INTERLEUKIN-17 AND 23 ANTAGONISTS

Included Products: Cosentyx (Secukinumab), Ilumya (tildrakizumab-asmn), Omvoh (mirikizumab-mrkz), Siliq (brodalumab), Skyrizi (risankizumab), Taltz (ixekizumab), Tremfya (guselkumab), Yesintek (ustekinumab-kfce), Starjemza (ustekinumab-hmny)

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Ilumya is nonformulary for outpatient benefit. Prior authorization required on medical benefit.

Effective April 1st, 2025 Stelara is nonformulary for outpatient benefit. It has been replaced by the biosimilar Yesintek and Starjemza. Use of preferred biosimilar is required.

All Diagnoses			
Initial Criteria: All Diagnoses		If yes	If no
1.	Is the requested agent indicated for or supported for use in the submitted diagnosis for the member's age?	Continue to #2.	Do not approve.
2.	Is the request for maintenance of remission in a patient who already achieved remission with the requested product or has already initiated therapy?	Continue to #3.	Continue to #5.
3.	Is the request for renewal of Stelara for a member who has been approved for Stelara through CareOregon?	Continue to #4.	Continue to renewal criteria for the submitted diagnosis.
4.	Has the member failed (or have a contraindication to) Yesintek or Starjemza (Stelara biosimilar)?	Continue to renewal criteria for the submitted diagnosis.	Do not approve.
5.	Has the risk of infections been addressed by the following?	Continue to #6.	Do not approve.

	a. Initial testing for latent TB and treatment, if necessary, before starting therapy. b. No current active infection at initiation of therapy. c. Risks and benefits documented in cases of chronic or recurrent infection.		
6.	Has the treatment been initiated by or is an appropriate specialist currently supervising it? a. Ankylosing Spondylitis and Axial Spondyloarthritis: Rheumatologist b. Crohn's Disease: Gastroenterologist c. Juvenile Idiopathic Arthritis: Rheumatologist d. Hidradenitis suppurativa: Dermatologist e. Plaque Psoriasis: Dermatologist f. Psoriatic Arthritis: Dermatologist or Rheumatologist g. Ulcerative Colitis: Gastroenterologist	Continue to #7.	Do not approve.
7.	Is the requested agent to be used in combination with another biologic or Otezla?	Do not approve.	Continue to #8.
8.	Proceed to specific criteria for the submitted indication.		

Ankylosing Spondylitis and Axial Spondyloarthritis

Initial Criteria		If yes	If no
1.	Does the member have ankylosing spondylitis or axial spondyloarthritis (radiographic or non-radiographic)? Diagnosis is definitive if the following are met: a. Back pain and stiffness for more than 3 months AND b. Signs of active inflammation on MRI OR radiological evidence of sacroiliitis OR	Continue to #2.	Do not approve.

	HLA-B27 positive.		
2.	Does the member have moderate to severe active disease at baseline, as evidenced by an objective test such as the BASDAI?	Continue to #3.	Do not approve.
3.	Is the member transitioning to the requested treatment from a different biologic product?	Continue to #5.	Continue to #4.
4.	Has the member tried and failed conventional therapy with both of the following: a. At least two NSAIDs for 3 months at maximum recommended or tolerated anti-inflammatory dose unless contraindicated, and b. Physical therapy/exercise program	Continue to #5.	Do not approve.
5.	Has the member tried and failed infliximab AND adalimumab?	Continue to #6.	Do not approve.
6.	Is the request for Cosentyx?	Continue to #7.	Continue to #8.
7.	Has the provider requested a loading dose? (induction dosing 150 mg at weeks 0, 1, 2, 3, and 4).	Do not approve.	Continue to #8.
8.	Approve for 6 months.		
Renewal Criteria		If yes	If no
1.	Does the member have significant improvement in signs and symptoms of AS/SpA and/or functioning, such as ASAS40 or 2-point improvement in BASDAI?	Continue to #2.	Do not approve.
2.	Approve for 12 months.		

Crohn's Disease

Initial Criteria		If yes	If no
1.	Is the member transitioning to the requested treatment from a different biologic product?	Continue to #3.	Continue to #2.
2.	Does the member have moderate to severe Crohn's disease?	Continue to #3.	Do not approve.

3.	Has the member tried and failed ALL of the following biologics? a. Infliximab (not required for members under 21), AND b. Adalimumab	Continue to #4.	Do not approve.
4.	Is the request for Yesintek or Starjemza (Stelara biosimilar)?	Continue to #8.	Continue to #5.
5.	Has the member tried and failed, or have contraindications to Yesintek or Starjemza (Stelara biosimilar)?	Continue to #6.	Do not approve.
6.	Is the request for Skyrizi?	Continue to #7.	Continue to #8.
7.	Has the member tried and failed Entyvio or a JAK inhibitor (Xeljanz or Rinvoq), or have contraindications to Entyvio and JAK inhibitors?	Continue to #8.	Do not approve.
8.	Approve for 6 months.		
Renewal Criteria		If yes	If no
1.	Has the member experienced a decrease in symptoms, reduction in enterocutaneous fistulas or clinical remission?	Continue to #2.	Do not approve.
2.	Approve for 12 months.		

Juvenile Idiopathic Arthritis

Initial Criteria		If yes	If no
1.	Is the member transitioning to the requested treatment from a different biologic product (i.e. previously approved for a biologic through CareOregon or already on biologic therapy and newly established with CareOregon)?	Continue to #6.	Continue to #2.
2.	Does the member have juvenile idiopathic arthritis with active systemic features of JIA, with a physician global assessment of 5 or higher (or any systemic activity in the absence of active joint involvement)?	Continue to #4.	Continue to #3.
3.	Does the member have juvenile idiopathic arthritis without active systemic features of JIA?	Continue to #5.	Do not approve.

4.	Has the member tried and failed systemic corticosteroids?	Continue to #5.	Do not approve.
5	Has the member tried and failed methotrexate or leflunomide for at least 3 months (or have a contraindication to both)?	Continue to #6.	Do not approve.
6.	Has the member tried and failed (or have contraindications to) adalimumab)?	Continue to #7.	Do not approve.
7.	Has the member tried and failed Actemra/Tyenne?	Continue to #8.	Do not approve.
8.	Is the dose appropriate for the member's age and weight?	Continue to #9.	Do not approve.
9.	Approve for 6 months.		
Renewal Criteria		If yes	If no
1.	Has the member experienced 20% or greater improvement in tender joint count and swollen joint count or stabilization of active systemic activity?	Continue to #2.	Do not approve.
2.	Approve for 12 months.		

Hidradenitis Suppurativa

Initial Criteria		If yes	If no
1.	Does the member have a diagnosis of moderate to severe hidradenitis suppurativa (Hurley II/Hurley III stage), characterized by recurrent, painful, and suppurating lesions recurring at least twice in 6 months?	Continue to #2.	Do not approve.
2.	Has the member tried and failed a 3 month treatment course of ALL of the following? a. Oral antibiotics, such as clindamycin and rifampin, dapsone, or doxycycline b. Intralesional corticosteroid injections c. Antiandrogenic hormonal treatments for women (oral contraceptives or spironolactone) d. Acitretin if not of child-bearing potential	Continue to #3.	Do not approve.

3.	Has the member failed all of the following biologics? a. Infliximab b. Adalimumab	Continue to #4.	Do not approve.
4.	Is the request for Yesintek or Starjemza (Stelara biosimilar)?	Continue to #7.	Continue to #5.
5.	Has the member tried and failed, or have contraindications to Yesintek or Starjemza (Stelara biosimilar)?	Continue to #7.	Do not approve.
7.	Approve for 6 months.		
Renewal Criteria		If yes	If no
1.	Is there a valid, medical reason surgical intervention is not being pursued?	Continue to #2.	Request a statement.
2.	Has there been a significant treatment response as defined as ONE of the following? a. A reduction of 25% or more in the total abscess and inflammatory nodule count; OR b. No increase in abscesses and draining fistulas	Continue to #3.	Do not approve.
3.	Approve for 12 months.		

Plaque Psoriasis

Initial Criteria		If yes	If no
1.	Is the member transitioning to the requested treatment from a different biologic product (i.e. previously approved for a biologic through CareOregon or already on biologic therapy and newly established with CareOregon)?	Continue to #7.	Continue to #2.
2.	Does the member have chronic, moderate to severe plaque psoriasis at baseline with functional impairment and one or more of the following? a. At least 10% body surface area involved	Continue to #5.	Continue to #3.

	b. Hand, foot, face, or mucous membrane involvement		
3.	Is the member under the age of 21?	Continue to #4.	Do not approve. Plaque psoriasis without functional impairment and hand, foot, face, or mucous membrane involvement or affecting 10% or more of body surface area is not covered for treatment by the Oregon Health Plan.
4.	Is it medically necessary or medically appropriate to treat the psoriasis due to contributing factors to a comorbid condition or impact on growth, learning, or development?	Continue to #5.	Do not approve based on medical necessity or appropriateness.
5.	Has the member tried and failed high-potency topical corticosteroids, such as augmented betamethasone cream 0.05%, desoximetasone 0.25% cream, or clobetasol AND a non-steroid topical?	Continue to #6.	Do not approve.
6.	Has the member tried and failed ONE of the following?: a. An oral DMARD (methotrexate, cyclosporine, or acitretin) OR b. Phototherapy	Continue to #7.	Do not approve.
7.	Has the member tried and failed infliximab AND adalimumab (or have contraindications to both)? Infliximab not required for members under 21	Continue to #8.	Do not approve.
8.	Is the request for Yesintek or Starjemza?	Continue to #10.	Continue to #9.
9.	For Cosentyx: Has the member failed Yesintek or Starjemza?	Continue to #10.	Do not approve.

	For all others (such as Skyrizi): Has the member failed Yesintek or Starjemza AND one of the following (or have contraindications to all)?: a. Cosentyx b. Ilumya c. Siliq		
10.	Is the dose within plan quantity limits and appropriate for age and weight?	Continue to #11.	Do not approve.
11.	Approve for 6 months.		
Renewal Criteria		If yes	If no
1.	Has the member experienced a clinically significant response, such as PASI-75 (75% improvement) and/or is there evidence of functional improvement?	Continue to #2.	Do not approve.
2.	Approve for 12 months.		

Psoriatic Arthritis

Initial Criteria		If yes	If no
1.	Is the member transitioning to the requested treatment from a different biologic product (i.e. previously approved for a biologic through CareOregon or already on biologic therapy and newly established with CareOregon)?	Continue to #4.	Continue to #2.
2.	Does the member have psoriatic arthritis based on at least 3 out of 5 of the following? a. Psoriasis (1 point for personal or family history, 2 points for current) b. Psoriatic nail dystrophy c. Negative test result for RF d. Dactylitis (current or history) e. Radiological evidence of juxta-articular new bone formation	Continue to #3.	Do not approve.
3.	Has the member failed or have	Continue to #4.	Do not approve.

	contraindications to conventional management with all of the following? a. NSAIDs, and b. Methotrexate or other DMARD such as leflunomide, sulfasalazine, or cyclosporine.		
4.	Has the member tried and failed infliximab AND adalimumab (or have contraindications to both)? - Infliximab not required for members under 21	Continue to #5.	Do not approve.
5.	Is the request for Yesintek or Starjemza?	Continue to #11.	Continue to #6.
6.	Has the member tried and failed (or have contraindications to) Yesintek or Starjemza?	Continue to #7.	Do not approve.
7.	Is the request for Skyrizi?	Continue to #8.	Continue to #9.
8.	Has the member tried and failed the following: a. Cosentyx, Taltz, or Tremfya, AND b. Xeljanz or Rinvoq	Continue to #11.	Do not approve.
9.	Is the request for Cosentyx?	Continue to #10.	Continue to #11.
10.	Has the provider requested a loading dose? (induction dosing 150 mg at weeks 0, 1, 2, 3, and 4.)	Do not approve.	Continue to #11.
11.	Is the dose within plan quantity limits and appropriate for age and weight?	Continue to #12.	Do not approve.
12.	Approve for 6 months.		
Renewal Criteria		If yes	If no
1.	Has the member experienced 20% or greater improvement in tender joint count and swollen joint count?	Continue to #2.	Do not approve.
2.	Approve for 12 months.		

Ulcerative Colitis		
Initial Criteria	If yes	If no

1.	Is the member transitioning to the requested treatment from a different biologic product (i.e. previously approved for a biologic through CareOregon or already on biologic therapy and newly established with CareOregon)?	Continue to #3.	Continue to #2.
2.	Does the member have a diagnosis of moderate to severe ulcerative colitis defined by the following criteria? a. Moderate = greater than or equal to 4 stools daily. b. Severe = greater than or equal to 6 bloody stools daily and evidence of toxicity such as fever, anemia, elevated ESR, or tachycardia.	Continue to #3.	Do not approve.
3.	Has the member tried and failed or have a contraindication to ALL of the following? a. Infliximab (not required for members under 21 years old), AND b. Adalimumab	Continue to #4.	Do not approve.
4.	Is the request for Yesintek or Starjemza?	Continue to #8.	Continue to #5.
5.	Has the member tried and failed (or have contraindications to) Yesintek or Starjemza?	Continue to #6.	Do not approve.
6.	Is the request for Skyrizi?	Continue to #7.	Continue to #8.
7.	Has the member tried and failed Entyvio or a JAK inhibitor (Xeljanz or Rinvoq), or have contraindications to Entyvio and JAK inhibitors?	Continue to #8.	Do not approve.
8.	Approve for 6 months.		
Renewal Criteria		If yes	If no
1.	Has the member demonstrated a significant response including the following? a. Decrease in bloody stools per day and/or b. Elimination of signs of toxicity	Continue to #2.	Do not approve.
2.	Approve for 12 months.		