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Last P&T Approval/Version: 10/29/2025  
Next Review Due By: 10/2026  
Policy Number: C17334-A

## Siliq (brodalumab)

### PRODUCTS AFFECTED

Siliq (brodalumab)

### COVERAGE POLICY

*Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Coverage Guideline must be read in its entirety to determine coverage eligibility, if any. This Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide Molina Healthcare complete medical rationale when requesting any exceptions to these guidelines.*

#### **Documentation Requirements:**

*Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.*

#### **DIAGNOSIS:**

Moderate to severe plaque psoriasis

#### **REQUIRED MEDICAL INFORMATION:**

This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. If a drug within this policy receives an updated FDA label within the last 180 days, medical necessity for the member will be reviewed using the updated FDA label information along with state and federal requirements, benefit being administered and formulary preferencing. Coverage will be determined on a case-by-case basis until the criteria can be updated through Molina Healthcare, Inc. clinical governance. Additional information may be required on a case-by-case basis to allow for adequate review. When the requested drug product for coverage is dosed by weight, body surface area or other member specific measurement, this data element is required as part of the medical necessity review. The Pharmacy and Therapeutics Committee has determined that the drug benefit shall be a mandatory generic and that generic drugs will be dispensed whenever available.

#### **A. FOR ALL INDICATIONS:**

1. Prescriber attests member does not have an active or latent untreated infection (e.g., Hepatitis B, tuberculosis, etc.), including clinically important localized infections, according to the FDA label  
AND

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2. Member is not on concurrent treatment or will not be used in combination with TNF- inhibitor, biologic response modifier or other biologic DMARDs, Janus kinase Inhibitors, or Phosphodiesterase 4 inhibitor (i.e., apremilast, tofacitinib, baricitinib) as verified by prescriber attestation, member medication fill history, or submitted documentation  
AND
3. Prescriber attests to (or the clinical reviewer has found that) the member not having any FDA labeled contraindications that haven't been addressed by the prescriber within the documentation submitted for review [Contraindications to Siliq (brodalumab) include: Crohn's disease, clinically significant hypersensitivity to brodalumab or to any of the excipients in Siliq or component of the container, avoid concurrent use of live vaccines]  
AND
4. IF THIS IS A NON-FORMULARY/NON-PREFERRED PRODUCT: Documentation of trial/failure of or serious side effects to a majority (not more than 3) of the preferred formulary/PDL alternatives for the given diagnosis. Submit documentation including medication(s) tried, dates of trial(s) and reason for treatment failure(s).

MOLINA REVIEWER NOTE: For Illinois Marketplace, please see Appendix.

### B. CHRONIC PLAQUE PSORIASIS:

1. Documented diagnosis of moderate to severe psoriasis (BSA  $\geq$  3%) OR < 3% body surface area with plaque psoriasis that involves sensitive areas of the body or areas that would significantly impact daily function (e.g., face, neck, hands, feet, genitals)  
AND
2. (a) Documentation of treatment failure or serious side effects to TWO of the following systemic therapies for  $\geq$  3 months: Methotrexate (oral or IM at a minimum dose of 15 mg/week), cyclosporine, acitretin, azathioprine, hydroxyurea, leflunomide, mycophenolate mofetil, or tacrolimus  
OR  
(b) Documentation of treatment failure to Phototherapy for  $\geq$  3 months with either psoralens with ultraviolet A (PUVA) or ultraviolet B (UVB) radiation. Provider to submit documentation of duration of treatment, dates of treatment, or number of sessions.  
OR  
(c) Documentation of contraindication to systemic therapy and phototherapy  
NOTE: Contraindications to phototherapy include type 1 or type 2 skin, history of photosensitivity, treatment of facial lesions, presence of premalignant lesions, history of melanoma or squamous cell carcinoma, or physical inability to stand for the required exposure time.  
AND
3. Documentation of prescriber baseline disease activity evaluation and goals for treatment to be used to evaluate efficacy of therapy at renewal [DOCUMENTATION REQUIRED]  
AND
4. Prescriber attests the member will be evaluated for adequate treatment response after 12-16 weeks per the FDA label for potential treatment discontinuation  
NOTE: *Continued treatment beyond 16 weeks in patients who have not achieved an adequate response is not likely to result in greater success.*

## CONTINUATION OF THERAPY:

### A. CHRONIC PLAQUE PSORIASIS:

1. Adherence to therapy at least 85% of the time as verified by the prescriber or member's medication fill history OR adherence less than 85% of the time due to the need for surgery or treatment of an infection, causing temporary discontinuation  
AND
2. Prescriber attests to or clinical reviewer has found no evidence of intolerable adverse effects or drug toxicity, including new or worsening psychiatric symptoms  
AND
3. Documentation of positive clinical response as demonstrated by low disease activity and/or improvements in the condition's signs and symptoms. [DOCUMENTATION REQUIRED]  
AND

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4. Prescriber attests to ongoing monitoring for development of infection (e.g., tuberculosis, Hepatitis B reactivation, etc.) according to the FDA label

### DURATION OF APPROVAL:

Initial authorization: 6 months, Continuation of therapy: 12 months

### PRESCRIBER REQUIREMENTS:

Prescribed by or in consultation with a board-certified dermatologist [If prescribed in consultation, consultation notes must be submitted with initial request and reauthorization requests]

### AGE RESTRICTIONS:

18 years of age and older

### QUANTITY:

210 mg by subcutaneous injection at Weeks 0,1, and 2 followed by 210mg every 2 weeks

### PLACE OF ADMINISTRATION:

The recommendation is that injectable medications in this policy will be for pharmacy benefit coverage and patient self-administered.

## DRUG INFORMATION

### ROUTE OF ADMINISTRATION:

Subcutaneous injection

### DRUG CLASS:

Antipsoriatics - Systemic

### FDA-APPROVED USES:

Indicated for the treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy or phototherapy and have failed to respond or have lost response to other systemic therapies.

### COMPENDIAL APPROVED OFF-LABELED USES:

None

## APPENDIX

### APPENDIX:

**Reserved for State specific information.** Information includes, but is not limited to, State contract language, Medicaid criteria and other mandated criteria.

### State Specific Information

#### State Marketplace

##### Illinois (Source: [Illinois General Assembly](#))

"(215 ILCS 134/45.1) Sec. 45.1. Medical exceptions procedures required. (c) An off-formulary exception request shall not be denied if: (1) the formulary prescription drug is contraindicated; (2) the patient has tried the formulary prescription drug while under the patient's current or previous health insurance or health benefit plan and the prescribing provider submits evidence of failure or intolerance; or (3) the patient is stable on a prescription drug selected by his or her health care provider for the medical condition under consideration while on a current or previous health insurance or health benefit plan. (d) Upon the granting of an exception request, the insurer, health plan, utilization review organization, or other entity shall authorize the coverage for the drug prescribed by the enrollee's treating health care provider, to the extent the prescribed drug is a covered drug under the policy

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or contract up to the quantity covered. (e) Any approval of a medical exception request made pursuant to this Section shall be honored for 12 months following the date of the approval or until renewal of the plan."

## BACKGROUND AND OTHER CONSIDERATIONS

### BACKGROUND:

Siliq a human monoclonal immunoglobulin G (IgG)2 antibody which selectively binds to interleukin (IL)-17RA and inhibits its interaction with cytokines IL-17A, IL-17-F, IL-17C, IL-17A/F heterodimer, and IL-25.1 Blocking IL-17RA inhibits IL-17 cytokine-induced responses, including the release of proinflammatory cytokines and chemokines. Siliq is indicated for treatment of adults with moderate- to severe plaque psoriasis who are candidates for systemic therapy or phototherapy and have failed to respond or have lost response to other systemic therapies. In plaque psoriasis, the recommended dose is 210 mg subcutaneously (SC) at Week 0, 1, and 2 followed by 210 mg once every 2 weeks (Q2W). Consider discontinuing if an adequate response has not been achieved after 12 to 16 weeks; continued treatment is unlikely to result in greater success. Siliq is intended for use under the guidance and supervision of a physician. Those trained in SC injection technique may self-inject when deemed appropriate.

### REMS Program

Siliq is available only through a restricted program under a REMS called the Siliq REMS Program because of the observed suicidal ideation and behavior in subjects treated with Siliq.

Notable requirements of the Siliq REMS Program include the following:

- Prescribers must be certified with the program.
- Patients must sign a Patient-Prescriber Agreement Form.
- Pharmacies must be certified with the program and must only dispense to patients who are authorized to receive Siliq.

Further information, including a list of qualified pharmacies, is available at [www.SILIQREMS.com](http://www.SILIQREMS.com) or by calling the Siliq REMS Program Call Center at 855-511-6135.

### Continuation of REMS

"The Hospital Anxiety and Depression Scale (HADS) is a 14-item questionnaire to assess patients on seven items reflecting anxiety and seven reflecting depression. A scaled score is given and HADS severity groups are categorized as normal, mild, moderate, and severe."<sup>2</sup> Clinical assessment of these scores, as well as other relevant information deemed appropriate by REMS certified physician or psychiatrist, should be interpreted to determine if Member is eligible to continue with treatment.

### CONTRAINDICATIONS/EXCLUSIONS/DISCONTINUATION:

All other uses of Siliq (brodalumab) are considered experimental/investigational and therefore, will follow Molina's Off- Label policy. Contraindications to Siliq (brodalumab) include: Crohn's disease, clinically significant hypersensitivity to brodalumab or to any of the excipients in Siliq or component of the container, avoid concurrent use of live vaccines.

### CONDITIONS NOT RECOMMENDED FOR APPROVAL:

Siliq has not been shown to be effective, or there are limited or preliminary data or potential safety concerns that are not supportive of general approval for the following conditions.

- Concurrent Use with other Biologics or with Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs).* Siliq should not be administered in combination with another biologic or with a targeted synthetic DMARD used for an inflammatory condition. Combination therapy is generally not recommended due to a potential for a higher rate of adverse effects with combinations and lack of evidence for additive efficacy.<sup>6-7</sup> Note: This does NOT exclude the use of conventional synthetic DMARDs (e.g., MTX, leflunomide, hydroxychloroquine, and sulfasalazine) in combination with Actemra IV.
- Crohn's Disease.* Siliq is contraindicated in patients with Crohn's disease. There is a published Phase II study evaluating Siliq in Crohn's disease (n = 130) that was terminated early due to a disproportionate number of worsening Crohn's disease and lack of efficacy.

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(c) *Rheumatoid Arthritis.* Efficacy has not been established. A published Phase II study (n = 252) did not demonstrate improvement in American College of Rheumatology (ACR) 20/50/70 responses with Siliq vs. placebo for treatment of rheumatoid arthritis in patients who had previously failed methotrexate

## OTHER SPECIAL CONSIDERATIONS:

Siliq has a Black Boxed Warning, Risk Evaluation and Mitigation Strategy (REMS) program, and limited distribution program due to risks of suicidal ideation and behavior. The REMS program requires prescribers and pharmacies to be certified. Patients must sign a patient-prescriber agreement form and be aware of the need to seek medical attention for any new/worsening suicidal thoughts or behavior, depression, anxiety, or mood changes.

## CODING/BILLING INFORMATION

**CODING DISCLAIMER.** Codes listed in this policy are for reference purposes only and may not be all-inclusive or applicable for every state or line of business. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry-standard coding practices for all submissions. Molina has the right to reject/deny the claim and recover claim payment(s) if it is determined it is not billed appropriately or not a covered benefit. Molina reserves the right to revise this policy as needed.

HCPCS CODE	DESCRIPTION
N/A	

## AVAILABLE DOSAGE FORMS:

Siliq SOSY 210MG/1.5ML

## REFERENCES

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4. Hsu S, Papp KA, Lebwohl MG, et al. Consensus guidelines for the management of plaque psoriasis. Arch Dermatol. 2012;148(1):95-102.
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SUMMARY OF REVIEW/REVISIONS	DATE
REVISION- Notable revisions: Required Medical Information Appendix	Q4 2025
REVISION- Notable revisions: Coding/Billing Information Template Update Required Medical Information Continuation of Therapy Contraindications/Exclusions/Discontinuation	Q4 2024
REVISION- Notable revisions: Required Medical Information Continuation of Therapy Prescriber Requirements Drug Class Appendix Background Available Dosage Forms	Q4 2023
REVISION- Notable revisions: Required Medical Information Continuation of Therapy Prescriber Requirements Age Restrictions Appendix Contraindications/Exclusions/Discontinuation Other Special Considerations References	Q4 2022
Q2 2022 Established tracking in new format	Historical changes on file