UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 1245-9
Program	Prior Authorization/Notification
Medication	Ilumya™ (tildrakizumab-asmn)* *Ilumya is excluded from coverage for the majority of our benefits
P&T Approval Date	5/2018, 2/2019, 2/2020, 2/2021, 2/2022, 2/2023, 7/2023, 10/2024, 10/2025
Effective Date	12/1/2025

1. Background:

Ilumya (tildrakizumab-asmn) is an interleukin-23 antagonist indicated for the treatment of adults with moderate to severe plaque psoriasis who are candidates for systemic therapy or phototherapy.

2. Coverage Criteria[a]:

A. Plaque Psoriasis

1. **Initial Authorization**

a. Ilumya will be approved based on **both** of the following criteria:

(1) Diagnosis of moderate to severe plaque psoriasis

-AND-

(2) Patient is not receiving Ilumya in combination with another systemic targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

Authorization will be issued for 12 months.

2. **Reauthorization**

a. Ilumya will be approved based on **both** of the following criteria:

(1) Documentation of positive clinical response to Ilumya therapy

-AND-

(2) Patient is not receiving Ilumya in combination with another systemic targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia

(certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- *Ilumya is excluded from coverage for the majority of our benefits
- Supply limits, Step Therapy, and/or Medical Necessity may be in place.

4. Reference:

1. Ilumya [package insert]. Cranbury, NJ: Sun Pharmaceutical Industries, Inc.; April 2024.

Program	Prior Authorization/Notification - Ilumya (tildrakizumab)
Change Control	
5/2018	New program
2/2019	Annual review with no change to clinical criteria.
2/2020	Annual review. Added coverage exclusion statement.
2/2021	Annual review. Updated reauthorization duration.
2/2022	Annual review with no changes to coverage criteria. Updated reference.
2/2023	Annual review. Updated listed examples from Humira to adalimumab and added Rinvoq. Added state mandate footnote.
7/2023	Updated not receiving in combination language to targeted immunomodulator and updated examples.
10/2024	Annual review with no changes to coverage criteria. Updated reference.
10/2025	Annual review with no changes to coverage criteria. Added “systemic” to clarify examples with no change to clinical intent. Updated reference.