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Kaiser Foundation Health Plan of Washington
Kaiser Foundation Health Plan of Washington Options, Inc.
Provider Communications, RCR-A3W-04
PO Box 34262, Seattle WA 98124-1262

March 31, 2026

TILDRAKIZUMAB-ASMN (ILUMYA) UPDATED PRIOR AUTHORIZATION CRITERIA

Dear Provider,

Tildrakizumab-asmn (Ilumya) is on the **non-Medicare** list of office-administered drugs requiring prior authorization. **Effective June 1, 2026,** the criteria for Ilumya will be updated to include a quantity limit. **This letter is a notification of the upcoming change in coverage for this medication under the medical benefit.**

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington, Options, Inc. (Kaiser Permanente) require prior authorization for a select group of injectable drugs that may be administered under the medical benefit in a physician's office or by home infusion. These reviews are intended to ensure consistent benefit adjudication as well as appropriate utilization in accordance with the Kaiser Permanente Pharmacy & Therapeutics Committee's evidence-based criteria for coverage.

Prior Authorization Criteria for Tildrakizumab-asmn (Ilumya) (changes are in bold):

DRUG NAME	COVERAGE CRITERIA

Tildrakizumab-asmn (Ilumya)	Psoriasis
	• Age ≥ 18 years
	• Diagnosis of moderate to severe psoriasis, including psoriasis involving the genital area
	• Failed an adequate trial, or has an allergy, intolerance, or contraindication to the following:
	  ○ Topical psoriasis treatment (e.g., topical corticosteroids, calcineurin inhibitors, vitamin D analogs, etc.)
	  ○ Non-Biologic Therapies (≥ 2 of the following):
	  ▪ Phototherapy (12-week trial)
	  ▪ Acitretin
	  ▪ Methotrexate
	  ▪ Note: Cyclosporine may count toward the required prerequisite therapy but is not required
	  ○ TNF Inhibitors (≥ 1 of the following):
	  ▪ adalimumab (e.g., Amjevita)
	  ▪ infliximab (e.g., Inflectra)
	  ○ IL-12/23 Inhibitor:
	  ▪ ustekinumab (e.g., Yesintek)
	  ○ IL-17 Inhibitor:
	  ▪ secukinumab (Cosentyx)
	  ○ IL-23 Inhibitors (all the following):
	  ▪ guselkumab (Tremfya)
	  ▪ risankizumab-rzaa (Skyrizi)
	Quantity Limits:
	• **100 mg at weeks 0, 4, and then every 12 weeks**
	Not covered for use in combination with disease modifying or other biologic therapies

DRUG NAME	COVERAGE CRITERIA
	Note: Must be administered in a non-hospital setting. See site of care policy for criteria, reauthorization, and exceptions for new starts.

Additional Information

A complete list of office-administered injectable drugs requiring prior authorization can be found on the Kaiser Permanente provider website at https://wa-provider.kaiserpermanente.org/provider-manual/clinical-review/officeinject.

To request prior authorization review, please use the Referral Request online form (login required) located on the Kaiser Permanente provider website. You can also fax your request to the Review Services department toll-free at 1-888-282-2685.

Thank you for the care you provide to our members, your patients. If you have any questions about this process, please call Review Services at 1-800-289-1363, Monday through Friday, from 8:00 a.m. to 5:00 p.m.

Sincerely,

Ravi Ubriani, MD, Chair
Pharmacy & Therapeutics Committee