Clinical Policy: Risankizumab (Skyrizi®)

Reference Number: QCP.PHAR.006
Date of Last Revision:

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Risankizumab (Skyrizi®) is a humanized monoclonal antibody.

Policy/Criteria
I. Initial Approval Criteria
A. Crohn's Disease (must meet all):
1. Diagnosis of CD;
2. Request is for IV: Skyrizi
3. Prescribed by or in consultation with a gastroenterologist;
4. Member meets one of the following (a or b):
    a. Failure of a ≥ 3 consecutive month trial of at least ONE immunomodulator (e.g., azathioprine, 6-mercaptopurine [6-MP], methotrexate [MTX]) at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated;
    b. Medical justification supports inability to use immunomodulators (see Appendix E);
5. age ≥ 18 years;
6. For Skyrizi: Quantity does not exceed one single dose vial or pre-filled cartridge per dose;
7. Member does not have combination use of biological disease-modifying antirheumatic drugs or JAK inhibitors (see Section III: Diagnoses/Indications for which coverage is NOT authorized);
8. Dose does not exceed maximum dose indicated in Section V.

Approval duration: 6 months

II. Continued Therapy
All Other Indications in Section I (must meet all):
1. Member currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. Quantity does not exceed 1 pre-filled cartridge every 8 weeks
4. Member does not have combination use of biological disease-modifying antirheumatic drugs or JAK inhibitors(see Section III: Diagnoses/Indications for which coverage is NOT authorized);
5. If request is for a dose increase, new dose does not exceed maximum dose indicated in Section V.

Approval duration: 12 months

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III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off-label use policy – HIM.PA.154 for health insurance marketplace or evidence of coverage documents;

B. Combination use of biological disease-modifying antirheumatic drugs (bDMARDs) or potent immunosuppressants, including but not limited to any tumor necrosis factor (TNF) antagonists [e.g., Cimzia®, Enbrel®, Humira® and its biosimilars, Simponi®, Avsola™, Inflectra™, Remicade®, Renflexis™], interleukin agents [e.g., Arcalyst® (IL-1 blocker), Ilaris® (IL-1 blocker), Kineret® (IL-1RA), Actemra® (IL-6RA), Kevzara® (IL-6RA), Stelara® (IL-12/23 inhibitor), Cosentyx® (IL-17A inhibitor), Taltz® (IL-17A inhibitor), Siliq™ (IL-17RA), Ilumya™ (IL-23 inhibitor), Skyrizi™ (IL-23 inhibitor), Tremfya® (IL23 inhibitor)], Janus kinase inhibitors (JAKi) [e.g., Xeljanz®/Xeljanz® XR, Cibinqo™, Olumiant™, Rinvoq™], anti-CD20 monoclonal antibodies [Rituxan®, Riabni™, Ruxience™, Truxima®, Rituxan Hycela®], selective co-stimulation modulators [Orencia®], and integrin receptor antagonists [Entyvio®] because of the additive immunosuppression, increased risk of neutropenia, as well as increased risk of serious infections

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CD: Crohn's disease
JAK: Janus kinase
MTX: methotrexate

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
azathioprine (Azasan®, Imuran®)	**CD*** 1.5 – 2 mg/kg/day PO	3 mg/kg/day
corticosteroids - Oral: e.g., prednisone, budesonide -Medium to very high potency topical: e.g., desoximetasone 0.05%, fluocinolone acetonide 0.025%, mometasone 0.1% cream, triamcinolone acetonide 0.1%, augmented betamethasone dipropionate 0.05%, clobetasol propionate 0.05% cream, ointment, gel, or solution, halobetasol propionate 0.05% cream, ointment	**CD*** Adult: -prednisone 40 mg – 60 mg PO QD for 1 to 2 weeks, then taper daily dose by 5 mg weekly until 20 mg PO QD, and then continue with 2.5 – 5 mg decrements weekly or IV 50 – 100 mg Q6H for 1 week - budesonide (Entocort EC□) 6 – 9 mg PO QD Pediatric:	Various

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	-Prednisone 1 to 2 mg/kg/day PO QD	
6-mercaptopurine (Purixan®)	**CD*** 50 mg PO QD or 0.75 – 1.5 mg/kg/day PO	1.5 mg/kg/day
methotrexate (Trexall®, Otrexup™, Rasuvo®, RediTrex®, Xatmep™, Rheumatrex®)	**CD*** 15 – 25 mg/week IM or SC	30 mg/week
Pentasa® (mesalamine)	**CD** 1,000 mg PO QID	4 g/day
tacrolimus (Prograf®)	**CD*** 0.27 mg/kg/day PO in divided doses or 0.15 – 0.29 mg/kg/day PO	N/A
biologic DMARDs (e.g., Humira, Enbrel, Cosentyx, Remicade, Simponi Aria, Otezla, Xeljanz/Xeljanz XR, Kevzara)	See Section V. Dosing and Administration	See Section V. Dosing and Administration

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.
*Off-label

Appendix C: Contraindications/Boxed Warnings

Contraindications: History of serious hypersensitivity reaction to risankizumab-rzaa or any of the excipients
BBW: None

Appendix D: General Information

- Definition of failure of MTX or DMARDs
    - Failure of a trial of conventional DMARDs:
        - Child-bearing age is not considered a contraindication for use of MTX. Each drug has risks in pregnancy. An educated patient and family planning would allow use of MTX in patients who have no intention of immediate pregnancy.
        - Social use of alcohol is not considered a contraindication for use of MTX. MTX may only be contraindicated if patients choose to drink over 14 units of alcohol per week. However, excessive alcohol drinking can lead to worsening of the condition, so patients who are serious about clinical response to therapy should refrain from excessive alcohol consumption.

Appendix E: Immunomodulator Medical Justification

- The following may be considered for medical justification supporting inability to use an immunomodulator for CD:

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- Inability to induce short-term symptomatic remission with a 3-month trial of systemic glucocorticoids
- 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
- For TNF-inhibitors, 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

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Risankizumabrzaa (Skyrizi)	CD	Induction: 600 mg IV at Week 0, Week 4 and Week 8	IV: 600 mg/dose

VI. Product Availability

Risankizumabrzaa (Skyrizi):
Intravenous infusion Single-dose vial: 600 mg/10 mL

References

1. Skyrizi Prescribing Information. North Chicago, IL: Abbvie Inc.; September 2022. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/761105s018lbl.pdf. Accessed February 10, 2023.
2. Feuerstein JD, Ho EY, Shmidt E, et al. AGA Clinical practice guidelines on the medical management of moderate to severe luminal and perianal fistulizing Crohn's disease. Gastroenterology 2021; 160:2496-2508. https://doi.org/10.1053/j.gastro.2021.04.022.
3. Lichtenstein GR, Loftus EV, Isaacs KL et al. ACG Clinical Guideline: Management of Crohn's Disease in Adults. Am J Gastroenterol. 2018 Apr;113(4):481-517. doi: 10.1038/ajg.2018.27.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to

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date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

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

Revision Log

Reviews, Revisions, and Approvals	Revision Date	Approval Date

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed healthcare professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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