Skyrizi® (risankizumab-rzaa)

Effective: June 1, 2023

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	Yes ☒ No ☐

Applies to:

Commercial Products

☐ Harvard Pilgrim Health Care Commercial products; Fax 617-673-0988
☐ Tufts Health Plan Commercial products; Fax 617-673-0988
CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Public Plans Products

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax 617-673-0988
☐ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax 617-673-0939
☐ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax 617-673-0939
☒ Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax 617-673-0956
*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

Senior Products

☒ Harvard Pilgrim Health Care Stride Medicare Advantage; Fax 617-673-0956
☒ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); Fax 617-673-0956
☒ Tufts Medicare Preferred HMO, (a Medicare Advantage product); Fax 617-673-0956
☒ Tufts Medicare Preferred PPO, (a Medicare Advantage product); Fax 617-673-0956

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Food and Drug Administration (FDA) Approved Indications:

SKYRIZI is an interleukin-23 antagonist 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

Clinical Guideline Coverage Criteria

The Plan may authorize coverage of Skyrizi (risankizumab-rzaa) when the following criteria is met:

Plaque Psoriasis

1. The Member has a diagnosis of moderately to severe plaque psoriasis

AND

2. Skyrizi has been prescribed by or in consultation with a dermatologist

Psoriatic Arthritis

1. The Member has a diagnosis of active psoriatic arthritis (PsA)

AND

2. Skyrizi has been prescribed by or in consultation with a rheumatologist

Crohn's Disease

1. The Member has a diagnosis of moderately to severely active Crohn's disease (CD)

AND

2. Skyrizi has been prescribed by or in consultation with a gastroenterologist

Limitations

- Any indications other than FDA-approved indications are considered experimental or investigational and will not be approved by the health plan
- Skyrizi (risankizumab-rzaa) pens and pre-filled syringes for subcutaneous injection are covered under the Member's Part D Prescription Drug Benefit when Skyrizi is being self-administered

Codes

The following code(s) require prior authorization:

Table 1: HCPCS Codes

HCPCS Codes	Description
J2327	Injection, risankizumab-rzaa, intravenous, 1mg

References:

1. Medicare Benefit Policy Manual. 1st ed.; 2017. Available at: https://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/downloads/bp102c15.pdf. Accessed March 6, 2020.
2. Skyrizi® (risankizumab-rzaa). [package insert]. North Chicago, IL; Abbvie, Inc.; December 2022.

Approval And Revision History

February 15, 2023: Reviewed by the Medical Policy Approval Committee (MPAC)

March 14, 2023: Reviewed by Pharmacy and Therapeutics Committee (P&T)

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment, or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.