PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Taltz (ixekizumab)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

For **reauthorization**:

1. Chart notes have been provided showing improvement of signs and symptoms of disease (ie. decreased morning stiffness, tenderness or inflammatory back pain, improved quality of life, etc).

If all the above requirements are met, the medication will be approved for an additional 12 months.

Non-radiographic axial spondyloarthritis (nr-axSpA)

***Note*: Diagnosis of axial spondyloarthritis (axSpA) is also accepted. SpA comprises of 2 subtypes – ankylosing spondylitis (AS) and non-radiographic axial spondyloarthritis (nr-axSpA).**

For **initial** authorization:

10. Member must be 18 years of age or older; AND
11. Member has a documented diagnosis of active ankylosing spondylitis (AS) or active non-radiographic axial spondyloarthritis (nr-axSpA); AND
12. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
13. Medication must be prescribed by or in consultation with a rheumatologist; AND
14. Member has had back pain for 3 months or more that began before the age of 50; AND
15. Member shows at least one of the following signs or symptoms of Spondyloarthritis:
    a) Elevated serum C-reactive protein (CRP) or erythrocyte sedimentation rate (ESR);
    b) Positive HLA-B27 test;
    c) Sacroiliitis; AND
16. Member has tried and failed to respond to treatment with at least **two** NSAIDs taken at the maximum recommended dosages. Treatment failure requires at least 4 weeks of therapy with each NSAID without an adequate response.
17. **Dosage allowed/Quantity limit:** AS: 160 mg (two 80 mg injections) at Week 0, followed by 80 mg every 4 weeks; nr-axSpA: 80 mg every 4 weeks. Quantity Limit: 1 injection per 28 days (after loading doses).

If all the above requirements are met, the medication will be approved for 12 months.

For **reauthorization**:

2. Chart notes have been provided showing improvement of signs and symptoms of disease (ie. decreased morning stiffness, tenderness or inflammatory back pain, improved quality of life, etc).

If all the above requirements are met, the medication will be approved for an additional 12 months.

8. **Dosage allowed/Quantity limit:**
   a) Adults: 160 mg (two 80 mg injections) at week 0, followed by 80 mg at week 2, 4, 6, 8, 10, and 12, then 80 mg every 4 weeks.
   b) Pediatrics:
      i) Weight > 50 3iTc 0.00,then 80 at 0,o l l o w e d 80 4

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15. Coates LC, Kavanaugh A, Mease PJ, et al. Group for Research and Assessment of Psoriasis and Psoriatic Arthritis 2015 Treatment Recommendations for Psoriatic Arthritis. Arthritis Rheumatol. 2016 May;68(5):1060-71.
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17. Ixekizumab: Drug information. In: Post TW, ed. UpToDate; 2022. Accessed February 22, 2022. https://www.uptodate.com/contents/ixekizumab-drug-information?search=Taltz&source=panel_search_result&selected Title=1~29&usage_type=panel&kp_tab=drug_general&display_rank=1#F46367472
18. Psoriatic arthritis. https://www.mayoclinic.org/diseases-conditions/psoriatic-arthritis/symptoms-causes/syc-20354076. Accessed February 22, 2022.
19. Non-Radiographic Axial Spondyloarthritis. https://www.webmd.com/arthritis/non-radiographic-axial-spondyloarthritis-overview#1. Accessed February 23, 2022.

Effective date: 04/07/2023
Revised date: 02/10/2023

Appendix
Preferred Biologic Products

Approved for Rheumatoid Arthritis	x Actemra (requires step through preferred adalimumab product: Humira, Hadlima, Adalimumab-adaz, Adalimumab-fkjp) x Enbrel x Humira x Hadlima x Adalimumab-adaz x Adalimumab-fkjp

Approved for Ulcerative Colitis	x Humira x Hadlima x Adalimumab-adaz

	x Adalimumab-fkjp x Stelara x Rinvoq