



## PRIOR AUTHORIZATION POLICY

**POLICY:** Inflammatory Conditions – Siliq Prior Authorization Policy

- Siliq® (brodalumab subcutaneous injection – Valeant)

**REVIEW DATE:** 06/04/2025; selected revision 07/16/2025 and 10/29/2025

---

### INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

## CIGNA NATIONAL FORMULARY COVERAGE:

### OVERVIEW

Siliq, an interleukin (IL)-17A antagonist, is indicated for treatment moderate to severe **plaque psoriasis** in adults who are candidates for systemic therapy or phototherapy and who have failed to respond or have lost response to other systemic therapies.<sup>1</sup> In the pivotal trial, patients were assessed for a response at Week 12.

### Guidelines

Joint guidelines from the American Academy of Dermatology and National Psoriasis Medical Board (2019) have been published for management of psoriasis with biologics.<sup>2</sup> These guidelines list Siliq as a monotherapy treatment option for patients with moderate to severe plaque psoriasis. Guidelines from the European Dermatology Forum (2025) recommend biologics (including Siliq) as second-line therapy for most patients requiring systemic treatment when there is inadequate

response, contraindication, or intolerance to conventional systemic agents (e.g., methotrexate, cyclosporine, acitretin).<sup>3</sup>

## **Safety**

Siliq has a Boxed Warning, Risk Evaluation and Mitigation Strategy (REMS) program, and limited distribution program due to risks of suicidal ideation and behavior. The REMS program requires prescribers and pharmacies to be certified to prescribe and/or dispense Siliq.<sup>4</sup> Patients must sign a patient-prescriber agreement form and be aware of the need to seek medical attention for any new/worsening suicidal thoughts or behavior, depression, anxiety, or mood changes.

## **POLICY STATEMENT**

Prior Authorization is recommended for prescription benefit coverage of Siliq. All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days. Because of the specialized skills required for evaluation and diagnosis of patients treated with Siliq as well as the monitoring required for adverse events and long-term efficacy, initial approval requires Siliq to be prescribed by or in consultation with a physician who specializes in the condition being treated.

- **Siliq® (brodalumab subcutaneous injection – Valeant) is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):**

## **FDA-Approved Indication**

**1. Plaque Psoriasis.** Approve for the duration noted if the patient meets ONE of the following (A or B):

A) Initial Therapy. Approve for 3 months if the patient meets ALL of the following (i, ii, iii, iv, v, and vi):

i. Patient is  $\geq$  18 years of age; AND

ii. Patient meets ONE of the following (a or b):

a) Patient has tried at least one traditional systemic agent for psoriasis for at least 3 months, unless intolerant; OR

Note: Examples include methotrexate, cyclosporine, or acitretin. A 3-month trial of psoralen plus ultraviolet A light (PUVA) also counts. An exception to the requirement for a trial of one traditional systemic agent for psoriasis can be made if the patient has already had a 3-month trial or previous intolerance to at least one biologic (other than the requested drug), Otezla/Otezla XR (apremilast tablets/extended-release tablets), or Sotyktu (deucravacitinib tablets). A biosimilar of the requested biologic does not count. Refer to [Appendix](#) for examples of biologics used for plaque psoriasis. A patient who has already tried a biologic for psoriasis, Otezla/Otezla XR, or Sotyktu is not required to “step back” and try a traditional systemic agent for psoriasis.

- b) According to the prescriber, the patient has a contraindication to methotrexate; AND
  - iii. According to the prescriber, the patient has been evaluated for risks of suicidal ideation or behavior versus benefits of therapy; AND
  - iv. According to the prescriber, the patient does **not** have moderately severe to severe depression; AND
  - v. According to the prescriber, within the past 5 years, the patient does **not** have a history of suicidal ideation or suicidal behavior; AND
  - vi. The medication is prescribed by or in consultation with a dermatologist; OR
- B) Patient is Currently Receiving Siliq. Approve for 1 year if the patient meets ALL of the following (i, ii, iii, iv, v, and vi):
- i. Patient has been established on therapy for at least 3 months; AND  
Note: A patient who has received < 3 months of therapy or who is restarting therapy is reviewed under criterion A (Initial Therapy).
  - ii. According to the prescriber, the patient has been evaluated for risks of suicidal ideation or behavior versus benefits of therapy; AND
  - iii. According to the prescriber, the patient does **not** have moderately severe to severe depression; AND
  - iv. According to the prescriber, the patient does **not** have suicidal ideation or suicidal behavior; AND
  - v. Patient experienced a beneficial clinical response, defined as improvement from baseline (prior to initiating Siliq) in at least one of the following: estimated body surface area, erythema, induration/thickness, and/or scale of areas affected by psoriasis; AND
  - vi. Compared with baseline (prior to receiving Siliq), patient experienced an improvement in at least one symptom, such as decreased pain, itching, and/or burning.

## CONDITIONS NOT COVERED

- **Siliq® (brodalumab subcutaneous injection – Valeant)** is(are) considered not medically necessary for ANY other use(s) including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

1. **Concurrent Use with a Biologic or with a Targeted Synthetic Oral Small Molecule Drug.** This medication should not be administered in combination with another biologic or with a targeted synthetic oral small molecule drug used for an inflammatory condition (see [Appendix](#) for examples). Combination therapy is generally not recommended due to a potentially higher rate of adverse events and lack of controlled clinical data supporting additive efficacy.  
Note: This does NOT exclude the use of conventional synthetic disease-modifying antirheumatic drug(s) [DMARDs] {e.g., methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine} in combination with this medication.

**2. Crohn’s Disease.** Siliq is contraindicated in patients with Crohn’s disease.<sup>1</sup> There is a published Phase II study evaluating Siliq in Crohn’s disease (n = 130) that was terminated early due to a disproportionate number of worsening Crohn’s disease and lack of efficacy.<sup>5</sup>

**3. Rheumatoid Arthritis.** Efficacy has not been established. A published Phase II study (n = 252) did not demonstrate improvement in American College of Rheumatology 20/50/70 responses with Siliq vs. placebo for treatment of rheumatoid arthritis in patients who had previously failed methotrexate.<sup>6</sup>

**REFERENCES**

1. Siliq® subcutaneous injection [prescribing information]. Bridgewater, NJ: Valeant; August 2024.
2. Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. *J Am Acad Dermatol.* 2019 80(4):1029-1072.
3. Nast A, Spuls PI, Dressler C, et al. EuroGuiDerm guideline for the systemic treatment of psoriasis vulgaris. Updated February 2025. Available at: <https://www.guidelines.edf.one/guidelines/psoriasis-guideline>. Accessed on May 20, 2025.
4. US Food and Drug Administration, US Department of Health and Human Services [Web site]. <https://www.accessdata.fda.gov/scripts/cder/remis/index.cfm?event=IndvRemsDetails.page&REMS=362>. Search term: Siliq. Updated July 19, 2023. Accessed on May 20, 2025.
5. Targan SR, Feagan B, Vermeire S, et al. A randomized, double-blind, placebo-controlled Phase 2 study of brodalumab in patients with moderate-to-severe Crohn's disease. *Am J Gastroenterol.* 2016;111(11):1599-1607.
6. Pavelka K, Chon Y, Newmark R, et al. A study to evaluate the safety, tolerability, and efficacy of brodalumab in subjects with rheumatoid arthritis and an inadequate response to methotrexate. *J Rheumatol.* 2015;42(6):912-919.

**HISTORY**

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	05/10/2023
Selected Revision	<b>Plaque Psoriasis:</b> For a patient currently taking Siliq, the timeframe for established on therapy was changed from 90 days to 3 months.	03/27/2024
Annual Revision	<b>Plaque Psoriasis:</b> In the Note, psoralen plus ultraviolet A light (PUVA) was removed from the examples of traditional systemic therapies. An additional Note was added that a 3-month trial of PUVA counts as a traditional systemic therapy.	06/12/2024
Selected Revision	<b>Conditions Not Covered:</b> Concurrent use with a Biologic or with a Targeted Synthetic Oral Small Molecule Drug was changed to as listed (previously oral small molecule drug was listed as Disease-Modifying Antirheumatic Drug).	09/11/2024
Selected Revision	<b>Plaque Psoriasis:</b> For initial approval and for a patient currently receiving Siliq, requirements were added that the prescriber attests the patient has been evaluated for the risks of suicidal ideation and behavior versus the benefits of therapy and that the patient does not have moderately severe to severe depression. For initial approval, a requirement was added that within the past 5 years, the patient does not have a history of suicidal ideation or suicidal behavior; for a patient currently receiving Siliq, a requirement was added that, according to the prescriber the patient does <u>not</u> have suicidal ideation or suicidal behavior.	10/02/2024

Annual Revision	No criteria changes.	06/04/2025
Selected Revision	<b>Plaque Psoriasis.</b> <u>Initial approval and for a patient currently receiving Siliq:</u> The requirement that the prescriber attests the patient has been assessed and evaluated for risks of suicidal ideation or behavior versus benefits of therapy was modified to "According to the prescriber, the patient has been evaluated for these risks versus benefits of therapy". "According to the prescriber" was added to the requirement that the patient does not have moderately severe to severe depression. <u>Initial approval:</u> "According to the prescriber" was added to the requirement that within the past 5 years, the patient does not have a history of suicidal ideation or suicidal behavior.	07/16/2025
Selected Revision	<b>Plaque Psoriasis:</b> For initial therapy, in the Note, a 3-month trial or prior intolerance to Otezla/Otezla XR (apremilast tablets/extended-release tablets) or Sotyktu (deucravacitinib tablets) was added as an exception to the requirement for a trial of one traditional systemic agent for psoriasis. For initial therapy, the requirement "patient has a contraindication to methotrexate, as determined by the prescriber" was modified to "according to the prescriber, the patient has a contraindication to methotrexate". In the Appendix, Otezla XR (apremilast extended-release tablets) was added under the Oral Therapies/Targeted Synthetic Oral Small Molecular Drugs.	10/29/2025

## APPENDIX

	Mechanism of Action	Examples of Indications*
<b>Biologics</b>		
<b>Adalimumab SC Products</b> (Humira®, biosimilars)	Inhibition of TNF	AS, CD, JIA, PsO, PsA, RA, UC
<b>Cimzia®</b> (certolizumab pegol SC injection)	Inhibition of TNF	AS, CD, JIA, nr-axSpA, PsO, PsA, RA
<b>Etanercept SC Products</b> (Enbrel®, biosimilars)	Inhibition of TNF	AS, JIA, PsO, PsA, RA
<b>Infliximab IV Products</b> (Remicade®, biosimilars)	Inhibition of TNF	AS, CD, PsO, PsA, RA, UC
<b>Zymfentra®</b> (infliximab-dyyb SC injection)	Inhibition of TNF	CD, UC
<b>Simponi®, Simponi Aria®</b> (golimumab SC injection, golimumab IV infusion)	Inhibition of TNF	SC formulation: AS, PsA, RA, UC
		IV formulation: AS, PJIA, PsA, RA
<b>Tocilizumab Products</b> (Actemra® IV, biosimilars; Actemra SC, biosimilars)	Inhibition of IL-6	SC formulation: PJIA, RA, SJIA
		IV formulation: PJIA, RA, SJIA
<b>Kevzara®</b> (sarilumab SC injection)	Inhibition of IL-6	RA
<b>Orencia®</b> (abatacept IV infusion, abatacept SC injection)	T-cell costimulation modulator	SC formulation: JIA, PSA, RA
		IV formulation: JIA, PsA, RA
<b>Rituximab IV Products</b> (Rituxan®, biosimilars)	CD20-directed cytolytic antibody	RA
<b>Kineret®</b> (anakinra SC injection)	Inhibition of IL-1	JIA <sup>^</sup> , RA
<b>OmvoH®</b> (mirikizumab IV infusion, SC injection)	Inhibition of IL-23	CD, UC
<b>Ustekinumab Products</b> (Stelara® IV, biosimilars; Stelara SC, biosimilars)	Inhibition of IL-12/23	SC formulation: CD, PsO, PsA, UC

		IV formulation: CD, UC
<b>Siliq</b> <sup>®</sup> (brodalumab SC injection)	Inhibition of IL-17	PsO
<b>Cosentyx</b> <sup>®</sup> (secukinumab SC injection; secukinumab IV infusion)	Inhibition of IL-17A	SC formulation: AS, ERA, nr-axSpA, PsO, PsA
		IV formulation: AS, nr-axSpA, PsA
<b>Taltz</b> <sup>®</sup> (ixekizumab SC injection)	Inhibition of IL-17A	AS, nr-axSpA, PsA, PsO
<b>Bimzelx</b> <sup>®</sup> (bimekizumab-bkzx SC injection)	Inhibition of IL-17A/17F	AS, HS, nr-axSpA, PsA, PsO
<b>Ilumya</b> <sup>®</sup> (tildrakizumab-asmn SC injection)	Inhibition of IL-23	PsO
<b>Skyrizi</b> <sup>®</sup> (risankizumab-rzaa SC injection, risankizumab-rzaa IV infusion)	Inhibition of IL-23	SC formulation: CD, PSA, PsO, UC
		IV formulation: CD, UC
<b>Tremfya</b> <sup>®</sup> (guselkumab SC injection, guselkumab IV infusion)	Inhibition of IL-23	SC formulation: CD, PsA, PsO, UC
		IV formulation: CD, UC
<b>Entyvio</b> <sup>®</sup> (vedolizumab IV infusion, vedolizumab SC injection)	Integrin receptor antagonist	CD, UC
<b>Oral Therapies/Targeted Synthetic Oral Small Molecule Drugs</b>		
<b>Otezla</b> <sup>®</sup> (apremilast tablets)	Inhibition of PDE4	PsO, PsA
<b>Otezla XR</b> <sup>™</sup> (apremilast extended-release tablets)	Inhibition of PDE4	PsO, PsA
<b>Cibinqo</b> <sup>™</sup> (abrocitinib tablets)	Inhibition of JAK pathways	AD
<b>Olumiant</b> <sup>®</sup> (baricitinib tablets)	Inhibition of JAK pathways	RA, AA
<b>Litfulo</b> <sup>®</sup> (ritlecitinib capsules)	Inhibition of JAK pathways	AA
<b>Leqselvi</b> <sup>®</sup> (deuruxolitinib tablets)	Inhibition of JAK pathways	AA
<b>Rinvoq</b> <sup>®</sup> (upadacitinib extended-release tablets)	Inhibition of JAK pathways	AD, AS, nr-axSpA, RA, PsA, UC
<b>Rinvoq</b> <sup>®</sup> LQ (upadacitinib oral solution)	Inhibition of JAK pathways	PsA, PJIA
<b>Sotyktu</b> <sup>®</sup> (deucravacitinib tablets)	Inhibition of TYK2	PsO
<b>Xeljanz</b> <sup>®</sup> (tofacitinib tablets/oral solution)	Inhibition of JAK pathways	RA, PJIA, PsA, UC
<b>Xeljanz</b> <sup>®</sup> XR (tofacitinib extended-release tablets)	Inhibition of JAK pathways	RA, PsA, UC
<b>Zeposia</b> <sup>®</sup> (ozanimod tablets)	Sphingosine 1 phosphate receptor modulator	UC
<b>Velsipity</b> <sup>®</sup> (etrasimod tablets)	Sphingosine 1 phosphate receptor modulator	UC

\* Not an all-inclusive list of indications. Refer to the prescribing information for the respective agent for FDA-approved indications; SC – Subcutaneous; TNF – Tumor necrosis factor; AS – Ankylosing spondylitis; CD – Crohn’s disease; JIA – Juvenile idiopathic arthritis; PsO – Plaque psoriasis; PsA – Psoriatic arthritis; RA – Rheumatoid arthritis; UC – Ulcerative colitis; nr-axSpA – Non-radiographic axial spondyloarthritis; IV – Intravenous, PJIA – Polyarticular juvenile idiopathic arthritis; IL – Interleukin; SJIA – Systemic juvenile idiopathic arthritis; ^ Off-label use of Kineret in JIA supported in guidelines; ERA – Enthesitis-related arthritis; DMARD – Disease-modifying antirheumatic drug; PDE4 – Phosphodiesterase 4; JAK – Janus kinase; AD – Atopic dermatitis; AA – Alopecia areata; TYK2 – Tyrosine kinase 2.

"Cigna Companies" refers to operating subsidiaries of The Cigna Group. All products and services are provided exclusively by or through such operating subsidiaries, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of The Cigna Group.© 2025 The Cigna Group.