# Ilumya *(tildrakizumab)*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses (FDA approved indication)** | Ilumya is an interleukin-23 antagonist indicated for the treatment of adults with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy. |
| **Exclusion Criteria** | Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis). |
| **Required Medical Information** | Medical records supporting the request must be provided, including documentation of prior therapies and responses to treatment. |
| **Age Restriction** | None. |
| **Prescriber Restrictions** | Prescriber is a specialist or has consulted with a specialist for the condition being treated. |
| **Coverage Duration** | Two years. Dose will be approved according to the FDA approved labeling or within accepted standards of medical practice. |
| **Other Criteria/Information** | Refer to the Gold Coast Health Plan Medicare Part B Reference and Summary of Evidence document. |

| HCPCS | Description | Billing Units/How Supplied |
|---|---|---|
| J3245 | Ilumya (tildrakizumab) | **Billing unit: 1 mg**<br><br>100 mg SD syringe |

| STATUS | DATE REVISED | REVIEW DATE | APPROVED/REVIEWED BY | EFFECTIVE DATE |
|---|---|---|---|---|
| Created | 3/26/2025 | 3/26/2025 | Dawn Shojai, PharmD, Senior Pharmacy Benefit Consultant (PSG) | N/A |
| Approved | N/A | 5/15/2025 | Pharmacy & Therapeutics (P&T) Committee | 5/15/2025 |
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