

Medical Policy Manual **Approved Rev: Do Not Implement until 12/1/26**

Risankizumab-rzaa (Skyrizi®)

IMPORTANT REMINDER

We develop Medical Policies to provide guidance to Members and Providers. This Medical Policy relates only to the services or supplies described in it. The existence of a Medical Policy is not an authorization, certification, explanation of benefits or a contract for the service (or supply) that is referenced in the Medical Policy. For a determination of the benefits that a Member is entitled to receive under his or her health plan, the Member's health plan must be reviewed. If there is a conflict between the medical policy and a health plan or government program (e.g., TennCare), the express terms of the health plan or government program will govern.

POLICY

INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

- Treatment of moderate-to-severe plaque psoriasis (PsO) in adults **and pediatric patients 6 years of age and older** who are candidates for systemic therapy or phototherapy
- Treatment of active psoriatic arthritis (PsA) in adults **and pediatric patients 6 years of age and older**
- Treatment of moderately to severely active Crohn's disease (CD) in adults
- Treatment of moderately to severely active ulcerative colitis (UC) in adults

All other indications are considered experimental/investigational and not medically necessary.

DOCUMENTATION

Submission of the following information is necessary to initiate the prior authorization review:

Plaque psoriasis (PsO)

Initial requests

- Chart notes or medical record documentation of affected area(s) and body surface area (BSA) affected (if applicable).
- Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.

Continuation requests

Chart notes or medical record documentation of decreased body surface area (BSA) affected and/or improvement in signs and symptoms.

Psoriatic arthritis (PsA)

Initial requests

Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.

Medical Policy Manual **Approved Rev: Do Not Implement until 12/1/26**

Continuation requests

Chart notes or medical record documentation supporting positive clinical response.

Crohn's disease (CD) and Ulcerative Colitis (UC)

Continuation requests: Chart notes or medical record documentation supporting positive clinical response to therapy or remission.

PRESCRIBER SPECIALTIES

This medication must be prescribed by or in consultation with one of the following:

- Plaque psoriasis: dermatologist
- Psoriatic arthritis: rheumatologist or dermatologist
- Crohn's disease and ulcerative colitis: gastroenterologist

COVERAGE CRITERIA

Plaque Psoriasis (PsO)

Authorization of 12 months may be granted for members **6 years of age or older** who have previously received a biologic or targeted synthetic drug (e.g., Sotyktu, Otezla) indicated for the treatment of moderate to severe plaque psoriasis.

Authorization of 12 months may be granted for members **6 years of age or older** for treatment of moderate to severe plaque psoriasis when any of the following criteria is met:

- Crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected.
- At least 10% of body surface area (BSA) is affected.
- At least 3% of body surface area (BSA) is affected and the member meets either of the following criteria:
 - Member has had an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin.
 - Member has a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin (see Appendix).

Psoriatic arthritis (PsA)

Authorization of 12 months may be granted for members **6 years of age or older** who have previously received a biologic or targeted synthetic drug (e.g., Rinvoq, Otezla) indicated for active psoriatic arthritis.

Authorization of 12 months may be granted for members **6 years of age or older** for treatment of active psoriatic arthritis when either of the following criteria is met:

- Member has mild to moderate disease and meets one of the following criteria:
 - Member has had an inadequate response to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine) administered at an adequate dose and duration.
 - Member has an intolerance or contraindication to methotrexate or leflunomide (see Appendix), or another conventional synthetic drug (e.g., sulfasalazine).
 - Member has enthesitis.
- Member has severe disease.



Medical Policy Manual **Approved Rev: Do Not Implement until 12/1/26**

Crohn's disease (CD)

Authorization of 12 months may be granted for treatment of moderately to severely active Crohn's disease.

Ulcerative colitis (UC)

Authorization of 12 months may be granted for treatment of moderately to severely active ulcerative colitis.

CONTINUATION OF THERAPY

Plaque psoriasis (PsO)

Authorization of 12 months may be granted for all members **6 years of age or older** (including new members) who are using the requested medication for moderate to severe plaque psoriasis and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when either of the following is met:

- Reduction in body surface area (BSA) affected from baseline
- Improvement in signs and symptoms from baseline (e.g., itching, redness, flaking, scaling, burning, cracking, pain)

Psoriatic arthritis (PsA)

Authorization of 12 months may be granted for all members **6 years of age or older** (including new members) who are using the requested medication for psoriatic arthritis and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:

- Number of swollen joints
- Number of tender joints
- Dactylitis
- Enthesitis
- Skin and/or nail involvement
- Functional status
- C-reactive protein (CRP)

Crohn's Disease (CD)

Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for moderately to severely active Crohn's disease and who achieve or maintain remission.

Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for moderately to severely active Crohn's disease and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:

- Abdominal pain or tenderness
- Diarrhea
- Body weight
- Abdominal mass
- Hematocrit

Medical Policy Manual **Approved Rev: Do Not Implement until 12/1/26**

- Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound
- Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index [CDAI] score)

Ulcerative colitis (UC)

Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for moderately to severely active ulcerative colitis and who achieve or maintain remission.

Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for moderately to severely active ulcerative colitis and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:

- Stool frequency
- Rectal bleeding
- Urgency of defecation
- C-reactive protein (CRP)
- Fecal calprotectin (FC)
- Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound
- Improvement on a disease activity scoring tool (e.g., Ulcerative Colitis Endoscopic Index of Severity [UCEIS], Mayo score)

OTHER

For all indications: **Member has been evaluated for tuberculosis (TB) infection prior to initiation of treatment with a biologic or targeted synthetic drug associated with an increased risk of TB.**

For all indications: Member cannot use the requested medication concomitantly with any other biologic drug or targeted synthetic drug for the same indication.

APPENDIX

Examples of Clinical Reasons to Avoid Pharmacologic Treatment with Methotrexate, Cyclosporine, Acitretin, or Leflunomide

- Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease
- Drug interaction
- Risk of treatment-related toxicity
- Pregnancy or currently planning pregnancy
- Breastfeeding
- Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension)
- Hypersensitivity
- History of intolerance or adverse event

DOSAGE AND ADMINISTRATION

Medical Policy Manual **Approved Rev: Do Not Implement until 12/1/26**

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

APPLICABLE TENNESSEE STATE MANDATE REQUIREMENTS

BlueCross BlueShield of Tennessee's Medical Policy complies with Tennessee Code Annotated Section 56-7-2352 regarding coverage of off-label indications of Food and Drug Administration (FDA) approved drugs when the off-label use is recognized in one of the statutorily recognized standard reference compendia or in the published peer-reviewed medical literature.

ADDITIONAL INFORMATION

For appropriate chemotherapy regimens, dosage information, contraindications, precautions, warnings, and monitoring information, please refer to one of the standard reference compendia (e.g., the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) published by the National Comprehensive Cancer Network®, Drugdex Evaluations of Micromedex Solutions at Truven Health, or The American Hospital Formulary Service Drug Information).

REFERENCES

1. Skyrizi [package insert]. North Chicago, IL: AbbVie Inc.; June 2026.
2. 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(3):451-485.
3. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Section 6: Guidelines of care for the treatment of psoriasis and psoriatic arthritis: case-based presentations and evidence-based conclusions. *J Am Acad Dermatol*. 2011;65(1):137-174.
4. Gordon KB, Strober B, Lebwohl M, et al. Efficacy and safety of risankizumab in moderate-to-severe plaque psoriasis (UltIMMa-1 and UltIMMa-2): results from two double-blind, randomised, placebo-controlled and ustekinumab-controlled phase 3 trials. *Lancet*. 2018;392(10148):650-661.
5. 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.
6. Singh JA, Guyatt G, Ogdie A, et al. 2018 American College of Rheumatology/National Psoriasis Foundation Guideline for the Treatment of Psoriatic Arthritis. *Arthritis Rheum*. 2018;71:5-32.
7. Gossec L, Kerschbaumer A, **Ferreira RJO**, et al. EULAR recommendations for the management of psoriatic arthritis with pharmacological therapies: 2023 update. *Annals of the Rheumatic Diseases*. 2024;83:706-719.
8. D'Haens G, Panaccione R, Baert F, et al. Risankizumab as induction therapy for Crohn's disease: results from the phase 3 ADVANCE and MOTIVATE induction trials. *Lancet*. 2022;399(10340):2015-2030.
9. Lichtenstein GR, Loftus EV, **Afzali A**, et al. ACG Clinical Guideline: Management of Crohn's Disease in Adults. *Am J Gastroenterol*. 2025;120:1225-1264.
10. Coates LC, Soriano ER, Corp N, et al. Group for Research and Assessment of Psoriasis and Psoriatic Arthritis (GRAPPA): updated treatment recommendations for psoriatic arthritis 2021. *Nat Rev Rheumatol*. 2022;18(8):465-479.
11. Menter A, Gelfand JM, Connor C, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management of psoriasis with systemic nonbiologic therapies. *J Am Acad Dermatol*. 2020;82(6):1445-1486.
12. Talley NJ, Abreu MT, Achkar J, et al. An evidence-based systematic review on medical therapies for inflammatory bowel disease. *Am J Gastroenterol*. 2011;106(Suppl 1):S2-S25.

Medical Policy Manual **Approved Rev: Do Not Implement until 12/1/26**

13. Rubin DT, Ananthakrishnan AN, Siegel CA, et al. ACG Clinical Guideline: Ulcerative Colitis in Adults. Am J Gastroenterol. 2025;120:1187-1224.
14. Singh S, Loftus EV Jr, Limketkai BN, et al. AGA Living Clinical Practice Guideline on Pharmacological Management of Moderate-to-Severe Ulcerative Colitis. Gastroenterology. 2024; 167(7):1307-1343.

EFFECTIVE DATE 12/1/2026

ID_CHS_30472026a_0926