Drug Coverage Policy

Effective Date……05/15/2026
Coverage Policy Number……IP0686
Policy Title….Ustekinumab Intravenous Products Prior Authorization Policy

Inflammatory Conditions – Ustekinumab Intravenous Products Prior Authorization Policy

- Stelara® (ustekinumab intravenous infusion – Janssen Biotech)
- Imuldosa® (ustekinumab-srlf intravenous infusion – Accord)
- Otulfi™ (ustekinumab-aauz intravenous infusion – Formycon/Fresenius)
- Pyzchiva™ (ustekinumab-ttwe intravenous infusion – Sandoz/Samsung)
- Selarsdi™ (ustekinumab-aekn intravenous infusion – Alvotech/Teva)
- Starjemza™ (ustekinumab-hmny intravenous infusion – BioThera)
- Steqeyma™ (ustekinumab-stba intravenous infusion – Celltrion)
- Ustekinumab intravenous infusion – (Janssen Biotech)
- Ustekinumab-aekn intravenous infusion (Alvotech/Teva)
- ustekinumab-ttwe intravenous infusion (Quallent)
- Wezlana™ (ustekinumab-auub intravenous infusion – Amgen)
- Yesintek™ (ustekinumab-kfce intravenous infusion – Biocon

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.

OVERVIEW

Ustekinumab intravenous (IV), a monoclonal antibody against the p40 subunit of the interleukin (IL)-12 and IL-23 cytokines, is indicated for the following conditions:[1,6-12, 14]

- **Crohn's disease** (CD), in adults and pediatric patients ≥ 2 years of age with moderate to severe active disease.
- **Ulcerative colitis** (UC), in adults with moderate to severe active disease.

In CD and UC, a single weight-based dose is administered by IV infusion. Following induction therapy with the IV product, the recommended maintenance dose is administered as a subcutaneous (SC) injection 8 weeks after the initial IV dose, then once every 8 weeks thereafter.

Guidelines

Guidelines for the treatment of inflammatory conditions recommend use of ustekinumab.

- **Crohn's Disease:** The American College of Gastroenterology (ACG) [2025] and the American Gastroenterological Association (AGA) [2025] have guidelines for the management of CD in adults.[2,13] Both guidelines recommend upfront use of advanced therapies, rather than step-up therapy after failure of corticosteroids and/or immunomodulators. Advanced therapies recommended include tumor necrosis factor (TNF) inhibitors, Entyvio® (vedolizumab IV infusion, SC injection), IL-23 inhibitors, IL-12/23 inhibitors, and Rinvoq® (upadacitinib extended-release tablets).
- **Ulcerative Colitis:** The AGA (2024) and the ACG (2025) have clinical practice guidelines on the management of moderate to severe UC.[3,4] In moderate to severe disease, systemic corticosteroids or advanced therapies may be utilized for induction of remission. Advanced therapies recommended include TNF inhibitors, Entyvio, IL-23 inhibitors, IL-12/23 inhibitors, sphingosine-1-phosphate (S1P) receptor modulators, and Janus kinase (JAK) inhibitors. If steroids are utilized for induction, efforts should be made to introduce steroid-sparing agents for maintenance therapy. Of note, guidelines state corticosteroids may be avoided entirely when other effective induction strategies are planned.[4] Both guidelines also recommend that any drug that effectively treats induction should be continued for maintenance.

Coverage Policy

Policy Statement

Prior Authorization is required for benefit coverage of ustekinumab intravenous. Approval is recommended for those who meet the **Criteria** and **Dosing** for the listed indications. Extended approvals are allowed if the patient continues to meet the Criteria and Dosing. Requests for doses outside of the established dosing documented in this policy will be considered on a case-by-case basis by a clinician (i.e., Medical Director or Pharmacist). Because of the specialized skills

required for evaluation and diagnosis of patients treated with ustekinumab intravenous as well as the monitoring required for adverse events and long-term efficacy, approval requires ustekinumab intravenous to be prescribed by or in consultation with a physician who specializes in the condition being treated. All approvals are provided for 30 days, which is an adequate duration for the patient to receive one dose.

NOTE: This product also requires the use of preferred ustekinumab intravenous products before approval of non-preferred ustekinumab intravenous products. Refer to the *Inflammatory Conditions – Ustekinumab Intravenous Products Preferred Specialty Management Policy* for additional preferred product criteria requirements and exceptions.

The following products are not covered on the pharmacy and medical benefits for Employer Plans and Individual and Family Plans: Imuldosa intravenous (NDCs starting with 51407), Wezlana intravenous. Refer to the customer's benefit plan document for details of covered product(s).

Ustekinumab intravenous products are considered medically necessary when ONE of the following is met (1 or 2):

FDA-Approved Indications

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1. Crohn's Disease. Approve a single dose if the patient meets the following (A, B, and C):
- **A)** Patient is ≥ 2 years of age; AND
- **B)** The medication will be used as induction therapy; AND
- **C)** The medication is prescribed by or in consultation with a gastroenterologist.

Dosing. Approve ONE of the following weight-based doses (A, B, C or D):
- **A)** ≥ 10 kg but ≤ 25 kg (≥ 22 lbs but ≤ 55 lbs): Approve up to 10 mg/kg as an intravenous infusion; OR
- **B)** > 25 kg but ≤ 55 kg (> 55 lbs but ≤ 121 lbs): Approve up to 260 mg as an intravenous infusion.
- **C)** > 55 kg but ≤ 85 kg (> 121 lbs but ≤ 187 lbs): Approve up to 390 mg as an intravenous infusion.
- **D)** > 85 kg (> 187 lbs): Approve up to 520 mg as an intravenous infusion.

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2. Ulcerative Colitis. Approve a single dose if the patient meets the following (A, B, and C):
- **A)** Patient is ≥ 18 years of age; AND
- **B)** The medication will be used as induction therapy; AND
- **C)** The medication is prescribed by or in consultation with a gastroenterologist.

Dosing. Approve ONE of the following weight-based doses (A, B, or C):
- **A)** ≤ 55 kg (121 lbs): Approve up to 260 mg as an intravenous infusion.
- **B)** > 55 kg but ≤ 85 kg (> 121 lbs but ≤ 187 lbs): Approve up to 390 mg as an intravenous infusion.
- **C)** > 85 kg (> 187 lbs): Approve up to 520 mg as an intravenous infusion.

Conditions Not Covered

Ustekinumab intravenous products for any other use are considered not medically necessary, including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

1. **Ankylosing Spondylitis (AS).** There are other biologic therapies indicated in AS. More data are needed to demonstrate efficacy of ustekinumab in this condition. There is a published proof-of-concept trial evaluating ustekinumab in AS (TOPAS – UsTekinumab for the treatment Of Patients with active Ankylosing Spondylitis).[4] TOPAS was a prospective, open-label study evaluating ustekinumab 90 mg subcutaneous at Week 0, 4, and 16 in patients (n = 20) with AS. After Week 16, patients were followed through Week 28. Patients who previously failed to respond to tumor necrosis factor inhibitor (TNFi) were excluded, but patients who discontinued a TNFi for reasons other than lack of efficacy were allowed to enroll. The primary endpoint was a 40% improvement in disease activity at Week 24 according to the Assessment of SpondyloArthritis International Society (ASAS) criteria (ASAS40). Efficacy analysis was completed in the intent-to-treat population which included all patients who received at least one dose of ustekinumab. In all, 65% of patients (95% confidence interval [CI]: 41%, 85%; n = 13/20) achieved an ASAS40 response at Week 24. There was at least a 50% improvement of the BASDAI (Bath Ankylosing Spondylitis Disease Activity Index) achieved by 55% of patients (95% CI: 32%, 77%; n = 11/20); improvement in other secondary endpoints were also noted. However, enthesitis (measured by MASES [Maastricht AS Entheses Score] and SPARCC [SPondyloArthritis Research Consortium of Canada] enthesitis indices) and the number of swollen joints were not significantly improved at Week 24. There was a significant reduction of active inflammation on magnetic resonance imaging at Week 24 compared with baseline in sacroiliac joints.

2. **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 agents (e.g., methotrexate, 6-mercaptopurine, azathioprine, and sulfasalazine) in combination with this medication.

3. **Plaque Psoriasis.** Ustekinumab for subcutaneous injection is indicated for treatment of plaque psoriasis.[1] Appropriate dosing of ustekinumab intravenous in plaque psoriasis is unclear.

4. **Psoriatic Arthritis.** Ustekinumab for subcutaneous injection is indicated for treatment of psoriatic arthritis.[1] Appropriate dosing of ustekinumab intravenous in psoriatic arthritis is unclear.

Coding Information

Note: 1) This list of codes may not be all-inclusive.

2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

HCPCS Codes	Description
C9399†	Unclassified drugs or biologicals
J3358	Ustekinumab, for intravenous injection, 1 mg
J3490†	Unclassified drugs
J3590†	Unclassified biologicals
Q5098	Injection, ustekinumab-srlf (Imuldosa), biosimilar, 1 mg
Q5099	Injection, ustekinumab-stba (Steqeyma), biosimilar, 1 mg
Q5100	Injection, ustekinumab-kfce (Yesintek), biosimilar, 1 mg
Q5138	Injection, ustekinumab-auub (Wezlana), biosimilar, IV, 1 mg
Q9997	Injection, ustekinumab-ttwe (Pyzchiva), intravenous, 1 mg
Q9998	Injection, ustekinumab-aekn (Selarsdi), biosimilar, 1 mg
Q9999	Injection, ustekinumab-aauz (Otulfi), biosimilar, 1 mg

†**Note:** Considered Medically Necessary when used to report Starjemza™ (ustekinumab-hmny intravenous infusion) and medical necessity criteria outlined in this Coverage Policy are met.

References

1. Stelara® subcutaneous injection [prescribing information]. Horsham, PA: Janssen Biotech; April 2026.
2. Lichtenstein G, Loftus E, Afzali A, et al. ACG Clinical Guideline: Management of Crohn's Disease in Adults. *Am J Gastroenterol.* 2025 June;120(6):1225-1264.
3. Singh S, Loftus EV Jr, Limketkai BN, et al. AGA Living Clinical Practice Guideline on Pharmacological Management of Moderate-to-Severe Ulcerative Colitis. *Gastroenterology*. 2024 Dec;167(7):1307-1343.
4. Rubin D, Ananthakrishnan A, Siegel C. ACG Clinical Guideline Update: Ulcerative Colitis in Adults. *Am J of Gastroenterol.* 2025 June;120(6):1187-1224.
5. Poddubnyy D, Hermann KG, Callhoff J, et al. Ustekinumab for the treatment of patients with active ankylosing spondylitis: results of a 28-week, prospective, open-label, proof-of-concept study (TOPAS). *Ann Rheum Dis*. 2014;73(5):817-823.
6. Otulfi® intravenous infusion, subcutaneous injection [prescribing information]. Lake Zurich, IL: Fresenius; December 2024.
7. Pyzchiva® intravenous infusion, subcutaneous injection [prescribing information]. Princeton, NJ: Sandoz; June 2024.
8. Selarsdi® intravenous infusion, subcutaneous injection [prescribing information]. Parsippany, NJ: Teva; October 2024.
9. Steqeyma® intravenous infusion, subcutaneous injection [prescribing information]. Incheon, Republic of Korea: Celltrion; December 2024.
10. Yesintek® intravenous infusion, subcutaneous injection [prescribing information]. Cambridge, MA: Biocon; December 2024.
11. Wezlana® intravenous infusion, subcutaneous injection [prescribing information]. Thousand Oaks, CA: Amgen; January 2025.
12. Imuldosa® intravenous infusion, subcutaneous injection [prescribing information]. Raleigh, NC: Accord; October 2025.

13. Scott FI, Ananthakrishnan AN, Click B, et al. AGA Living Clinical Practice Guideline on the Pharmacologic Management of Moderate-to-Severe Crohn's Disease. *Gastroenterology*. 2025 Dec;169(7):1397-1448.
14. Starjemza™ intravenous infusion, subcutaneous injection [prescribing information]. Guangzhou, Guang dong, China: Bio-Thera; May 2025.

Revision Details

Summary of Changes	Review Date	Effective Date
New policy	09/12/2024	11/1/2024
Policy name was updated to more generally list Ustekinumab Intravenous Products; previously policy was specific to Stelara Intravenous. Otulfi, Pyzchiva, ustekinumab-ttwe, Selarsdi, Steqeyma, and Yesintek intravenous were added to the policy; the same criteria apply for all ustekinumab intravenous products. **Updated HCPCS Coding** **Added HCPCS**: J3358, Q9997, Q9998, Q9999	03/20/2025	04/15/2025
Updated HCPCS Coding: **Added** Q5099 Q5100 (Codes Effective 7/1/2025)	--	4/15/2025
Ustekinumab intravenous (unbranded Stelara) and ustekinumab-aekn intravenous (unbranded Selarsdi) were added to the policy; the same criteria apply as the other ustekinumab intravenous products. **Ulcerative Colitis:** Removed the following conditions of approval: (1) the patient has tried one systemic therapy; (2) the patient has pouchitis and tried an antibiotic, probiotic, corticosteroid enema, or mesalamine enema.	07/24/2025	09/01/2025
Imuldosa intravenous was added to the policy; the same criteria apply for all ustekinumab intravenous products. **Coding Information** **Added:** HCPCS code Q5098	09/11/2025	10/15/2025
Starjemza intravenous injection was added to the policy; the same criteria apply as the other ustekinumab intravenous products. A "Note" was added to the policy stating that "The following products are not covered on the pharmacy and medical benefits for Employer Plans and Individual and Family Plans: Imuldosa intravenous (NDCs starting with 51407), Wezlana intravenous. Refer to the customer's benefit plan document for details of covered product(s)."	01/29/2026	03/01/2026

Crohn's Disease: For initial therapy, the following options of approval were removed: The patient has tried or is currently taking systemic corticosteroids, or corticosteroids are contraindicated; patient has tried one conventional systemic therapy for Crohn's disease along with the associated Note; patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas; patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence). **Appendix:** Otezla XR (apremilast extended-release tablets) was added.	02/19/2026	03/15/2026
Crohn's Disease: The age requirement was modified from ≥ 18 years to ≥ 2 years of age. Dosing was updated to add an option for a patient weighing ≥ 10 kg but ≤ 25 kg. In a patient weighing ≤ 55 kg, specified the lower limit of weight as > 25 kg. **Coding Information** • **Updated** the description for HCPCS code Q9998 to align with the current HCPCS coding book. • **Added** HCPCS code Q5138 • **Added** the following dagger note to HCPCS codes C9399, J3490, and J3590: o Considered Medically Necessary when used to report Starjemza™ (ustekinumab-hmny intravenous infusion), provided the medical necessity criteria outlined in this Coverage Policy are met.	04/30/2026	05/15/2026

The policy effective date is in force until updated or retired.

APPENDIX

	Mechanism of Action	Examples of Indications*
Biologics		
Adalimumab SC Products (Humira®, biosimilars)	Inhibition of TNF	AS, CD, JIA, PsO, PsA, RA, UC
Cimzia® (certolizumab pegol SC injection)	Inhibition of TNF	AS, CD, nr-axSpA, PsO, PsA, RA
Etanercept SC Products (Enbrel®, biosimilars)	Inhibition of TNF	AS, JIA, PsO, PsA, RA
Infliximab IV Products (Remicade®, biosimilars)	Inhibition of TNF	AS, CD, PsO, PsA, RA, UC
Zymfentra® (infliximab-dyyb SC injection)	Inhibition of TNF	CD, UC
Simponi®, Simponi Aria® (golimumab SC injection, golimumab IV infusion)	Inhibition of TNF	SC formulation: AS, PsA, RA, UC
		IV formulation: AS, PJIA, PsA, RA
Tocilizumab Products (Actemra® IV, biosimilar; Actemra SC, biosimilar)	Inhibition of IL-6	SC formulation: PJIA, RA, SJIA

		IV formulation: PJIA, RA, SJIA
Kevzara® (sarilumab SC injection)	Inhibition of IL-6	RA
Orencia® (abatacept IV infusion, abatacept SC injection)	T-cell costimulation modulator	SC formulation: JIA, PSA, RA
		IV formulation: JIA, PsA, RA
Rituximab IV Products (Rituxan®, biosimilars)	CD20-directed cytolytic antibody	RA
Kineret® (anakinra SC injection)	Inhibition of IL-1	JIA^, RA
Omvoh® (mirikizumab IV infusion, SC injection)	Inhibition of IL-23	UC, CD
Ustekinumab Products (Stelara® SC injection, biosimilar; Stelara IV infusion, biosimilar)	Inhibition of IL-12/23	SC formulation: CD, PsO, PsA, UC
		IV formulation: CD, UC
Siliq® (brodalumab SC injection)	Inhibition of IL-17	PsO
Cosentyx® (secukinumab SC injection; secukinumab IV infusion)	Inhibition of IL-17A	SC formulation: AS, ERA, nr-axSpA, PsO, PsA
		IV formulation: AS, nr-axSpA, PsA
Taltz® (ixekizumab SC injection)	Inhibition of IL-17A	AS, nr-axSpA, PsO, PsA
Bimzelx® (bimekizumab-bkzx SC injection)	Inhibition of IL-17A/17F	PsO, AS, nr-axSpA, PsA
Ilumya® (tildrakizumab-asmn SC injection)	Inhibition of IL-23	PsO
Skyrizi® (risankizumab-rzaa SC injection, risankizumab-rzaa IV infusion)	Inhibition of IL-23	SC formulation: CD, PSA, PsO, UC
		IV formulation: CD, UC
Tremfya® (guselkumab SC injection, guselkumab IV infusion)	Inhibition of IL-23	SC formulation: CD, PsA, PsO, UC
		IV formulation: CD, UC
Entyvio® (vedolizumab IV infusion, vedolizumab SC injection)	Integrin receptor antagonist	CD, UC
Oral Therapies/Targeted Synthetic Oral Small Molecule Drugs		
Otezla® (apremilast tablets)	Inhibition of PDE4	PsO, PsA
Otezla XR™ (apremilast extended-release tablets)	Inhibition of PDE4	PsO, PsA
Cibinqo™ (abrocitinib tablets)	Inhibition of JAK pathways	AD
Olumiant® (baricitinib tablets)	Inhibition of JAK pathways	RA, AA
Litfulo® (ritlecitinib capsules)	Inhibition of JAK pathways	AA
Leqselvi® (deuruxolitinib tablets)	Inhibition of JAK pathways	AA
Rinvoq® (upadacitinib extended-release tablets)	Inhibition of JAK pathways	AD, AS, nr-axSpA, RA, PsA, CD, UC
Rinvoq® LQ (upadacitinib oral solution)	Inhibition of JAK pathways	PsA, PJIA
Sotyktu® (deucravacitinib tablets)	Inhibition of TYK2	PsO
Xeljanz® (tofacitinib tablets/oral solution)	Inhibition of JAK pathways	RA, PJIA, PsA, UC
Xeljanz® XR (tofacitinib extended-release tablets)	Inhibition of JAK pathways	RA, PsA, UC
Zeposia® (ozanimod tablets)	Sphingosine 1 phosphate receptor modulator	UC

Velsipity® (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.