Clinical Policy: Ustekinumab (Stelara), Ustekinumab-aauz, Ustekinumab-srlf (Imuldosa), (Otulfi), Ustekinumab-ttwe (Pyzchiva), Ustekinumab-aekn (Selarsdi), Ustekinumab-hmny (Starjemza), Ustekinumab-stba (Steqeyma), Ustekinumab-auub (Wezlana), Ustekinumab-kfce (Yesintek)

Reference Number: CP.PHAR.264
Effective Date: 08.16
Last Review Date: 06.25
Line of Business: Medicaid

Coding Implications
Revision Log

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

Description

Ustekinumab (Stelara®), ustekinumab-srlf (Imuldosa™), ustekinumab-aauz (Otulfi®), ustekinumab-ttwe (Pyzchiva®), ustekinumab-aekn (Selarsdi™), ustekinumab-hmny (Starjemza™), ustekinumab-stba (Steqeyma®), ustekinumab-auub (Wezlana™), and ustekinumab-kfce (Yesintek™) are human interleukin-12 (IL-12) and -23 (IL-23) antagonists.

FDA Approved Indication(s)

Stelara, Imuldosa, Otulfi, Pyzchiva, Selarsdi, Starjemza, Steqeyma, Wezlana, and Yesintek are indicated for the treatment of:

- Patients 6 years and older with moderate-to-severe plaque psoriasis (PsO) who are candidates for phototherapy or systemic therapy
- Patients 6 years and older with active psoriatic arthritis (PsA)
- 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, Imuldosa, Otulfi, Pyzchiva, Selarsdi, Starjemza, Steqeyma, ustekinumab, ustekinumab-aekn, ustekinumab-ttwe, Wezlana, and Yesintek are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

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

1. Diagnosis of CD;
2. Prescribed by or in consultation with a gastroenterologist;
3. Age ≥ 18 years;
4. 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 clinically significant adverse effects are experienced or all are contraindicated;
   b. Medical justification supports inability to use immunomodulators (*see Appendix E*);
5. For requests other than the following preferred biosimilars, member must use all of the following preferred biosimilars, unless clinically significant adverse effects are experienced or all are contraindicated: Otulfi, Pyzchiva (branded), Selarsdi (or unbranded ustekinumab-aekn), Steqeyma, Yesintek;
   **Prior authorization may be required for ustekinumab products*
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. Dose does not exceed both of the following (a and b):
   a. Initial dose (IV):
      i. Weight ≤ 55 kg: 260 mg once;
      ii. Weight > 55 kg to 85 kg: 390 mg once;
      iii. Weight > 85 kg: 520 mg once;
   b. Maintenance dose (SC): 90 mg 8 weeks after the initial IV dose, followed by maintenance dose of 90 mg every 8 weeks.

Approval duration: 6 months

B. 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;
   b. Member has intolerance or contraindication to MTX (*see Appendix D*), and failure of a ≥ 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;
6. For requests other than the following preferred biosimilars, member must use all of the following preferred biosimilars, unless clinically significant adverse effects are experienced or all are contraindicated: Otulfi, Pyzchiva (branded), Selarsdi (or unbranded ustekinumab-aekn), Steqeyma, Yesintek;
   **Prior authorization may be required for 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 one of the following (*see Appendix G for dose rounding guidelines*) (a or b):
   a. Adult: weight-based dosing initially and 4 weeks later, followed by maintenance dose every 12 weeks (i or ii);
      i. Weight ≤ 100 kg: 45 mg per dose;
      ii. Weight > 100 kg: 90 mg per dose;
   b. Pediatric: weight-based dosing initially and 4 weeks later, followed by maintenance dose every 12 weeks (i, ii, or iii);
      i. Stelara, Otulfi, Pyzchiva, Starjemza, Steqeyma, Wezlana, and Yesintek only: Weight < 60 kg: 0.75 mg/kg per dose;
      ii. Weight 60 kg to 100 kg: 45 mg per dose;
      iii. Weight > 100 kg: 90 mg per dose.

Approval duration: 6 months

C. Psoriatic Arthritis (must meet all)**:**
1. Diagnosis of PsA;
2. Request is for SC formulation;
3. Prescribed by or in consultation with a dermatologist or rheumatologist;
4. Age ≥ 6 years;
5. For requests other than the following preferred biosimilars, member must use all of the following preferred biosimilars, unless clinically significant adverse effects are experienced or all are contraindicated: Otulfi, Pyzchiva (branded), Selarsdi (or unbranded ustekinumab-aekn), Steqeyma, Yesintek;
   **Prior authorization may be required for ustekinumab products*
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. Dose does not exceed one of the following (a or b):
   a. Adult: weight-based dosing initially and 4 weeks later, followed by maintenance dose every 12 weeks (i or ii):
      i. 45 mg per dose;
      ii. Co-existent PsO and weight > 100 kg: 90 mg per dose;
   b. Pediatric: weight-based dosing initially and 4 weeks later, followed by maintenance dose every 12 weeks (i, ii, or iii):
      i. Stelara, Otulfi, Pyzchiva, Starjemza, Steqeyma, Wezlana, and Yesintek only: Weight < 60 kg: 0.75 mg/kg per dose;
      ii. Weight ≥ 60 kg: 45 mg per dose;
      iii. Co-existent PsO and weight > 100 kg: 90 mg per dose.

Approval duration: 6 months

D. Ulcerative Colitis (must meet all)**:**
1. Diagnosis of UC;
2. Prescribed by or in consultation with a gastroenterologist;
3. Age ≥ 18 years;
4. Documentation of a Mayo Score ≥ 6 or modified Mayo Score ≥ 5 (*see Appendix F*);

5. Failure of an 8-week trial of systemic corticosteroids, unless contraindicated or clinically significant adverse effects are experienced;
6. For requests other than the following preferred biosimilars, member must use all of the following preferred biosimilars, unless clinically significant adverse effects are experienced or all are contraindicated: Otulfi, Pyzchiva (branded), Selarsdi (or unbranded ustekinumab-aekn), Steqeyma, Yesintek;
   **Prior authorization may be required for 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. Initial dose (IV):
      i. Weight ≤ 55 kg: 260 mg once;
      ii. Weight > 55 kg to 85 kg: 390 mg once;
      iii. Weight > 85 kg: 520 mg once;
   b. Maintenance dose (SC): 90 mg 8 weeks after the initial IV dose, followed by maintenance dose of 90 mg every 8 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 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. Request is for SC formulation;
4. For requests other than the following preferred biosimilars, member must use all of the following preferred biosimilars, unless clinically significant adverse effects are

experienced or all are contraindicated: Otulfi, Pyzchiva (branded), Selarsdi (or unbranded ustekinumab-aekn), Steqeyma, Yesintek;
**Prior authorization may be required for ustekinumab products*

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. If request is for a dose increase, new dose does not exceed one of the following (a, b, or c):
   a. PsO alone (*see Appendix G for dose rounding guidelines*) (i or ii):
      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, Otulfi, Pyzchiva, Starjemza, Steqeyma, Wezlana, and Yesintek 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 (i or ii):
      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, Otulfi, Pyzchiva, Starjemza, Steqeyma, Wezlana, and Yesintek 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;
   c. CD, UC: 90 mg every 8 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 policies – 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, Simponi®], interleukin agents [e.g., Actemra® (IL-6RA) and its biosimilars, 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), Spevigo® (IL-36 antagonist), Stelara® (IL-12/23 inhibitor) and its biosimilars, Taltz® (IL-17A inhibitor), Tremfya® (IL-23 inhibitor)], Janus kinase inhibitors (JAKi) [e.g., Cibinqo™, Olumiant™, Rinvoq™, Xeljanz®/Xeljanz® XR,], anti-CD20 monoclonal antibodies [Rituxan® and its biosimilars], 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
acitretin (Soriatane®)	**PsO** 25 or 50 mg PO daily	50 mg/day
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	Various

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	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	
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®, Rheumatrex®, Jylamvo®)	**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

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

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 or Modified 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

- 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.

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-srlf (Imuldosa), ustekinumab-aauz (Otulfi), ustekinumab-ttwe (Pyzchiva), ustekinumab-aekn (Selarsdi), ustekinumab-hmny (Starjemza), ustekinumab-stba (Steqeyma), ustekinumab-auub (Wezlana), ustekinumab-kfce (Yesintek) **Also see Appendix G: Dose Rounding Guidelines for Weight-Based Doses*	CD, UC	Weight based dosing IV at initial dose: Weight ≤ 55 kg: 260 mg Weight > 55 kg to 85 kg: 390 mg Weight > 85 kg: 520 mg Maintenance dose: 90 mg SC every 8 weeks	90 mg every 8 weeks
	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, Otulfi, Pyzchiva, Starjemza, Steqeyma, Wezlana, Yesintek:** Weight < 60 kg: 0.75 mg/kg **Stelara, Imuldosa, Otulfi, Pyzchiva, Selarsdi, Starjemza, Steqeyma, Wezlana, Yesintek:** Weight 60 to 100 kg: 45 mg Weight > 100 kg: 90 mg	90 mg every 12 weeks
	PsA	Weight based dosing SC at weeks 0 and 4, followed by maintenance dose every 12 weeks *Adult:* 45 mg SC at weeks 0 and 4, followed by 45 mg every 12 weeks	45 mg every 12 weeks

Drug Name	Indication	Dosing Regimen	Maximum Dose
		Pediatrics (age 6 years to 17 years): Weight based dosing SC at weeks 0 and 4, then every 12 weeks thereafter **Stelara, Otulfi, Pyzchiva, Starjemza, Steqeyma, Wezlana, Yesintek:** Weight < 60 kg: 0.75 mg/kg **Stelara, Imuldosa, Otulfi, Pyzchiva, Selarsdi, Starjemza, Steqeyma, Wezlana, Yesintek:** Weight ≥ 60 kg: 45 mg	
	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-aauz (Otulfi)	• 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-aekn (Selarsdi)	• Single-dose prefilled syringe for SC injection: 45 mg/0.5 mL, 90 mg/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 prefilled autoinjector (ConfiPen) for SC injection: 45 mg/0.5 mL, 90 mg/mL • Single-dose vial for IV infusion: 130 mg/26 mL
Ustekinumab-hmny (Starjemza)	• 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-kfce (Yesintek)	• Single-dose prefilled syringe for SC: 45 mg/0.5 mL, 90 mg/mL • Single-dose vial for SC: 45 mg/0.5 mL • Single-dose vial for IV: 130 mg/26 mL

Drug Name	Availability
Ustekinumab-srlf (Imuldosa)	• Single-dose prefilled syringe for SC injection: 45 mg/0.5 mL, 90 mg/mL • Single-dose vial for IV infusion: 130 mg/26 mL
Ustekinumab-stba (Steqeyma)	• 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-ttwe (Pyzchiva)	• 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
C9399, J3590	Unclassified drugs or biologicals
J3357	Ustekinumab, for subcutaneous injection,1 mg
J3358	Ustekinumab, for intravenous injection, 1 mg
Q5098	Injection, ustekinumab-srlf (imuldosa), biosimilar, 1 mg
Q5099	Injection, ustekinumab-stba (steqeyma), biosimilar, 1 mg
Q5100	Injection, ustekinumab-kfce (yesintek), biosimilar, 1 mg
Q5137	Injection, ustekinumab-auub (wezlana), biosimilar, subcutaneous, 1 mg
Q5138	Injection, ustekinumab-auub (wezlana), biosimilar, intravenous, 1 mg

HCPCS Codes	Description
Q9996	Injection, ustekinumab-ttwe (pyzchiva), subcutaneous, 1 mg
Q9997	Injection, ustekinumab-ttwe (pyzchiva), intravenous, 1 mg
Q9998	Injection, ustekinumab-aekn (selarsdi), 1 mg
Q9999	Injection, ustekinumab-aauz (otulfi), biosimilar, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2021 annual review: added additional criteria related to diagnosis of moderate-to-severe PsO per 2019 AAD/NPF guidelines specifying at least 3% BSA involvement or involvement of areas that severely impact daily function; added combination of bDMARDs under Section III; references reviewed and updated.	02.23.21	05.21
Per August SDC and prior clinical guidance, for PsA removed Simponi as a redirect option and modified to require a trial of all; for UC added requirement for trial of Humira, Simponi, and Zeposia in a step-wise manner. Add coverage for dose escalation with Stelara for CD (per A&G report) and UC (per SDC direction) requiring redirection to preferred agents [Humira, Simponi, Zeposia, infliximab (Avsola, Inflectra and Renflexis are preferred)] per SDC; for Xeljanz redirection requirements added bypass for members with cardiovascular risk and qualified redirection to apply only for member that has not responded or is intolerant to one or more TNF blockers; added Legacy WellCare line of business to policy (WCG.CP.PHAR.264 to be retired) and revised its initial approval duration from 12 months to 6 months.	08.16.21	11.21
2Q 2022 annual review: added Xeljanz as required agent for off-label dosing request for UC; 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
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 Taltz, Otezla, and infliximab due to their lack of pediatric safety and efficacy data in PsO.	05.18.22	
RT4: for PsA, updated criteria and dosing per FDA approved pediatric extension. Template changes applied to other diagnoses/indications and continued therapy section.	09.09.22	
Per February SDC, added Amjevita as an alternative option to Humira for CD and UC.	02.13.23	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
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.	02.10.23	05.23
Per July SDC: added criteria requiring use one adalimumab product and stating Yusimry, Hadlima, unbranded adalimumab-fkjp, and unbranded adalimumab-adaz as preferred; for PsA and PsO, removed criteria requiring use of Enbrel; for UC, removed criteria requiring use of Simponi, Humira, and Amjevita; updated Appendix B with relevant therapeutic alternatives.	07.25.23	
Per December SDC, added adalimumab-adbm to listed examples of preferred adalimumab products. RT4: added newly approved biosimilar Wezlana to criteria; for initial criteria, corrected spelling error in "dose does not exceed" criteria.	12.06.23	02.24
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; references reviewed and updated.	01.22.24	05.24
RT4: added newly approved biosimilar Selarsdi to criteria. Added HCPCS codes [Q5137, Q5138].	05.03.24	
Per June SDC, added Simlandi to listed examples of preferred adalimumab products. RT4: added newly approved biosimilar Pyzchiva to criteria. Per SDC, added unbranded adalimumab-aaty to listed examples of preferred adalimumab products.	07.23.24	08.24
RT4: added newly approved biosimilar Otulfi to criteria.	10.03.24	11.24
RT4: added newly approved biosimilar Imuldosa to criteria; RT4: for Selarsdi, added newly approved indications for CD and UC; added new dosage formulation [single-dose vial for IV infusion 130 mg/26 mL]. Added HCPCS codes [Q9996, Q9997, Q9998].	11.19.24	
RT4: added newly approved biosimilar Yesintek to criteria; RT4: for Pyzchiva, added new dosage formulation [single-dose vial for SC injection 45 mg/0.5 mL]; for PsO and PsA, added Pyzchiva to "weight < 60 kg: 0.75 mg/kg per dose" pediatric dosing criteria; RT4: for Wezlana, added new dosage formulation [single-dose prefilled autoinjector (ConfiPen) 45 mg/0.5 mL, 90 mg/mL]; RT4: added newly approved biosimilar Steqeyma to criteria.	01.07.25	
2Q 2025 annual review: for UC initial criteria, added option for documentation of modified Mayo Score ≥ 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	04.03.25	05.25

Reviews, Revisions, and Approvals	Date	P&T Approval Date
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 F, added supplemental information on modified Mayo Score; added HCPCS codes [Q9999, C9399, J3590]; updated section III.B with Spevigo and biosimilar verbiage; references reviewed and updated. RT4: for Otulfi, added new dosage formulation [single-dose vial for SC injection: 45 mg/0.5 mL]; for PsA and PsO, added Otulfi to "weight < 60 kg: 0.75 mg/kg per dose" pediatric dosing criteria.		
Per April SDC: added criteria requiring use of preferred Stelara biosimilars Otulfi, Pyzchiva (branded), Selarsdi (or unbranded ustekinumab-aekn), Steqeyma, Yesintek; removed redirection criteria for requests that are above the labeled maximum dose; for CD, removed criteria requiring use of preferred adalimumab products; for PsO, removed criteria requiring use of preferred adalimumab products and Taltz; for PsA, removed criteria requiring use of preferred adalimumab products, Otezla, Taltz, Xeljanz/Xeljanz XR; for UC, removed criteria requiring use of Zeposia. Added HCPCS codes [Q5098, Q5099, and Q5100].	04.23.25	06.25
RT4: added newly approved biosimilar Starjemza to criteria; RT4: for Steqeyma, added new dosage formulation [single-dose vial for SC injection: 45 mg/0.5 mL] and updated pediatric dosing for PsO and PsA.	06.12.25	

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.