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Last P&T Approval/Version: 07/31/2024
Next Review Due By: 10/2024
Policy Number: C17336-A

Skyrizi (risankizumab-rzaa)

PRODUCTS AFFECTED

Skyrizi (risankizumab-rzaa)

COVERAGE POLICY

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Coverage Guideline must be read in its entirety to determine coverage eligibility, if any. This Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide Molina Healthcare complete medical rationale when requesting any exceptions to these guidelines.

Documentation Requirements:
Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational, or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

DIAGNOSIS:
Moderate-to-severe Plaque Psoriasis, Psoriatic Arthritis, Crohn's Disease, Ulcerative Colitis

REQUIRED MEDICAL INFORMATION:
This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. If a drug within this policy receives an updated FDA label within the last 180 days, medical necessity for the member will be reviewed using the updated FDA label information along with state and federal requirements, benefit being administered and formulary preferencing. Coverage will be determined on a case-by case basis until the criteria can be updated through Molina Healthcare, Inc. clinical governance. Additional information may be required on a case-by-case basis to allow for adequate review. When the requested drug product for coverage is dosed by weight, body surface area or other member specific measurement, this data element is required as part of the medical necessity review. The Pharmacy and Therapeutics Committee has determined that the drug benefit shall be a mandatory generic and that generic drugs will be dispensed whenever available.

FOR ALL INDICATIONS

1. (a) Prescriber attests, or clinical reviewer has found, member has had a negative TB screening* or TB test** (if indicated) result within the last 12 months for initial and continuation of therapy requests

*MOLINA REVIEWER NOTE: TB SCREENING assesses patient for future or ongoing TB exposure or risk and includes reviewing if they have been exposed to tuberculosis, if they have resided or traveled to areas of endemic tuberculosis, if patient resides or works in a congregate setting (e.g., correctional facilities, long-term care facilities, homeless shelters), etc.
**MOLINA REVIEWER NOTE: TB SKIN TEST (TST, PPD) AND TB BLOOD TEST (QuantiFERON TB Gold, T-Spot) are not required or recommended in those without risk factors for tuberculosis
OR
(b) For members who have a positive test for latent TB, provider documents member has completed a treatment course (a negative chest x-ray is also required every 12 months) OR that member has been cleared by an infectious disease specialist to begin treatment
AND

2. Member is not on concurrent treatment or will not be used in combination with TNF-inhibitor, biologic response modifier or other biologic DMARDs, Janus kinase Inhibitors, or Phosphodiesterase 4 inhibitor (i.e., apremilast, tofacitinib, baricitinib) as verified by prescriber attestation, member medication fill history, or submitted documentation
AND
3. Prescriber attests member does not have an active infection, including clinically important localized infections
AND
4. IF THIS IS A NON-FORMULARY/NON-PREFERRED PRODUCT: Documentation of trial/failure of or serious side effects to a majority (not more than 3) of the preferred formulary/PDL alternatives for the given diagnosis. Submit documentation including medication(s) tried, dates of trial(s) and reason for treatment failure(s).

A. PLAQUE PSORIASIS:

1. Documented diagnosis of moderate to severe psoriasis (BSA ≥ 3) OR < 3% body surface area with plaque psoriasis that involves sensitive areas of the body or areas that would significantly impact daily function (e.g., face, neck, hands, feet, genitals)
AND
2. (a) Documentation of treatment failure, serious side effects, or clinical contraindication to TWO of the following systemic therapies for ≥ 3 months: Methotrexate (oral or IM at a minimum dose of 15 mg/week), cyclosporine, acitretin, azathioprine, hydroxyurea, leflunomide, mycophenolate mofetil, or tacrolimus
OR
(b) Documentation of treatment failure to Phototherapy for ≥3 months with either psoralens with ultraviolet A (PUVA) or ultraviolet B (UVB) radiation (provider to submit documentation of duration of treatment, dates of treatment, and number of sessions; contraindications include type 1 or type 2 skin, history of photosensitivity, treatment of facial lesions, presence of premalignant lesions, history of melanoma or squamous cell carcinoma, or physical inability to stand for the required exposure time)
AND
3. Documentation of prescriber baseline disease activity evaluation and goals for treatment to be used to evaluate efficacy of therapy at renewal [DOCUMENTATION REQUIRED]

B. PSORIATIC ARTHRITIS (PsA):

1. Documentation of active psoriatic arthritis
AND
2. Documentation of prescriber baseline disease activity evaluation and goals for treatment to be used to evaluate efficacy of therapy [DOCUMENTATION REQUIRED]
AND
3. (a) Documented treatment failure, serious side effects or clinical contraindication to a minimum 3- month trial of ONE of the following: Leflunomide, Methotrexate, Sulfasalazine, Cyclosporine
OR

(b) Documentation member has severe psoriatic arthritis [erosive disease, elevated markers of inflammation, long term damage that interferes with function, highly active disease that causes a major impairment in quality of life, active PsA at many sites including dactylitis, enthesitis, function-limiting PsA at a few sites or rapidly progressive disease]
OR
(c) Documentation member has severe psoriasis [PASI ≥12, BSA of >5-10%, significant involvement in specific areas (e.g., face, hands or feet, nails, intertriginous areas, scalp), impairment of physical or mental functioning with lower amount of surface area of skin involved]

C. MODERATE TO SEVERE ACTIVE CROHN'S DISEASE:
1. Documentation of a diagnosis of Crohn's Disease
AND
2. Prescriber attests that members liver enzymes and bilirubin levels have been obtained and reviewed prior to initiating therapy with Skyrizi (risankizumab)
NOTE: For the treatment of Crohn's disease, evaluate liver enzymes and bilirubin at baseline, and during induction at least up to 12 weeks of treatment. Monitor thereafter according to routine patient management.
AND
3. Member has one or more high risk feature:
   i. Diagnosis at a younger age (<30 years old)
   ii. History of active or recent tobacco use
   iii. Elevated C-reactive protein and/or fecal calprotectin levels
   iv. Deep ulcers on colonoscopy
   v. Long segments of small and/or large bowel involvement
   vi. Perianal disease
   vii. Extra-intestinal manifestations
   viii. History of bowel resections
AND
4. (a) Documentation of treatment failure, serious side effects or clinical contraindication to an adequate trial (> 3 months) of ONE immunomodulator (e.g., azathioprine, 6-mercaptopurine, methotrexate) up to maximally indicated doses
OR
(b) Prescriber provides documented medical justification that supports the inability to use immunomodulators
   i. Inability to induce short-term symptomatic remission with a 3-month trial of systemic glucocorticoids
   ii. High-risk factors for intestinal complications may include: Initial extensive ileal, ileocolonic, or proximal GI involvement, Initial extensive perianal/severe rectal disease, Fistulizing disease (e.g., perianal, enterocutaneous, and rectovaginal fistulas), Deep ulcerations, Penetrating, stricturing or stenosis disease and/or phenotype, Intestinal obstruction or abscess
   iii. High risk factors for postoperative recurrence may include: Less than 10 years duration between time of diagnosis and surgery, Disease location in the ileum and colon, Perianal fistula, Prior history of surgical resection, Use of corticosteroids prior to surgery
AND
5. Documentation of prescriber baseline disease activity evaluation and goals for treatment to be used to evaluate efficacy of therapy at renewal [DOCUMENTATION REQUIRED]

D. ULCERATIVE COLITIS:
1. Documentation of ulcerative colitis diagnosis with evidence of moderate to severe disease activity
AND
2. (a) Documentation of treatment failure, serious side effects or clinical contraindication to a 2-month trial of one systemic agent (e.g., 6-mercaptopurine, azathioprine, cyclosporine,

tacrolimus, or a corticosteroid such as prednisone, methylprednisolone) for ulcerative colitis or will continue to take concurrently.
NOTE: A previous trial of a biologic (e.g., an adalimumab product [e.g., Humira], Simponi SC [golimumab SC injection], or Entyvio [vedolizumab IV infusion]) also counts as a trial of one systemic agent for UC
OR
b) The Member has pouchitis AND has tried therapy with an antibiotic (e.g., metronidazole, ciprofloxacin), probiotic, corticosteroid enema [for example, Cortenema® (hydrocortisone enema, generics)], or topical mesalamine
AND

3. Documentation of prescriber baseline disease activity evaluation and goals for treatment to be used to evaluate efficacy of therapy at renewal [DOCUMENTATION REQUIRED]

CONTINUATION OF THERAPY:

A. ALL INDICATIONS:

1. Adherence to therapy at least 85% of the time as verified by the prescriber or member medication fill history OR adherence less than 85% of the time due to the need for surgery or treatment of an infection, causing temporary discontinuation
AND
2. Prescriber attests to or clinical reviewer has found no evidence of intolerable adverse effects or drug toxicity (e.g., drug-induced liver injury in Crohn's Disease)
AND
3. Documentation of positive clinical response as demonstrated by low disease activity and/or improvements in the condition's signs and symptoms. [DOCUMENTATION REQUIRED]
AND
4. (a) Prescriber attests, or clinical reviewer has found, member has had a negative TB screening* or TB test (if indicated)** result within the last 12 months for initial and continuation of therapy requests
*MOLINA REVIEWER NOTE: TB SCREENING assesses patient for future or ongoing TB exposure or risk and includes reviewing if they have been exposed to tuberculosis, if they have resided or traveled to areas of endemic tuberculosis, if patient resides or works in a congregate setting (e.g., correctional facilities, long-term care facilities, homeless shelters), etc.
**MOLINA REVIEWER NOTE: TB SKIN TEST (TST, PPD) AND TB BLOOD TEST (QuantiFERON TB Gold, T-Spot) are not required or recommended in those without risk factors for tuberculosis
OR
(b) For members who have a positive test for latent TB, provider documents member has completed a treatment course (a negative chest x-ray is also required every 12 months) OR that member has been cleared by an infectious disease specialist to begin treatment

DURATION OF APPROVAL:

Initial authorization: 6 months, Continuation of therapy: 12 months.

PRESCRIBER REQUIREMENTS:

Prescribed by or in consultation with a board-certified dermatologist, rheumatologist or gastroenterologist. [If prescribed in consultation, consultation notes must be submitted with initial request and reauthorization requests]

AGE RESTRICTIONS:

18 years of age and older

QUANTITY:

Plaque Psoriasis and Psoriatic Arthritis:150 mg administered by subcutaneous injection at Week 0, Week 4 and every 12 weeks thereafter.

Crohn's Disease:

Initial dosing: 600 mg administered by intravenous infusion over at least one hour at Week 0, Week 4, and Week 8.
Maintenance dosage: Max 360 mg administered by subcutaneous injection at Week 12, and every 8 weeks thereafter

Ulcerative Colitis:
Initial dosing: 1200 mg administered by intravenous infusion over at least two hours at Week 0, Week 4, and Week 8
Maintenance dosage: Max 360 mg administered by subcutaneous injection at Week 12, and every 8 weeks thereafter

PLACE OF ADMINISTRATION:
The recommendation is that subcutaneous injectable medications in this policy will be for pharmacy benefit coverage and patient self-administered.

The recommendation is that infused medications in this policy will be for pharmacy or medical benefit coverage administered in a place of service that is a non-inpatient hospital facility-based location as per the Molina Health Care Site of Care program.

Note: Site of Care Utilization Management Policy applies for Skyrizi (risankizumab-rzaa) to channel to the prescription drug benefit for member self-administration as appropriate. For information on site of care, see Specialty Medication Administration Site of Care Coverage Criteria (molinamarketplace.com)

DRUG INFORMATION

ROUTE OF ADMINISTRATION:
Intravenous, Subcutaneous

DRUG CLASS:
Antipsoriatics - Systemic/Interleukin Antagonists

FDA-APPROVED USES:
Indicated for the treatment of:

- moderate-to-severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy
- active psoriatic arthritis in adults
- moderately to severely active Crohn's disease in adults
- moderately to severely active ulcerative colitis in adults

COMPENDIAL APPROVED OFF-LABELED USES:
None

APPENDIX

APPENDIX:
Reserved for State specific information. *Information includes, but is not limited to, State contract language, Medicaid criteria and other mandated criteria.*

State Specific Information
State Marketplace
Texas (Source: Texas Statutes, Insurance Code)
"Sec. 1369.654. PROHIBITION ON MULTIPLE PRIOR AUTHORIZATIONS.
(a) A health benefit plan issuer that provides prescription drug benefits *may not require an enrollee to receive more than one prior authorization annually* of the prescription drug benefit for *a prescription drug prescribed to treat an autoimmune disease, hemophilia, or Von Willebrand disease*.
(b) This section does not apply to:

(1) opioids, benzodiazepines, barbiturates, or carisoprodol;
(2) prescription drugs that have a typical treatment period of less than 12 months;
(3) drugs that:
(A) have a boxed warning assigned by the United States Food and Drug Administration for use; and
(B) must have specific provider assessment; or
(4) the use of a drug approved for use by the United States Food and Drug Administration in a manner other than the approved use."

BACKGROUND AND OTHER CONSIDERATIONS

BACKGROUND:

Psoriasis is a cell-mediated autoimmune and inflammatory disease that affects about 3% of the population. Plaque psoriasis accounts for about 80% to 90% of all patients with psoriasis. Patients are considered to have a "moderate-to-severe" degree of plaque psoriasis when the disease affects more than 5% to 10% of a patient's body surface. Roughly 70% to 80% of patients with plaque psoriasis have mild disease that can be adequately managed with topical therapy.

Skyrizi, an interleukin (IL)-23 blocker, is indicated for treatment of adults with moderate to severe plaque psoriasis who are candidates for systemic therapy or phototherapy. Skyrizi selectively binds to the p19 subunit of the IL-23 cytokine and inhibits interaction with the IL-23 receptor. IL-23, a key cytokine involved in inflammatory and immune responses, is thought to be linked to several chronic immune-mediated diseases such as plaque psoriasis. The recommended dose of Skyrizi is 150 mg(two 75 mg injections) administered subcutaneously (SC) at Weeks 0 and 4 and then once every 12 weeks (Q12W) thereafter. Administer each dose at a different anatomic location such as the thighs or abdomen.

Efficacy:

Four multicenter, randomized, double-blind studies ULTIMMA-1, ULTIMMA-2, IMMHANCE, and IMMVENT enrolled 2109 subjects 18 years of age and older with moderate -to-severe plaque psoriasis who had a body surface area (BSA) involvement of ≥10%, a static Physician's Global Assessment (sPGA) score of ≥3 ("moderate") in the overall assessment (plaque thickness/induration, erythema, and scaling) of psoriasis on a severity scale of 0 to 4, and a Psoriasis Area and Severity Index (PASI) score ≥12. Overall, subjects had a median baseline PASI score of 17.8 and a median BSA of 20.0%. Baseline sPGA score was 4 ("severe") in 19% of subjects. A total of 10% of study subjects had a history of diagnosed psoriatic arthritis. Across all studies, 38% of subjects had received prior phototherapy, 48% had received prior nonbiologic systemic therapy, and 42% had received prior biologic therapy for the treatment of psoriasis. In ULTIMMA-1 and ULTIMMA-2, 997 subjects were enrolled (including 598 subjects randomized to the SKYRIZI 150 mg group, 200 subjects randomized to the placebo group, and 199 to the biologic active control group). Subjects received treatment at Weeks 0, 4, and every 12 weeks thereafter.

Both studies assessed the responses at Week 16 compared to placebo for two co-primary endpoints:

- the proportion of subjects who achieved an sPGA score of 0 ("clear") or 1 ("almost clear")
- the proportion of subjects who achieved at least a 90% reduction from baseline PASI (PASI 90)

Secondary endpoints included the proportion of subjects who achieved PASI 100, sPGA 0, and PSS0 at Week 16.

Examination of age, gender, race, body weight, baseline PASI score and previous treatment with systemic or biologic agents did not identify differences in response to Skyrizi among these subgroups at Week 16. In ULTIMMA-1 and ULTIMMA-2 at Week 52, subjects receiving Skyrizi achieved sPGA 0 (58% and 60%, respectively), PASI 90 (82% and 81%, respectively), and PASI 100 (56% and 60%, respectively).

IMMHANCE enrolled 507 subjects (407 randomized to Skyrizi 150 mg and 100 to placebo). Subjects received treatment at Weeks 0, 4, and every 12 weeks thereafter. At Week 16, Skyrizi was superior to placebo on the co-primary endpoints of sPGA 0 or 1 (84% SKYRIZI and 7% placebo) and PASI 90 (73% Skyrizi and 2% placebo). The respective response rates for Skyrizi and placebo at Week 16 were: sPGA 0 (46% Skyrizi and 1% placebo); PASI 100 (47% Skyrizi and 1% placebo); and PASI 75 (89% Skyrizi and

8% placebo). In ULTIMMA-1 and ULTIMMA-2, among the subjects who received Skyrizi and had PASI 100 at Week 16, 80% (206/258) of the subjects who continued on Skyrizi had PASI 100 at Week 52. For PASI 90 responders at Week 16, 88% (398/450) of the subjects had PASI 90 at Week 52. In IMMHANCE, subjects who were originally on Skyrizi and had sPGA 0 or 1 at Week 28 were re- randomized to continue Skyrizi every 12 weeks or withdrawal of therapy. At Week 52, 87% (97/111) of the subjects re-randomized to continue treatment with Skyrizi had sPGA 0 or 1 compared to 61% (138/225) who were re-randomized to withdrawal of Skyrizi.

Adverse Effects

A total of 2234 subjects were treated with Skyrizi in clinical development studies in plaque psoriasis. Of these, 1208 subjects with psoriasis were exposed to Skyrizi for at least one year. Data from placebo- and active-controlled studies were pooled to evaluate the safety of Skyrizi for up to 16 weeks. In total, 1306 subjects were evaluated in the Skyrizi 150 mg group. Table 1 summarizes the adverse drug reactions that occurred at a rate of at least 1% and at a higher rate in the Skyrizi group than the placebo group during the 16-week controlled period of pooled clinical studies. Adverse drug reactions that occurred in < 1% but > 0.1% of subjects in the Skyrizi group and at a higher rate than in the placebo group through Week 16 were folliculitis and urticaria. In the first 16 weeks, infections occurred in 22.1% of the Skyrizi group (90.8 events per 100 subject- years) compared to 14.7% of the placebo group (56.5 events per 100 subject-years) and did not lead to discontinuation of Skyrizi. The rates of serious infections for the Skyrizi group and the placebo group were ≤0.4%. Serious infections in the Skyrizi group included cellulitis, osteomyelitis, sepsis and herpes zoster. In ULTIMMA-1 and ULTIMMA-2, through Week 52, the rate of infections (73.9 events per 100 subject- years) was similar to the rate observed during the first 16 weeks of treatment. Through Week 52, no new adverse reactions were identified, and the rates of the adverse reactions were similar to those observed during the first 16 weeks of treatment. During this period, serious infections that led to study discontinuation included pneumonia.

Inflammatory bowel disease (IBD) is a chronic inflammatory disorder of the gastrointestinal tract of unknown etiology and characterized by a chronic idiopathic inflammation of the intestine and consists of two main forms, ulcerative colitis (UC) and Crohn's disease (CD). While UC and CD have similar clinical presentations, they differ in the body areas affected. CD is characterized by deeper and more erratic inflammation that can occur throughout the entire digestive tract. In UC, inflammation is continuous and widespread and disturbs the superficial mucosal layer of the large intestine or the colon.

Crohn's disease (CD) is a chronic, inflammatory, multisystem disorder of unknown etiology with genetic, immunologic, and environmental influences. CD involves any area of the gastrointestinal tract (GIT) from the oral cavity to the anus, but it is limited primarily to the colon with or without small- intestine disease. Moreover, the inflammation in CD is often described as transmural, damaging each mucosal layer of the GIT, and noncontinuous. Therapy for CD includes medical therapy with pharmacologic agents consisting of 5-aminosalicylates (5-ASA), antibiotics, corticosteroids, immunomodulators, and biologics. Surgery is reserved for patients who are refractory to medical therapy. The key symptoms of CD include abdominal pain, diarrhea, and fatigue. Weight loss, fever, growth failure, anemia, recurrent fistulas, or extraintestinal manifestations (e.g., arthritis, iritis) can also occur. There is no single laboratory test that can make an unequivocal diagnosis of CD.

Ulcerative colitis (UC) is a chronic inflammatory condition characterized by relapsing and remitting episodes of inflammation that involves the rectum and colon. The definitive etiology of ulcerative colitis is unknown, but suspected causes are similar to those of CD. Inflammation can be mild, moderate, or severe. UC is limited to the superficial mucosa of the colon. UC more commonly involves the entire colon in children than in adults, who more commonly will have limited left-sided disease. The goals of treatment are to control acute attacks, prevent recurrent attacks, and promote healing of the colon. Severe attacks may require hospitalization. Generally, first-line treatment of UC includes corticosteroids, 6- mercaptopurine and azathioprine.

The anti-tumor necrosis factor (anti-TNF) agents (infliximab, adalimumab, and certolizumab pegol) are effective for treatment of patients with CD who respond inadequately to treatment with corticosteroids, thiopurines, and methotrexate. Anti-TNF agents have rapid onset of effect, with benefit often noted within 2 weeks of initiating therapy. Anti–TNF agents are reserved for moderate to severe disease refractory to corticosteroids and immunomodulators in both CD and UC. Infliximab and adalimumab carry approvals for

both CD and UC, though certolizumab pegol is approved only for CD.

American College of Gastroenterology (ACG)

In March 2018, the ACG released an updated guideline on managing CD in adult patients. It includes preferable approaches on diagnosis, disease modifiers, and medical therapy for the various disease severities. Nonsteroidal anti-inflammatory drugs (NSAIDs) may exacerbate disease activity and should be avoided when possible in patients with Crohn disease. Sulfasalazine is effective for treating symptoms of colonic Crohn disease that is mild to moderately active and can be used as treatment for this member population.

For patients with low risk of progression, treatment of active symptoms with antidiarrheals, other nonspecific medications, and dietary manipulation, along with careful observation for inadequate symptom relief, worsening inflammation, or disease progression, is acceptable. Oral corticosteroids are effective and can be employed for short-term use in alleviating signs and symptoms of moderately to severely active Crohn disease. Thiopurines (azathioprine, 6- mercaptopurine) are effective and should be considered for use for steroid sparing in Crohn disease. Azathioprine and 6- mercaptopurine are effective therapies and should be considered for treatment of patients with Crohn disease for maintenance of remission. Methotrexate (up to 25 mg once weekly intramuscularly [IM] or subcutaneously [SC]) is effective and should be considered for use in alleviating signs and symptoms in patients with steroid- dependent Crohn disease and for maintaining remission. Anti–tumor necrosis factor (anti-TNF) agents (infliximab, adalimumab, certolizumab pegol) should be used to treat Crohn disease that is resistant to treatment with corticosteroids. Anti-TNF agents should be given for Crohn disease refractory to thiopurines or methotrexate. Combination therapy of infliximab with immunomodulators (thiopurines) is more effective than treatment with either immunomodulators alone or infliximab alone in patients who are naive to those agents.

For patients with moderately to severely active Crohn disease and objective evidence of active disease, anti-integrin therapy (with vedolizumab) with or without an immunomodulator is more effective than placebo and should be considered for use in induction of symptomatic remission inpatients with Crohn disease. Natalizumab is more effective than placebo and should be considered for use in induction of symptomatic response and remission in patients with active Crohn disease. Natalizumab should be used for maintenance of natalizumab-induced remission of Crohn disease only if serum antibody to John Cunningham (JC) virus is negative. Testing for anti-JC virus antibody should be repeated every 6 months and treatment stopped if the result is positive. Ustekinumab should be given for moderate to severe Crohn disease patients who failed previous treatment with corticosteroids, thiopurines, methotrexate, or anti-TNF inhibitors or who have had no prior exposure to anti-TNF inhibitors. Intravenous corticosteroids should be used to treat severe or fulminant Crohn disease.

Anti-TNF agents (infliximab, adalimumab, certolizumab pegol) can be considered to treat severely active Crohn disease. Infliximab may be administered to treat fulminant Crohn disease. Infliximab is effective and should be considered in treating perianal fistulas in Crohn disease. Infliximab may be effective and should be considered in treating enterocutaneous and rectovaginal fistulas in Crohn disease. Adalimumab and certolizumab pegol may be effective and should be considered in treating perianal fistulas in Crohn disease. Thiopurines (azathioprine, 6-mercaptopurine) may be effective and should be considered in treating fistulizing Crohn disease. Once remission is induced with corticosteroids, a thiopurine or methotrexate should be considered. Anti- TNF therapy, specifically infliximab, adalimumab, and certolizumab pegol, should be used to maintain remission of anti-TNF–induced remission. Anti-TNF monotherapy is effective at maintaining anti-TNF–induced remission, but because of the potential for immunogenicity and loss of response, combination with azathioprine/6- mercaptopurine or methotrexate should be considered. Imidazole antibiotics (metronidazole and ornidazole) at doses between 1 and 2 g/day can be used after small intestinal resection in Crohn disease patients to prevent recurrence.

ACG Clinical Guideline: Ulcerative Colitis in Adults

The management of ulcerative colitis (UC) has changed since the last guideline was published in 2010. The recommendations in the current update are based on the quality of evidence using GRADE (Grading of Recommendations Assessment, Development, and Evaluation) methodology. An updated clinical guideline on the management of UC shifts the focus from symptom-based treatment to both symptom management and mucosal healing. New tests, including those based on serum drug levels and fecal calprotectin, as well as newer FDA-approved therapies, including budesonide, vedolizumab, and tofacitinib. Key

recommendations include: Treat patients with UC to achieve mucosal healing, increase the likelihood of sustained steroid- free remission, and prevent hospitalizations and surgery. In patients with moderately active UC, use non-systemic corticosteroids, such as budesonide MMX, before systemic therapy. In patients with moderately to severely active UC, use vedolizumab to induce remission.
In patients with moderately to severely active UC, use tofacitinib (10 mg orally twice daily for 8 weeks) to induce remission. Do not defer colectomy because of exposure to infliximab and cyclosporine, as these agents do not increase the risk for postoperative complications. In patients with acute severe UC and concomitant *Clostridium difficile* infection, use vancomycin instead of metronidazole. Perform surveillance colonoscopies in patients with UC at 1- to 3-year intervals, based on the combined risk factors for colorectal cancer in UC and the findings on previous colonoscopy.

AGA Guidelines Moderate to Severe Ulcerative Colitis
Recommendations from the recent 2020 guideline update include:

- In adult outpatients with moderate to severe UC who are naïve to biologic agents, the AGA suggests using infliximab or vedolizumab rather than adalimumab, for induction of remission.
- Updated FDA recommendations (July 26, 2019) on indications for use of tofacitinib in UC recommends its use only after failure of or intolerance to TNF-a antagonists.
- In adult outpatients with moderate to severe UC who have previously been exposed to infliximab, particularly those with primary nonresponse, the AGA suggests using ustekinumab or tofacitinib rather than vedolizumab or adalimumab for induction of remission.
- In adult outpatients with moderate to severe UC, the AGA suggests against using methotrexate monotherapy for induction or maintenance of remission
- In adult outpatients with active moderate to severe UC, the AGA suggests using biologic monotherapy (TNF-a antagonists, vedolizumab, or ustekinumab) or tofacitinib rather than thiopurine monotherapy for induction of remission.
- In adult outpatients with moderate to severe UC, the AGA suggests combining TNF-a antagonists, vedolizumab or ustekinumab with thiopurines or methotrexate rather than biologic monotherapy.
- In adult outpatients with moderate to severe UC who have achieved remission with biologic agents and/or immunomodulators or tofacitinib, the AGA suggests against continuing 5-ASA for induction and maintenance of remission.

CONTRAINDICATIONS/EXCLUSIONS/DISCONTINUATION:
All other uses of Skyrizi (risankizumab-rzaa) are considered experimental/investigational and therefore, will follow Molina's Off-Label policy. Contraindications to Skyrizi (risankizumab-rzaa) include: a history of serious hypersensitivity reaction to risankizumab-rzaa or any of the excipients, use with live vaccines.

OTHER SPECIAL CONSIDERATIONS:
None

CODING/BILLING INFORMATION

Note: 1) This list of codes may not be all-inclusive. 2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement

HCPCS CODE	DESCRIPTION
J2327	Injection, Risankizumab-rzaa, intravenous, 1mg

AVAILABLE DOSAGE FORMS:
Skyrizi (150 MG Dose) PSKT 75MG/0.83ML (2 x 75 MG/0.83ML Prefilled syringe Kit)
Skyrizi Pen SOAJ 150MG/ML Auto-injector
Skyrizi SOCT 180MG/1.2ML

REFERENCES

1. Skyrizi™ [prescribing information]. North Chicago, IL: AbbVie, Inc.; June 2024.
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(4):1029-1072.
3. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis: Section 4. Guidelines of care for the management and treatment of psoriasis with traditional systemic agents. J Am Acad Dermatol. 2009;61:451-485.
4. Menter, A., Strober, B., Kaplan, D., Kivelevitch, D., Prater, E., & Stoff, B. et al. (2019). Joint AAD- NPF guidelines of care for the management and treatment of psoriasis with biologics. Journal Of The American Academy Of Dermatology, 80(4), 1029-1072. doi: 10.1016/j.jaad.2018.11.057
5. Menter, A., Gelfand, J., Connor, C., Armstrong, A., Cordoro, K., & Davis, D. et al. (2020). Joint American Academy of Dermatology–National Psoriasis Foundation guidelines of care for the management of psoriasis with systemic nonbiologic therapies. Journal Of The American Academy Of Dermatology, 82(6), 1445-1486. doi: 10.1016/j.jaad.2020.02.044
6. Elmets, C., Lim, H., Stoff, B., Connor, C., Cordoro, K., & Lebwohl, M. et al. (2019). Joint American Academy of Dermatology–National Psoriasis Foundation guidelines of care for the management and treatment of psoriasis with phototherapy. Journal Of The American Academy Of Dermatology, 81(3), 775-804. doi: 10.1016/j.jaad.2019.04.042
7. Singh, J., Guyatt, G., Ogdie, A., Gladman, D., Deal, C., & Deodhar, A. et al. (2018). 2018 American College of Rheumatology/National Psoriasis Foundation Guideline for the Treatment of Psoriatic Arthritis. Arthritis & Rheumatology, 71(1), 5-32. doi: 10.1002/art.40726
8. Feuerstein, J. D., Ho, E. Y., Shmidt, E., Singh, H., Falck-Ytter, Y., Sultan, S., … Spechler, S. J. (2021). AGA Clinical Practice Guidelines on the Medical Management of Moderate to Severe Luminal and Perianal Fistulizing Crohn's Disease. Gastroenterology, 160(7), 2496–2508. https://doi.org/10.1053/j.gastro.2021.04.022
9. Dassapouls T, Cohen R, Scherl E, et al. Ulcerative colitis clinical care pathway. American Gastroenterological Association, 2015. Available at: http://campaigns.gastro.org/algorithms/UlcerativeColitis/index.html. Accessed March 2019.
10. Kornbluth A, Sachar DB. American College of Gastroenterology Practice Guidelines. Ulcerative Colitis Practice Guidelines in Adults: American College of Gastroenterology, Practice Parameters Committee. Am J Gastroenterol.2010;105:501-23.
11. Rubin DT et al. ACG clinical guideline: Ulcerative colitis in adults. Am J Gastroenterol 2019Mar; 114:384. Available at: https://journals.lww.com/ajg/Fulltext/2019/03000/ACG_Clinical_Guideline_Ulcerative_Colitis_in.10.aspx#pdf-link
12. Feuerstein, J., Isaacs, K., Schneider, Y., Siddique, S., Falck-Ytter, Y., & Singh, S. et al. (2020). AGA Clinical Practice Guidelines on the Management of Moderate to Severe Ulcerative Colitis. Gastroenterology, 158(5), 1450-1461. doi: 10.1053/j.gastro.2020.01.006

SUMMARY OF REVIEW/REVISIONS	DATE
REVISION- Notable revisions: Diagnosis Required Medical Information Continuation of Therapy Quantity FDA-Approved Uses Background References	Q3 2024
REVISION- Notable revisions: Required Medical Information Continuation of Therapy Drug Class Contraindications/Exclusions/Discontinuation Other Special Considerations Coding/Billing Information Available Dosage Forms References	Q4 2023
REVISION- Notable revisions: Required Medical Information Continuation of Therapy	Q4 2022
REVISION- Notable revisions: Diagnosis Required Medical Information Prescriber Requirements Quantity Place of administration Route of Administration FDA-Approved Uses Coding/Billing Information Available Dosage Forms References	Q3 2022
Q2 2022 Established tracking in new format	Historical changes on file