YouthCare
HealthChoice Illinois

Clinical Policy: Ustekinumab (Stelara), Ustekinumab-aekn (Selarsdi), Ustekinumab-auub (Wezlana)

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Coding Implications
Revision Log

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

Description

Ustekinumab (Stelara®), ustekinumab-aekn (Selarsdi™), and ustekinumab-auub (Wezlana™) are a human interleukin-12 (IL-12) and -23 (IL-23) antagonist.

FDA Approved Indication(s)

Stelara, Selarsdi, and Wezlana indicated for the treatment of:

- Patients 6 years or older with moderate-to-severe plaque psoriasis (PsO) who are candidates for phototherapy or systemic therapy
- Patients 6 years or older with active psoriatic arthritis (PsA)

Stelara and Wezlana are also indicated for the treatment of:

- Adult patients with moderately to severely active Crohn's disease (CD)
- Adult patients with moderately to severely active ulcerative colitis (UC)

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Stelara Selarsdi, and Wezlana are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Plaque Psoriasis (must meet all)**:**

1. Diagnosis of moderate-to-severe PsO as evidenced by involvement of one of the following (a or b):
   a. ≥ 3% of total body surface area;
   b. Hands, feet, scalp, face, or genital area;
2. Request is for SC formulation;
3. Prescribed by or in consultation with a dermatologist or rheumatologist;
4. Age ≥ 6 years ;
5. Member meets one of the following (a,b or c):
   a. Failure of a ≥ 3 consecutive month trial of methotrexate (MTX) at up to maximally indicated doses unless contraindicated or clinically significant adverse effects are experienced;

b. If intolerance or contraindication to MTX (*see Appendix D*), failure of a ≥ 3 consecutive month trial of cyclosporine at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
c. Member has intolerance or contraindication to MTX and cyclosporine, and failure of phototherapy, unless contraindicated or clinically significant adverse effects are experienced

6. Member meets one of the following (a or b):
   a. Adults ≥18 years old: Failure of TWO of the following, each used for ≥ 3 consecutive months, unless contraindicated or clinically significant adverse effects are experienced: Cimzia®, Enbrel®, Humira®;
   b. Pediatrics ≤ 17 years old: Failure of Enbrel®, used for ≥ 3 consecutive months, unless contraindicated or clinically significant adverse effects are experienced;

   **Prior authorization is required for Enbrel, Humira, Cimzia*
7. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
8. Request meets one of the following (a or b):
   a. Dose does not exceed one of the following (*see Appendix G for dose rounding guidelines*) (i or ii):

   i. Adult: weight-based dosing initially and 4 weeks later, followed by maintenance dose every 12 weeks (i or ii);
      1. Weight ≤ 100 kg: 45 mg per dose;
      2. Weight > 100 kg: 90 mg per dose;

   ii. Pediatrics: weight-based dosing initially and 4 weeks later, followed by maintenance dose every 12 weeks (i, ii, or iii);
      1. Weight < 60 kg: 0.75 mg/kg per dose;
      2. Weight 60 kg to 100 kg: 45 mg per dose;
      3. Weight > 100 kg: 90 mg per dose.

   b. If request is for a dose that exceeds 90 mg every 12 weeks, all of the following (i, ii, and iii):
      i. Documentation supports inadequate response to a ≥ 3 month trial of the maximum dose indicated in Section V;
      ii. Member meets ONE of the following, unless contraindicated or clinically significant adverse effects are experienced (1 or 2):
         1) Adult:
            1. One of the following (i, ii, or iii, *see Appendix D*):
               i. Failure of both of the following, each used for ≥ 3 consecutive months: Enbrel® and infliximab;
               ii. If member has had a history of failure of one TNF blocker, then failure of one of the following TNF blockers used for for ≥ 3 consecutive months: Enbrel or infliximab;
               iii. History of failure of two TNF blockers;
         2) Pediatric: Failure of Enbrel used for ≥ 3 consecutive months, unless the member has had a history of failure of two TNF blockers;

iii. Dose not exceed 90 mg every 8 weeks.

Approval duration: 6 months

B. Psoriatic Arthritis (must meet all)**:**

1. Diagnosis of PsA;
2. For Stelara and Wezlana: Request is for SC formulation;
   ;
3. Prescribed by or in consultation with a dermatologist or rheumatologist;
4. Age ≥ 6 years;
5. If member is ≥ 18 years, failure of at least TWO of the following, each used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated (a, b, and c *See Appendix D*):
   a. : Enbrel®, Humira® (unless the member has had a history of failure of two TNF blockers)
   b. Cimzia®,
   c. *If member has not responded or is intolerant to one or more TNF blockers,* Xeljanz®/Xeljanz XR®, unless member has cardiovascular risk and benefits do not outweigh the risk of treatment;

   **Prior authorization is required for Enbrel, Humira, Cimzia, and Xeljanz/Xeljanz XR*
6. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);

7. Request meets one of the following (a or b):
   a. Dose does not exceed one of the following (i or ii):
      i. Adult: weight-based dosing initially and 4 weeks later, followed by maintenance dose every 12 weeks (1 or 2):
         1. 45 mg per dose;
         2. Co-existent PsO and weight > 100 kg: 90 mg per dose;
      ii. Pediatric: weight-based dosing initially and 4 weeks later, followed by maintenance dose every 12 weeks (1, 2, or 3):
         1. Stelara and Wezlana only: Weight < 60 kg: 0.75 mg/kg per dose;
         2. Weight ≥ 60 kg: 45 mg per dose;
         3. Co-existent PsO and weight > 100 kg: 90 mg per dose;
   b. If request is for a dose that exceeds 45 mg every 12 weeks, all of the following (i, ii, and iii):
      i. Documentation supports inadequate response to a ≥ 3 month trial of the maximum dose indicated in Section V;
      ii. Member is ≥ 18 years and meets one of the following, unless contraindicated or clinically significant adverse effects are experienced (1 or 2, *see Appendix D*):
         a. Failure of infliximab (*Avsola, Inflectra, and Renflexis are preferred*), used for ≥ 3 consecutive months;
         b. History of failure of two TNF blockers;
      iii. Dose does not exceed 90 mg every 12 weeks.

Approval duration: 6 months

C. Crohn's Disease (must meet all)**:**
1. Diagnosis of CD;
2. Request is for Stelara or Wezlana;
3. Prescribed by or in consultation with a gastroenterologist;
4. Age ≥ 18 years;
5. 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], MTX) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
   b. Medical justification supports inability to use immunomodulators (*see Appendix E*);
6. Failure of a ≥ 3 consecutive month trial of certolizumab (*Cimzia is preferred*) AND adalimumab *(Humira is preferred)* unless prior history of failure of two TNF blockers, contraindicated or clinically significant adverse effects are experienced;
   **Prior authorization is required for adalimumab and certolizumab*
7. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
8. Request meets one of the following (a or b):
   a. Dose does not exceed maximum dose indicated in Section V (i and ii):
      i. Initial dose (IV):
         1) Weight ≤ 55 kg: 260 mg once;
         2) Weight > 55 kg to 85 kg: 390 mg once;
         3) Weight > 85 kg: 520 mg once;
      ii. Maintenance dose (SC): 90 mg 8 weeks after the initial IV dose, followed by maintenance dose of 90 mg every 8 weeks;
   b. If request is for a dose that exceeds 90 mg every 8 weeks, all of the following (i, and ii):
      i. Documentation supports inadequate response to a ≥ 3 month trial of the maximum dose indicated in Section V;
      ii. Dose not exceed 90 mg every 4 or 6 weeks.

Approval duration: 6 months

D. Ulcerative Colitis (must meet all)**:**
1. Diagnosis of UC;
2. Request is for Stelara or Wezlana;
3. Prescribed by or in consultation with a gastroenterologist;
4. Age ≥ 18 years;
5. Documentation of a Mayo Score ≥ 6 (*see Appendix F*);
6. Failure of an 8-week trial of systemic corticosteroids, unless contraindicated or clinically significant adverse effects are experienced;
7. Failure of a ≥ 3 consecutive month trial of adalimumab unless history of failure of two TNF blockers (*Humira is preferred*) and tofacitinib (*Xeljanz/Xeljanz XR is preferred*), unless contraindicated or clinically significant adverse effects are experienced;
   **Prior authorization is required for adalimumab and tofacitinib*

8. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
9. Request meets one of the following (a or b):
    a. Dose does not exceed maximum dose indicated in Section V:
        i. Initial dose (IV):
            1) Weight ≤ 55 kg: 260 mg once;
            2) Weight > 55 kg to 85 kg: 390 mg once;
            3) Weight > 85 kg: 520 mg once;
        ii. Maintenance dose (SC): 90 mg 8 weeks after the initial IV dose, followed by maintenance dose of 90 mg every 8 weeks;
    b. If request is for a dose that exceeds 90 mg every 8 weeks, all of the following (a, b, and c):
        a. Documentation supports inadequate response to a ≥ 3 month trial of the maximum dose indicated in Section V;
        b. Failure of a trial of ≥ 3 consecutive months of infliximab unless member has a prior history of two TNF blockers and Xeljanz/Xeljanz XR, unless contraindicated or clinically significant adverse effects are experienced;
        c. Dose does not exceed 90 mg every 4 or 6 weeks.

Approval duration: 6 months

E. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
    a. For drugs on the PDL, the no coverage criteria policy: CP.PMN.255; or
    b. For drugs NOT on the PDL (Medicaid), refer to the non-formulary policy: CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy: CP.PMN.53.

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**

1. Member meets one of the following (a or b):
    a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
    b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy;
3. For Stelara and Wezlana: Request is for SC formulation;
4. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
5. Member meets one of the following (a or b):

a. If request is for a dose increase, new dose does not exceed one of the following (i, ii, or iii):
    a. PsO alone (*see Appendix G for dose rounding guidelines*) (1 or 2):
        i. Adults (a or b):
            a) Weight ≤ 100 kg: 45 mg every 12 weeks;
            b) Weight > 100 kg: 90 mg every 12 weeks;
        ii. Pediatrics (a, b, or c):
            a) Stelara and Wezlana only: Weight < 60 kg: 0.75 mg/kg every 12 weeks;
            b) Weight 60 kg to 100 kg: 45 mg every 12 weeks;
            c) Weight > 100 kg: 90 mg every 12 weeks;
    b. PsA (1 or 2):
        i. Adults (a or b):
            a) 45 mg every 12 weeks;
            b) Co-existent PsO and weight > 100 kg: 90 mg every 12 weeks;
        ii. Pediatrics (a, b, or c):
            a) Stelara and Wezlana only: Weight < 60 kg: 0.75 mg/kg every 12 weeks;
            b) Weight ≥ 60 kg: 45 mg every 12 weeks;
            c) Co-existent PsO and weight > 100 kg: 90 mg every 12 weeks;
        iii. CD, UC: 90 mg every 8 weeks;
b. If request is for a dose increase and new maintenance dose exceeds the maximum dose and frequency indicated in Section V, all of the following (i, ii, and iii):
    i. Documentation supports inadequate response to a ≥ 3 month trial of the maximum dose indicated in Section V;
    ii. One of the following (1, 2, 3 or 4):
        1) CD: Failure of a trial of ≥ 3 consecutive months of Humira and infliximab unless prior history of failure of two TNF blockers, contraindicated or clinically significant adverse effects are experienced;
        2) UC: Failure of ALL of the following, each used for ≥ 3 consecutive months, unless prior history of failure of two TNF blockers, clinically significant adverse effects are experienced or both are contraindicated: Humira, Xeljanz/Xeljanz XR, infliximab;
        3) For PsO: Failure of ALL of the following, each used for ≥ 3 consecutive months, unless history of failure of two TNF blockers, clinically significant adverse effects are experienced or both are contraindicated (a or b):
            a. Adult: Enbrel and infliximab;
            b. Pediatric: Enbrel;
        4) For PsA: If member is ≥ 18 years, failure of ALL of the following, each used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated: Enbrel, Otezla, Taltz, Xeljanz/Xeljanz XR,;
    iii. New dose does not exceed one of the following (1, 2, or 3):
        a) CD, UC: 90 mg every 4 or 6 weeks;
        b) PsO: 90 mg every 8 weeks;

c) PsA: 90 mg every 12 weeks.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary PDL (Medicaid), refer to the no coverage criteria policy: CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the PDL,refer to the non-formulary policy: CP.PMN.; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy: CP.PMN.53 for Medicaid.

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 – CP.PMN.53 for Medicaid or evidence of coverage documents.

B. Combination use with 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, Remicade® and its biosimilars (Avsola™, Inflectra™, Renflexis™, Zymfentra®), Simponi®], interleukin agents [e.g., Actemra® (IL-6RA), Arcalyst® (IL-1 blocker), Bimzelx® (IL-17A and F antagonist), Cosentyx® (IL-17A inhibitor), Ilaris® (IL-1 blocker), Ilumya™ (IL-23 inhibitor), Kevzara® (IL-6RA), Kineret® (IL-1RA), Omvoh™ (IL-23 antagonist), Siliq™ (IL-17RA), Skyrizi™ (IL-23 inhibitor), Stelara® (IL-12/23 inhibitor), Taltz® (IL-17A inhibitor), Tofidence™ (IL-6), Tremfya® (IL-23 inhibitor), Wezlana™ (IL-12/23 inhibitor)], Janus kinase inhibitors (JAKi) [e.g., Cibinqo™, Olumiant™, Rinvoq™, Xeljanz®/Xeljanz® XR,], anti-CD20 monoclonal antibodies [Rituxan® and its biosimilars (Riabni™, Ruxience™, Truxima®), Rituxan Hycela®], selective co-stimulation modulators [Orencia®], integrin receptor antagonists [Entyvio®], tyrosine kinase 2 inhibitors [Sotyktu™], and sphingosine 1-phosphate receptor modulator [Velsipity™] 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

6-MP: 6-mercaptopurine
CD: Crohn's disease
FDA: Food and Drug Administration
GI: gastrointestinal
IL-12: interleukin-12
IL-23: interleukin-23
JAKi: Janus kinase inhibitors
MTX: methotrexate
PsO: plaque psoriasis
PsA: psoriatic arthritis
TNF: tumor necrosis factor
UC: ulcerative colitis

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 – 2.5 mg/kg/day PO	2.5 mg/kg/day
corticosteroids	**CD*** 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 **UC** *Adult:* Prednisone 40 mg – 60 mg PO QD, then taper dose by 5 to 10 mg/week Budesonide (Uceris®) 9 mg PO QAM for up to 8 weeks	Various
cyclosporine (Sandimmune®, Neoral®)	**PsO** 2.5 – 4 mg/kg/day PO divided BID	4 mg/kg/day
6-mercaptopurine (Purixan®)	**CD** 50 mg PO QD or 1 – 2 mg/kg/day PO	2 mg/kg/day
methotrexate (Trexall®, Otrexup™, Rasuvo®, RediTrex®, Jylamvo®) Rheumatrex®)	**CD*** 15 – 25 mg/week IM or SC **PsO** 10 to 25 mg/week IM, SC or PO or 2.5 mg PO Q12 hr for 3 doses/week	30 mg/week
Pentasa® (mesalamine)	**CD** 1,000 mg PO QID	4 g/day
Enbrel® (etanercept)	**PsA** 25 mg SC twice weekly or 50 mg SC once weekly	50 mg/week

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Humira® , Amjevita™ (adalimumab); Hadlima (adalimumab-bwwd), Yusimry (adalimumab-aqvh), adalimumab-adaz (Hyrimoz®), adalimumab-fkjp (Hulio®), adalimumab-adbm (Cyltezo®)	**CD, UC** Initial dose: 160 mg SC on Day 1, then 80 mg SC on Day 15 Maintenance dose: 40 mg SC every other week starting on Day 29 **PsA** 40 mg SC every other week **PsO** Initial dose: 80 mg SC Maintenance dose: 40 mg SC every other week starting one week after initial dose	40 mg every other week
Xeljanz® (tofacitinib)	**PsA, UC** 5 mg PO BID	10 mg/day
Xeljanz XR® (tofacitinib extended-release)	**PsA, UC** 11 mg PO QD	11 mg/day
Cimzia® (certolizumab)	**CD** Initial dose: 400 mg SC at 0, 2, and 4 weeks Maintenance dose: 400 mg SC every 4 weeks **PsA** Initial dose: 400 mg SC at 0, 2, and 4 weeks Maintenance dose: 200 mg SC every other week (or 400 mg SC every 4 weeks) **PsO** 400 mg SC every other week. For some patients (with body weight ≤ 90 kg), a dose of 400 mg SC at 0, 2 and 4 weeks, followed by 200 mg SC every other week may be considered.	CD, PsA: 400 mg every 4 weeks PsO: 400 mg every other week

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

- Contraindication(s): clinically significant hypersensitivity to ustekinumab products or any of the excipients
- Boxed warning(s): none reported

Appendix D: General Information

- Definition of failure of MTX or 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.
- Examples of positive response to therapy may include, but are not limited to:
  - Reduction in joint pain/swelling/tenderness
  - Improvement in erythrocyte sedimentation rate/C-reactive protein (ESR/CRP) levels
  - Improvements in activities of daily living
- TNF blockers:
  - Etanercept (Enbrel®), adalimumab (Humira®), adalimumab-atto (Amjevita™), infliximab (Remicade®) and infliximab biosimilars (Avsola™, Renflexis™, Inflectra®), certolizumab pegol (Cimzia®), and golimumab (Simponi®, Simponi Aria®).

Appendix E: Immunomodulator Medical Justification

- The following may be considered for medical justification supporting inability to use an immunomodulator for Crohn's disease:
  - 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
  - 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

Appendix F: Mayo Score

- Mayo Score: evaluates ulcerative colitis stage, based on four parameters: stool frequency, rectal bleeding, endoscopic evaluation and Physician's global assessment. Each parameter of the score ranges from zero (normal or inactive disease) to 3 (severe activity) with an overall score of 12.

Score	Decoding
0 – 2	Remission
3 – 5	Mild activity
6 – 10	Moderate activity
>10	Severe activity

- The following may be considered for medical justification supporting inability to use an immunomodulator for ulcerative colitis:
  - Documentation of Mayo Score 6 – 12 indicative of moderate to severe ulcerative colitis.

Appendix G: Dose Rounding Guidelines for PsO

Weight-based Dose Range	Quantity Recommendation
Subcutaneous, Syringe	
≤ 46.99 mg	1 syringe of 45 mg/0.5 mL
47 to 94.49 mg	1 syringe of 90 mg/1 mL
94.5 to 141.49 mg	1 syringe of 45 mg/0.5 mL and 1 syringe of 90 mg/1 mL
Subcutaneous, Vial	
≤ 46.99 mg	1 vial of 45 mg/0.5 mL
47 to 94.49 mg	2 vials of 45 mg/0.5 mL

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Ustekinumab (Stelara), ustekinumab-auub (Wezlana)	CD, UC	Weight based dosing IV at initial dose, followed by 90 mg SC every 8 weeks Weight ≤ 55 kg: 260 mg Weight > 55 kg to 85 kg: 390 mg Weight > 85 kg: 520 mg	90 mg every 8 weeks
Ustekinumab (Stelara), Ustekinumab-aekn (Selarsdi), ustekinumab-auub (Wezlana)	PsO	Weight based dosing SC at weeks 0 and 4, followed by maintenance dose every 12 weeks *Adult:* Weight ≤ 100 kg: 45 mg Weight > 100 kg: 90 mg *Pediatrics (age 6 years to 17 years):* **Stelara, Wezlana:**	90 mg every 12 weeks

Drug Name	Indication	Dosing Regimen	Maximum Dose
		Weight < 60 kg: 0.75 mg/kg **Stelara, Selarsdi, Wezlana:** Weight 60 to 100 kg: 45 mg Weight > 100 kg: 90 mg	
	PsA	*Adult:* 45 mg SC at weeks 0 and 4, followed by 45 mg every 12 weeks *Pediatrics (age 6 years to 17 years):* Weight based dosing SC at weeks 0 and 4, then every 12 weeks thereafter. **Stelara, Wezlana:** Weight < 60 kg: 0.75 mg/kg **Stelara, Selarsdi, Wezlana:** Weight ≥ 60 kg: 45 mg	45 mg every 12 weeks
	PsA with co-existent PsO	Weight > 100 kg: 90 mg SC at weeks 0 and 4, followed by 90 mg every 12 weeks	90 mg every 12 weeks

VI. Product Availability

Drug Name	Availability
Ustekinumab (Stelara)	• Single-dose prefilled syringe for SC injection: 45 mg/0.5 mL, 90 mg/mL • Single-dose vial for SC injection: 45 mg/0.5 mL • Single-dose vial for IV infusion: 130 mg/26 mL
Ustekinumab-auub (Wezlana)	• Single-dose prefilled syringe for SC injection: 45 mg/0.5 mL, 90 mg/mL • Single-dose vial for SC injection: 45 mg/0.5 mL • Single-dose vial for IV infusion: 130 mg/26 mL

VII. References

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

HCPCS Codes	Description
J3357	Ustekinumab, for subcutaneous injection,1 mg
J3358	Ustekinumab, for intravenous injection, 1 mg
Q5137	Injection, ustekinumab-auub (wezlana), biosimilar, subcutaneous, 1 mg
Q5138	Injection, ustekinumab-auub (wezlana), biosimilar, intravenous, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New policy created, adapted from CP.PHAR.264 Ustekinumab (Stelara) policy.	11.21.19	
Criteria added for new FDA indication: ulcerative colitis; references reviewed and updated.	12.31.19	1.7.20
2Q 2021Review: Updated FDA approve indication; updated diagnosis and age requirement for plaque psoriasis; Added Mayo score, removed trial immunosuppresive, added 8 week trial of systemic corticosteroids to Ulcertative colitis; updated and reviewed references	6.14.21	
3Q2022 Review: Fixed the following typos: removed “for CD and UC” in continued therapy section for off-label dose requests, as preferred agents should be tried for all indications prior to off-label dose escalation; in continued therapy, off-label dose escalation requests, added “for age ≥ 18 years” as qualifiers of redirections to infliximab due to their lack of pediatric safety and efficacy data in PsO.	6.17.22	
RT4: for PsA, updated criteria and dosing per FDA approved pediatric extension. Template changes applied to other	9.27.22	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
diagnoses/indications and continued therapy section, references reviewed and updated		
2Q 2023 annual review: updated off-label dosing in Appendix B; for CD, PsO, PsA, and UC, added TNFi criteria to allow bypass if member has had history of failure of two TNF blockers; references reviewed and updated.	4.19.23	
2Q 2024 annual review: updated Appendix D with removal of PsA guideline and pediatric pharmacokinetic studies supplemental information; added Bimzelx, Zymfentra, Omvoh, Tofidence, Sotyktu, and Velsipity to section III.B; added newly approved biosimilar Wezlana to criteria; updated Appendix E and product availability; Clarified t/f criteria for Plaque Psoriasis; references reviewed and updated.	6.7.24	
RT4: added newly approved biosimilar Selarsdi to criteria. Added HCPCS codes [Q5137, Q5138], and updated initial criteria, product availability and dosing sections, accordingly, updated pediatric dosing in PSA initial criteria section, updated dosing in continuing criteria.	7.1.24	

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care 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.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a

discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy; HIM.PA.103.