMS Program**: Notable requirements of the program include the following:
    - Prescribers must be certified with the program.
    - Patients must sign a Patient-Prescriber Agreement Form.
    - Pharmacies must be certified with the program and must only dispense to patients who are authorized to receive brodalumab.

  Further information, including a list of qualified pharmacies, is available at www.SILIQREMS.com or by calling the SILIQ REMS Program Call Center at 855-511-6135.
- **Hypersensitivity Reactions**: Serious hypersensitivity reactions, including anaphylaxis, have been reported with postmarket use of brodalumab. Some cases required hospitalization. If a serious hypersensitivity reaction occurs, immediately discontinue brodalumab and initiate appropriate therapy.
- **Infections**: Serious infections have occurred. Consider the risks and benefits prior to initiating brodalumab in patients with a chronic infection or a history of recurrent infection. Instruct patients to seek medical advice if signs or symptoms of clinically important chronic or acute infection occur. If a serious infection develops, discontinue brodalumab until the infection resolves.
- **Tuberculosis (TB**): Evaluate patients for TB infection prior to initiating treatment with brodalumab.
- **Crohn's Disease**: Crohn's disease occurred during clinical trials. Discontinue brodalumab if patient develops Crohn's disease while taking brodalumab.
- **Immunizations**: Avoid using live vaccines concurrently with brodalumab.
- **CYP450 Substrates**: The formation of CYP450 enzymes can be altered by increased levels of certain cytokines during chronic inflammation, and treatment with brodalumab may modulate serum levels of some cytokines. Therefore, upon initiation or discontinuation of brodalumab 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.

- **Pregnancy**: There are no human data on brodalumab use in pregnant women to inform a drug associated risk. Human IgG antibodies are known to cross the placental barrier; therefore, brodalumab may be transmitted from the mother to the developing fetus. See the package insert for additional information.

BILLING/CODING INFORMATION

HCPCS Coding

J3590	Unclassified biologics

ICD-10 Diagnosis Codes That Support Medical Necessity

L40.0	Psoriasis vulgaris

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 guideline creation**.**

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:

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.

RELATED GUIDELINES:

Adalimumab Products, 09-J0000-46
Apremilast (Otezla) Tablet, 09-J2000-19
Bimekizumab (Bimzelx), 09-J4000-70
Certolizumab pegol (Cimzia), 09-J0000-77

Deucravacitinib (Sotyktu), 09-J4000-37
Etanercept (Enbrel), 09-J0000-38
Guselkumab (Tremfya), 09-J2000-87
Infliximab Products, 09-J0000-39
Ixekizumab (Taltz), 09-J2000-62
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.

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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:

06/15/17	New Medical Coverage Guideline.
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.
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, related guidelines, and references.
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, definitions, 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, and definitions.
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.
09/15/21	Update to Table 1 in Position Statement.
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 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 sections.
05/15/22	Update to Table 1 in Position Statement.
07/15/22	Update to Table 1 in Position Statement.
09/15/22	Update to Table 1 in Position Statement.
01/01/23	Review and revision to guideline consisting of updating the description section, position statement, other section, and references. 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 added 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.
10/01/24	Revision to guideline consisting of updating the position statement. Updates to Table 1. Simlandi added among the required prerequisite agents.
01/01/25	Review and revision to guideline consisting of updating the position statement, precautions, other section, and references. Adalimumab-aaty, Adalimumab-adaz, and 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 updated. 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.
01/01/26	Review and revision to guideline consisting of updating the description, position statement and references.