

**Clinical Policy: Guselkumab (Tremfya)**

Reference Number: CP.PHAR.364

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Line of Business: Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

**Description**

Guselkumab (Tremfya<sup>®</sup>) is an interleukin-23 (IL-23) blocker.

**FDA Approved Indication(s)**

Tremfya is indicated for the treatment of:

- Adults and pediatric patients 6 years of age and older who also weigh at least 40 kg with moderate-to-severe plaque psoriasis (PsO) and who are candidates for systemic therapy or phototherapy
- Adults and pediatric patients 6 years of age and older who also weigh at least 40 kg with active psoriatic arthritis (PsA)
- Adults with moderately to severely active ulcerative colitis (UC)
- Adults with moderately to severely active Crohn's disease (CD)

**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<sup>®</sup> that Tremfya is **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.  $\geq 3\%$  of total body surface area;
  - b. Hands, feet, scalp, face, or genital area;
2. Prescribed by or in consultation with a dermatologist or rheumatologist;
3. Member meets one of the following (a or b):
  - a. Age  $\geq 18$  years;
  - b. Both of the following (i and ii):
    - i. Age  $\geq 6$  years;
    - ii. Body weight  $\geq 40$  kg;
4. Member meets one of the following, unless previously failed a biologic agent for PsO (a, b, or c):
  - a. Failure of a  $\geq 3$  consecutive month trial of methotrexate (MTX) at up to maximally indicated doses;

- b. Member has intolerance or contraindication to MTX (*see Appendix D*), and failure of a  $\geq 3$  consecutive month trial of cyclosporine or acitretin at up to maximally indicated doses, unless clinically significant adverse effects are experienced or both are contraindicated;
- c. Member has intolerance or contraindication to MTX, cyclosporine, and acitretin, and failure of phototherapy, unless contraindicated or clinically significant adverse effects are experienced;
5. If age  $\geq 18$  years, member meets ONE of the following, unless contraindicated or clinically significant adverse effects are experienced (a or b, *see Appendix D*):
  - a. Failure of a  $\geq 3$  consecutive month trial of one\* adalimumab product (e.g., *Hadlima*<sup>™</sup>, *Simlandi*<sup>®</sup>, *Yusimry*<sup>™</sup>, *adalimumab-aaty*, *adalimumab-adaz*, *adalimumab-adbm*, and *adalimumab-fkjp* are preferred);
  - b. History of failure of two TNF blockers;  
*\*Prior authorization may be required for adalimumab products*
6. Failure of a  $\geq 3$  consecutive month trial of Taltz<sup>®\*</sup>, unless contraindicated or clinically significant adverse effects are experienced;  
*\*Prior authorization may be required for Taltz*
7. Failure of a  $\geq 3$  consecutive month trial of one ustekinumab product (e.g., *Otulf*<sup>®</sup>, *Pyzchiva*<sup>®</sup> (branded), *Selarsdi*<sup>™</sup>, *Steqeyma*<sup>®</sup>, *Yesintek*<sup>™</sup> are preferred), unless clinically significant adverse effects are experienced or all are contraindicated;  
*\*Prior authorization may be required for ustekinumab products*
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. Dose does not exceed 100 mg at weeks 0 and 4, followed by maintenance dose of 100 mg every 8 weeks.

**Approval duration: 12 months**

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

1. Diagnosis of PsA;
2. Prescribed by or in consultation with a dermatologist or rheumatologist;
3. Member meets one of the following (a or b):
  - a. Age  $\geq 18$  years;
  - b. Both of the following (i and ii):
    - i. Age  $\geq 6$  years;
    - ii. Body weight  $\geq 40$  kg;
4. Failure of ALL\* of the following\*, each used for  $\geq 3$  consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated (a, b c, d, and e, *see Appendix D*):
  - a. One adalimumab product (e.g., *Hadlima*, *Simlandi*, *Yusimry*, *adalimumab-aaty*, *adalimumab-adaz*, *adalimumab-adbm*, and *adalimumab-fkjp* are preferred), unless the member has had a history of failure of two TNF blockers or member is less than 18 years old;
  - b. *Otezla*<sup>®</sup>/*Otezla XR*<sup>™</sup>;
  - c. Taltz, unless member is less than 18 years old;
  - d. One ustekinumab product (e.g., *Otulf*<sup>®</sup>, *Pyzchiva*<sup>®</sup> (branded), *Selarsdi*<sup>™</sup>, *Steqeyma*<sup>®</sup>, *Yesintek*<sup>™</sup> are preferred);

- e. If member has not responded or is intolerant to one or more TNF blockers, Xeljanz<sup>®</sup>/Xeljanz XR<sup>®</sup>, unless member has cardiovascular risk and benefits do not outweigh the risk of treatment or member is less than 18 years old;  
*\*Prior authorization may be required for adalimumab products, Otezla/Otezla XR, Taltz, ustekinumab products, and Xeljanz/Xeljanz XR*
5. 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*);
6. Dose does not exceed 100 mg at weeks 0 and 4, followed by maintenance dose of 100 mg every 8 weeks.

**Approval duration: 12 months**

**C. Ulcerative Colitis (must meet all):**

1. Diagnosis of UC;
2. Prescribed by or in consultation with a gastroenterologist;
3. Age  $\geq$  18 years;
4. Documentation of a Mayo Score  $\geq$  6, modified Mayo Score  $\geq$  5, or Mayo Endoscopic Score  $\geq$  2 (*see Appendix E*);
5. Failure of an 8-week trial of systemic corticosteroids, unless contraindicated, clinically significant adverse effects are experienced, or previously failed a biologic agent for UC;
6. Failure of one of the following, used for  $\geq$  3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated (a or b):
  - a. One adalimumab product (e.g., *Hadlima, Simlandi, Yusimry, adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, and adalimumab-fkjp are preferred*), unless the member has had a history of failure of two TNF blockers;
  - b. One ustekinumab product (e.g., *Otulft<sup>®</sup>, Pyszchiva<sup>®</sup> (branded), Selarsdi<sup>™</sup>, Steqeyma<sup>®</sup>, Yesintek<sup>™</sup> are preferred*);  
*\*Prior authorization may be required for adalimumab products and ustekinumab products*
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. Dose does not exceed both of the following (a and b):
  - a. Induction (i or ii):
    - i. IV: 200 mg at Weeks 0, 4, and 8;
    - ii. SC: 400 mg at Weeks 0, 4, and 8;
  - b. Maintenance (i or ii):
    - i. SC: 100 mg at Week 16 and every 8 weeks thereafter;
    - ii. SC: 200 mg at Week 12 and every 4 weeks thereafter.

**Approval duration: 12 months**

**D. Crohn's Disease (must meet all):**

1. Diagnosis of CD;
2. Prescribed by or in consultation with a gastroenterologist;
3. Age  $\geq$  18 years;

4. Member meets one of the following (a or b):
  - a. Failure of a  $\geq 3$  consecutive month trial of at least ONE immunomodulator (e.g., azathioprine, 6-mercaptopurine [6-MP], MTX) at up to maximally indicated doses, unless clinically significant adverse effects are experienced, all are contraindicated, or previously failed a biologic agent for CD;
  - b. Medical justification supports inability to use immunomodulators (*see Appendix F*);
5. Member meets of one\* of the following, unless clinically significant adverse effects are experienced or all are contraindicated (a or b, *see Appendix D*):
  - a. Failure of one adalimumab product (e.g., *Hadlima, Simlandi, Yusimry, adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, and adalimumab-fkjp are preferred*), used for  $\geq 3$  consecutive months;
  - b. History of failure of two TNF blockers;  
*\*Prior authorization may be required for adalimumab products*
6. Failure of a  $\geq 3$  consecutive month trial of one ustekinumab product (e.g., *Otufi<sup>®</sup>, Pyzchiva<sup>®</sup> (branded), Selarsdi<sup>™</sup>, Stegeyma<sup>®</sup>, Yesintek<sup>™</sup> are preferred*), unless clinically significant adverse effects are experienced or all are contraindicated;  
*\*Prior authorization may be required for ustekinumab products*
7. Member does not have combination use of biological disease-modifying antirheumatic drugs or JAK inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
8. Dose does not exceed both of the following (a and b):
  - a. Induction (i or ii):
    - i. IV: 200 mg at Weeks 0, 4, and 8;
    - ii. SC: 400 mg at Weeks 0, 4, and 8;
  - b. Maintenance (i or ii):
    - i. SC: 100 mg at Week 16 and every 8 weeks thereafter;
    - ii. SC: 200 mg at Week 12 and every 4 weeks thereafter.

**Approval duration: 12 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 formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
  - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: 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 for the relevant line of business: CP.PMN.53 for Medicaid.

## 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. 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*);
4. If request is for a dose increase, new dose does not exceed one of the following (a or b):
  - a. For PsO, PsA: 100 mg every 8 weeks;
  - b. For CD, UC: 200 mg every 4 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 (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
  - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: 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 for the relevant line of business: 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<sup>®</sup>, Enbrel<sup>®</sup>, Humira<sup>®</sup> and its biosimilars, Remicade<sup>®</sup> and its biosimilars, Simponi<sup>®</sup>], interleukin agents [e.g., Actemra<sup>®</sup> (IL-6RA) and its biosimilars, Arcalyst<sup>®</sup> (IL-1 blocker), Bimzelx<sup>®</sup> (IL-17A and F antagonist), Cosentyx<sup>®</sup> (IL-17A inhibitor), Ilaris<sup>®</sup> (IL-1 blocker), Ilumya<sup>™</sup> (IL-23 inhibitor), Kevzara<sup>®</sup> (IL-6RA), Kineret<sup>®</sup> (IL-1RA), Omvoh<sup>™</sup> (IL-23 antagonist), Siliq<sup>™</sup> (IL-17RA), Skyrizi<sup>™</sup> (IL-23 inhibitor), Spevigo<sup>®</sup> (IL-36 antagonist), Stelara<sup>®</sup> (IL-12/23 inhibitor) and its biosimilars, Taltz<sup>®</sup> (IL-17A inhibitor), Tremfya<sup>®</sup> (IL-23 inhibitor)], Janus kinase inhibitors (JAKi)

[e.g., Cibinqo<sup>™</sup>, Olumiant<sup>™</sup>, Rinvoq<sup>™</sup>, Xeljanz<sup>®</sup>/Xeljanz<sup>®</sup> XR,], anti-CD20 monoclonal antibodies [Rituxan<sup>®</sup> and its biosimilars], selective co-stimulation modulators [Orencia<sup>®</sup>], integrin receptor antagonists [Entyvio<sup>®</sup>], tyrosine kinase 2 inhibitors [Sotyktu<sup>™</sup>], and sphingosine 1-phosphate receptor modulator [Velsipity<sup>™</sup>] 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*

CD: Crohn's disease

FDA: Food and Drug Administration

IL-23: interleukin-23

JAKi: Janus kinase inhibitors

MTX: methotrexate

PsA: psoriatic arthritis

PsO: plaque psoriasis

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
acitretin (Soriatane <sup>®</sup> )	<b>PsO</b> 25 or 50 mg PO daily	50 mg/day
azathioprine (Azasan <sup>®</sup> , Imuran <sup>®</sup> )	<b>CD*</b> 1.5 – 2.5 mg/kg/day PO	2.5 mg/kg/day
corticosteroids	<b>UC</b> Prednisone 40 mg – 60 mg PO QD, then taper dose by 5 to 10 mg/week  Budesonide (Uceris <sup>®</sup> ) 9 mg PO QAM for up to 8 weeks	Various
cyclosporine (Sandimmune <sup>®</sup> , Neoral <sup>®</sup> )	<b>PsO</b> 2.5 – 4 mg/kg/day PO divided BID	4 mg/kg/day
6-mercaptopurine (Purixan <sup>®</sup> )	<b>CD*</b> 50 mg PO QD or 0.75 – 1.5 mg/kg/day	1.5 mg/kg/day
methotrexate (Trexall <sup>®</sup> , Otrexup <sup>™</sup> , Rasuvo <sup>®</sup> , RediTrex <sup>®</sup> , Rheumatrex <sup>®</sup> , Jylamvo <sup>®</sup> )	<b>CD*</b> 15 – 25 mg/week IM or SC  <b>PsO</b> 10 to 25 mg/week IM, SC or PO or 2.5 mg PO Q12 hr for 3 doses/week	30 mg/week
Hadlima (adalimumab- bwwd), Simlandi	<b>CD, UC</b> <u>Initial dose:</u> 160 mg SC on Day 1, then 80 mg SC on Day 15	40 mg every other week

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
(adalimumab-ryvk), Yusimry (adalimumab-aqvh), adalimumab-aaty (Yuflyma <sup>®</sup> ), adalimumab-adaz (Hyrimoz <sup>®</sup> ), adalimumab-fkjp (Hulio <sup>®</sup> ), adalimumab-adbm (Cyltezo <sup>®</sup> )	<p><u>Maintenance dose:</u> 40 mg SC every other week starting on Day 29</p> <p><b>PsA</b> 40 mg SC every other week</p> <p><b>PsO</b> <u>Initial dose:</u> 80 mg SC</p> <p><u>Maintenance dose:</u> 40 mg SC every other week starting one week after initial dose</p>	
Otezla <sup>®</sup> , Otezla XR <sup>™</sup> (apremilast)	<p><b>PsA</b> <u>Initial dose:</u> Otezla only: Day 1: 10 mg PO QAM Day 2: 10 mg PO QAM and 10 mg PO QPM Day 3: 10 mg PO QAM and 20 mg PO QPM Day 4: 20 mg PO QAM and 20 mg PO QPM Day 5: 20 mg PO QAM and 30 mg PO QPM</p> <p><u>Maintenance dose:</u> Day 6 and thereafter: • Otezla: 30 mg PO BID • Otezla XR: 75 mg PO QD</p> <p><b>Pediatric:</b> Otezla only: <i>Weight ≥ 50 kg:</i> <u>Initial dose:</u> Day 1: 10 mg PO QAM Day 2: 10 mg PO QAM and 10 mg PO QPM Day 3: 10 mg PO QAM and 20 mg PO QPM Day 4: 20 mg PO QAM and 20 mg PO QPM Day 5: 20 mg PO QAM and 30 mg PO QPM</p> <p><u>Maintenance dose:</u> Day 6 and thereafter: • Otezla: 30 mg PO BID • Otezla XR: 75 mg PO QD</p> <p><i>Weight 20 kg to &lt; 50 kg:</i> <u>Initial dose:</u> Day 1: 10 mg PO QAM</p>	<p>Adults:</p> <ul style="list-style-type: none"> <li>• Otezla: 60 mg/day</li> <li>• Otezla XR: 75 mg/day</li> </ul> <p>Pediatric: <i>Weight ≥ 50 kg:</i></p> <ul style="list-style-type: none"> <li>• Otezla: 60 mg/day</li> <li>• Otezla XR: 75 mg/day</li> </ul> <p><i>Weight 20 kg to &lt; 50 kg:</i> 40 mg/day</p>

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	<p>Day 2: 10 mg PO QAM and 10 mg PO QPM Day 3: 10 mg PO QAM and 20 mg PO QPM Day 4: 20 mg PO QAM and 20 mg PO QPM Day 5: 20 mg PO QAM and 20 mg PO QPM</p> <p><u>Maintenance dose:</u> Day 6 and thereafter, Otezla only: 20 mg PO BID</p>	
<p>Otulfi<sup>®</sup> (ustekinumab- aaaz), Pyzchiva<sup>®</sup> (ustekinumab- ttwe), Selarsdi<sup>™</sup> (ustekinumab- aekn), Steqeyma<sup>®</sup> (ustekinumab- stba), Yesintek<sup>™</sup> (ustekinumab- kfce)</p>	<p><b>CD, UC</b> <u>Weight based dosing IV at initial dose:</u> Weight ≤ 55 kg: 260 mg Weight &gt; 55 kg to 85 kg: 390 mg Weight &gt; 85 kg: 520 mg</p> <p><u>Maintenance dose:</u> 90 mg SC every 8 weeks</p> <p><b>PsO</b> Weight based dosing SC at weeks 0 and 4, followed by maintenance dose every 12 weeks</p> <p><i>Adult:</i> Weight ≤ 100 kg: 45 mg Weight &gt; 100 kg: 90 mg</p> <p><i>Pediatrics (age 6 years to 17 years):</i> <b>Otulfi, Pyzchiva, Yesintek:</b> Weight &lt; 60 kg: 0.75 mg/kg</p> <p><b>Otulfi, Pyzchiva, Selarsdi, Steqeyma, Yesintek:</b> Weight 60 to 100 kg: 45 mg Weight &gt; 100 kg: 90 mg</p> <p><b>PsA</b> Weight based dosing SC at weeks 0 and 4, followed by maintenance dose every 12 weeks</p> <p><i>Adult:</i> 45 mg SC at weeks 0 and 4, followed by 45 mg every 12 weeks</p> <p><i>Pediatrics (age 6 years to 17 years):</i> Weight based dosing SC at weeks 0 and 4, then every 12 weeks thereafter</p>	<p>CD, UC: 90 mg every 8 weeks</p> <p>PsO: 90 every 12 weeks</p> <p>PsA: 45 mg every 12 weeks</p>

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	<p><b>Otufi, Pyzchiva, Yesintek:</b> Weight &lt; 60 kg: 0.75 mg/kg</p> <p><b>Otufi, Pyzchiva, Selarsdi, Steqeyma, Yesintek:</b> Weight ≥ 60 kg: 45 mg</p>	
Taltz <sup>®</sup> (ixekizumab)	<p><b>PsO</b> <u>Initial dose:</u> 160 mg (two 80 mg injections) SC at week 0, then 80 mg SC at weeks 2, 4, 6, 8, 10, and 12 <u>Maintenance dose:</u> 80 mg SC every 4 weeks</p> <p><b>PsA</b> <u>Initial dose:</u> 160 mg (two 80 mg injections) SC at week 0 <u>Maintenance dose:</u> 80 mg SC every 4 weeks</p>	80 mg every 4 weeks
Xeljanz <sup>®</sup> (tofacitinib)	<b>PsA</b> 5 mg PO BID	10 mg/day
Xeljanz XR <sup>®</sup> (tofacitinib extended-release)	<b>PsA</b> 11 mg PO QD	11 mg/day

Therapeutic alternatives are listed as Brand name<sup>®</sup> (generic) when the drug is available by brand name only and generic (Brand name<sup>®</sup>) when the drug is available by both brand and generic.

*Appendix C: Contraindications/Boxed Warnings*

- Contraindication(s): history of serious hypersensitivity reaction to guselkumab 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.

- TNF blockers:
  - Etanercept (Enbrel®), adalimumab (Humira®) and its biosimilars, infliximab (Remicade®) and its biosimilars (Avsola™, Renflexis™, Inflectra®), certolizumab pegol (Cimzia®), and golimumab (Simponi®, Simponi Aria®).

*Appendix E: Mayo Score, Modified Mayo Score, or Mayo Endoscopic 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

- Modified Mayo Score: developed from the full Mayo score and evaluates ulcerative colitis stage, based on three parameters: stool frequency, rectal bleeding, and endoscopic evaluation. The modified Mayo Score gives a maximum overall score of 9. The FDA currently accepts the modified Mayo Score for the assessment of disease activity in pivotal UC clinical trials.
- Mayo Endoscopic Score: tool used to assess severity based on endoscopic findings during a colonoscopy and ranges from 0 to 3. A score of 2 or higher means there is moderate-to-severe inflammation.

Score	Decoding
0	Normal or inactive disease
1	Mild disease (erythema, decreased vascular pattern, mild friability)
2	Moderate disease (marked erythema, absent vascular pattern, moderate friability, erosions)
3	Severe disease (spontaneous bleeding, ulcerations)

*Appendix F: Immunomodulator Medical Justification*

- The following may be considered for medical justification supporting inability to use an immunomodulator for CD:
  - 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
  - For TNF-inhibitors, 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

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Maintenance Dose
CD, UC	<p><u>Induction:</u> 200 mg IV at weeks 0, 4, and 8, or 400 mg SC at weeks 0, 4, and 8</p> <p><u>Maintenance:</u> 100 mg SC at week 16, and every 8 weeks thereafter, or 200 mg SC at week 12, and every 4 weeks thereafter</p>	200 mg/4 weeks
PsA, PsO	<p><u>Initial dose:</u> 100 mg SC at weeks 0 and 4</p> <p><u>Maintenance dose:</u> 100 mg SC every 8 weeks</p>	100 mg/8 weeks

**VI. Product Availability**

- Subcutaneous injection
  - Single-dose prefilled syringe: 100 mg/mL, 200 mg/2 mL
  - Single-dose One Press patient-controlled injector: 100 mg/mL
  - Single-dose prefilled pen (Tremfya Pen): 100 mg/mL, 200 mg/2 mL
- Intravenous infusion
  - Single-dose vial: 200 mg/20 mL

**VII. References**

1. Tremfya Prescribing Information. Horsham, PA: Janssen Biotech, Inc.; September 2025. Available at: [https://www.accessdata.fda.gov/drugsatfda\\_docs/label/2025/761061s028s029lbl.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761061s028s029lbl.pdf). Accessed January 20, 2026.
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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
J1628	Injection, guselkumab, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2022 annual review: for PsO, allowed phototherapy as alternative to systemic conventional DMARD if contraindicated or clinically significant adverse effects are experienced; reiterated requirement against combination use with a bDMARD or JAKi from Section III to Sections I and II; references reviewed and updated.	02.21.22	05.22
Template changes applied to other diagnoses/indications and continued therapy section,	09.22.22	
2Q 2023 annual review: for PsA, added TNFi criteria to allow bypass if member has had history of failure of two TNF blockers; updated	02.10.23	05.23

Reviews, Revisions, and Approvals	Date	P&T Approval Date
dosing in Appendix B to reflect dosing for redirected indications; references reviewed and updated.		
Per July SDC: for PsA, removed criteria requiring use of Enbrel; for PsO and PsA, added criteria requiring use of one adalimumab product and stating Yusimry, Hadlima, unbranded adalimumab-fkjp, and unbranded adalimumab-adaz as preferred; updated Appendix B with relevant therapeutic alternatives.	07.25.23	
Per December SDC, added adalimumab-adbm to listed examples of preferred adalimumab products.	12.06.23	02.24
2Q 2024 annual review: added Bimzelx, Zymfentra, Omvoh, Wezlana, Sotyktu, Tofidence, and Velsipity to section III.B; references reviewed and updated.	01.25.24	05.24
Per June SDC, added Simlandi to listed examples of preferred adalimumab products. Per SDC, added unbranded adalimumab-aaty to listed examples of preferred adalimumab products.	07.23.24	08.24
RT4: added criteria for newly approved indication for UC; added appendix E with Mayo Score supplemental information; added new subcutaneous formulations [single-dose prefilled syringe 200 mg/2 mL; single-dose prefilled pen (Tremfya Pen) 200 mg/2 mL] and intravenous formulation [single-dose vial 200 mg/20 mL].	09.19.24	11.24
2Q 2025 annual review: for UC initial criteria, added option for documentation of modified Mayo Score $\geq 5$ ; removed redirection to preferred adalimumab products as adalimumab is not recommended due to low efficacy per 2024 AGA guidelines; revised redirection to Zeposia with bypass allowance stating member must use Zeposia unless member has had history of failure of biological disease-modifying antirheumatic drug or Janus kinase inhibitor as supported by 2024 AGA guidelines; for Appendix E, added supplemental information on modified Mayo Score; updated section III.B with Spevigo and biosimilar verbiage; references reviewed and updated. RT4: added criteria for newly approved indication for CD, including Appendix F with immunomodulator medical justification; RT4: added new strength [100 mg/mL] for single-dose prefilled pen (Tremfya Pen).	03.27.25	05.25
Per April SDC: for PsO, PsA, CD, and UC, added criteria requiring use of one preferred Stelara biosimilar (Otulfi, Pyzchiva (branded), Selarsdi, Yesintek, and Steqeyma are preferred); for UC, removed criteria requiring use of preferred agent Zeposia; for UC, revised requirement to include option for step through preferred adalimumab product or preferred ustekinumab product.	04.23.25	06.25
For UC, added option for Mayo Endoscopic Score $\geq 2$ to define moderate-to-severe UC; for PsO, UC, and CD, added bypass of conventional therapies if a member has failed a biologic agent to	09.30.25	11.25

Reviews, Revisions, and Approvals	Date	P&T Approval Date
clarify intention of not stepping back from biologic agent to conventional therapy. RT4: added pediatric age extension for PsO and PsA; updated UC induction dosing per PI. Extended initial approval durations to 12 months for chronic conditions.		
2Q 2026 annual review: no significant changes; references reviewed and updated. RT4: For PsA, allowed Otezla XR to be used in place of Otezla.	03.30.26	05.26

**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.

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**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.

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