UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 2204-11
Program	Prior Authorization/Medical Necessity
Medication	*Ustekinumab: **Otulfi® (ustekinumab-aauz), **Pyzchiva® (ustekinumab-ttwe), **Selarsdi™ (ustekinumab-aekn), **Stelara® (ustekinumab), Steqeyma® (ustekinumab-stba), **Ustekinumab-ttwe, Wezlana™ (ustekinumab-auub), and Yesintek™ (ustekinumab-kfce) *This program applies to the subcutaneous formulation of ustekinumab. **Otulfi (ustekinumab-aauz), Pyzchiva (ustekinumab-ttwe), Selarsdi (ustekinumab-aekn), Stelara® (ustekinumab), and Ustekinumab-ttwe are excluded from coverage for the majority of our benefits.
P&T Approval Date	5/2020, 5/2021, 6/2021, 12/2021, 9/2022, 3/2023, 7/2023, 10/2024, 3/2025, 5/2025
Effective Date	9/15/2025

1. Background:

Ustekinumab is a human interleukin-12 and -23 antagonist indicated for the treatment of adult and pediatric patients 6 years of age or older with active psoriatic arthritis and for moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy. It is also indicated in adult patients with moderately to severely active Crohn's disease and for moderately to severely active ulcerative colitis.

2. Coverage Criteria[a]:

A. <u>Plaque Psoriasis</u>

1. **<u>Initial Authorization</u>**

a. **Ustekinumab** 45 mg/0.5 mL will be approved based on **<u>all</u>** of the following criteria:

(1) Diagnosis of moderate to severe plaque psoriasis

-AND-

(2) **<u>One</u>** of the following:

(a) **<u>All</u>** of the following:

i. Greater than or equal to 3% body surface area involvement, palmoplantar, facial, genital involvement, or severe scalp psoriasis

-AND-

ii. History of failure to **one** of the following topical therapies, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial):

a. Corticosteroids (e.g., betamethasone, clobetasol, desonide)
b. Vitamin D analogs (e.g., calcitriol, calcipotriene)
c. Tazarotene
d. Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
e. Anthralin
f. Coal tar

-AND-

iii. History of failure to a 3 month trial of methotrexate at maximally indicated dose, unless contraindicated or clinically significant adverse effects are experienced (document date and duration of trial)[b]

-OR-

(b) Patient has been previously treated with a targeted immunomodulator FDA-approved for the treatment of plaque psoriasis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., Cimzia (certolizumab), adalimumab, Otezla (apremilast), Skyrizi (risankizumab), Tremfya (guselkumab)].

-OR-

(c) **Both** of the following:

i. Patient is currently on the requested ustekinumab product therapy as documented by claims history or submission of medical records (Document date and duration of therapy):

-AND-

ii. Patient has **not** received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from a manufacturer sponsored program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of the requested ustekinumab product *

-AND-

(3) Patient is not receiving the requested ustekinumab product in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

-AND-

(4) Prescribed by or in consultation with a dermatologist

***** Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from a manufacturersponsored program **shall be required** to meet initial authorization criteria as if patient were new to therapy.

Authorization will be issued for 12 months.

b. **Ustekinumab** 90 mg/1 mL will be approved based on **all** of the following criteria:

(1) Diagnosis of moderate to severe plaque psoriasis

-AND-

(2) Patient's weight is > 100 kg (220 lbs.)

-AND-

(3) **One** of the following:

(a) **All** of the following:

i. Greater than or equal to 3% body surface area involvement, palmoplantar, facial, genital involvement, or severe scalp psoriasis

-AND-

ii. History of failure to **one** of the following topical therapies, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial):

a. Corticosteroids (e.g., betamethasone, clobetasol, desonide)
b. Vitamin D analogs (e.g., calcitriol, calcipotriene)
c. Tazarotene
d. Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
e. Anthralin
f. Coal tar

-AND-

iii. History of failure to a 3 month trial of methotrexate at maximally indicated dose, unless contraindicated or clinically significant adverse effects are experienced (document date and duration of trial)[b]

-OR-

(b) Patient has been previously treated with a targeted immunomodulator FDA-approved for the treatment of plaque psoriasis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., Cimzia (certolizumab), adalimumab, Otezla (apremilast), Skyrizi (risankizumab), Tremfya (guselkumab)].

-OR-

(c) **Both** of the following:

i. Patient is currently on the requested ustekinumab product therapy as documented by claims history or submission of medical records (Document date and duration of therapy):

-AND-

ii. Patient has **not** received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from a manufacturer sponsored program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of the requested ustekinumab product *

-AND-

(4) Patient is not receiving the requested ustekinumab product in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

-AND-

(5) Prescribed by or in consultation with a dermatologist

* Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from a manufacturersponsored program **shall be required** to meet initial authorization criteria as if patient were new to therapy.

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Ustekinumab** 45 mg/0.5 mL or 90 mg/mL will be approved based on **all** of the following criteria:

(1) Documentation of positive clinical response to the requested ustekinumab therapy

-AND-

(2) Patient is not receiving the requested ustekinumab product in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

Authorization will be issued for 12 months.

B. Psoriatic Arthritis (PsA)

1. **Initial Authorization**

a. **Ustekinumab** 45 mg/0.5 mL will be approved based on **all** of the following criteria:

(1) Diagnosis of active psoriatic arthritis

-AND-

(2) **One** of the following:

(a) History of failure to a 3 month trial of methotrexate at maximally indicated dose, unless contraindicated or clinically significant adverse effects are experienced (document date and duration of trial)[b]

-OR-

(b) Patient has been previously treated with a targeted immunomodulator FDA-approved for the treatment of psoriatic arthritis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Tremfya (guselkumab) Xeljanz (tofacitinib), Otezla (apremilast), Rinvoq (upadacitinib)].

-OR-

(c) **Both** of the following:

i. Patient is currently on the requested ustekinumab product therapy as documented by claims history or submission of medical records (Document date and duration of therapy):

-AND-

ii. Patient has **not** received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from a manufacturer

sponsored program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of the requested ustekinumab product *

-AND-

(3) Patient is not receiving the requested ustekinumab product in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

-AND-

(4) Prescribed by or in consultation with **one** of the following:

(a) Rheumatologist
(b) Dermatologist

* Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from a manufacturersponsored program **shall be required** to meet initial authorization criteria as if patient were new to therapy.

Authorization will be issued for 12 months.

b. **Ustekinumab** 90 mg/1 mL will be approved based on **all** of the following criteria:

(1) Diagnosis of active psoriatic arthritis

-AND-

(2) Patient's weight is > 100 kg (220 lbs.)

-AND-

(3) **One** of the following:

(a) History of failure to a 3 month trial of methotrexate at maximally indicated dose, unless contraindicated or clinically significant adverse effects are experienced (document date and duration of trial)[b]

-OR-

(b) Patient has been previously treated with a targeted immunomodulator FDA-approved for the treatment of psoriatic arthritis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., Cimzia (certolizumab), adalimumab, Simponi

(golimumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), Otezla (apremilast), Rinvoq (upadacitinib)].

-OR-

(c) **Both** of the following:

i. Patient is currently on the requested ustekinumab product therapy as documented by claims history or submission of medical records (Document date and duration of therapy):

-AND-

ii. Patient has **not** received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from a manufacturer sponsored program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of the requested ustekinumab product

-AND-

(4) Patient is not receiving the requested ustekinumab product in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

-AND-

(5) Prescribed by or in consultation with **one** of the following:

(a) Rheumatologist
(b) Dermatologist

***** Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from a manufacturersponsored program **shall be required** to meet initial authorization criteria as if patient were new to therapy.

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Ustekinumab** 45 mg/0.5 mL or 90 mg/mL will be approved based on **all** of the following criteria:

(1) Documentation of positive clinical response to the requested ustekinumab therapy

-AND-

(2) Patient is not receiving the requested ustekinumab product in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

***** Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from a manufacturer sponsored program **shall be required** to meet initial authorization criteria as if patient were new to therapy.

Authorization will be issued for 12 months.

C. Crohn's Disease (CD)

1. **Initial Authorization for Maintenance Dosing**

a. **Ustekinumab** 90 mg/1 mL will be approved based on **all** of the following criteria:

(1) Diagnosis of moderately to severely active Crohn's disease

-AND-

(2) **One** of the following:

(a) Patient has been established on therapy with the requested ustekinumab product under an active UnitedHealthcare medical benefit prior authorization for treatment of moderately to severely active Crohn's disease

-OR-

(b) **Both** of the following:

i. Patient is currently on the requested ustekinumab product therapy for moderately to severely active Crohn's disease as documented by claims history or submission of medical records (Document date and duration of therapy):

-AND-

ii. Patient has **not** received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from a manufacturersponsored program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of the requested ustekinumab product *

-AND-

(3) Patient is not receiving the requested ustekinumab product in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Skyrizi (risankizumab)]

-AND-

(4) Prescribed by or in consultation with a gastroenterologist

***** Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from a manufacturer sponsored program **shall be required** to meet initial authorization criteria as if patient were new to therapy.

Authorization will be issued for 12 months.

2. **Reauthorization**

a. Ustekinumab will be approved based on **all** of the following criteria:

(1) Documentation of positive clinical response to the requested ustekinumab therapy

-AND-

(2) Patient is not receiving the requested ustekinumab product in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Skyrizi (risankizumab)]

Authorization will be issued for 12 months.

D. Ulcerative Colitis

1. **Initial Authorization**

a. **Ustekinumab** 90 mg/1 mL will be approved based on **all** of the following criteria:

(1) Diagnosis of moderately to severely active ulcerative colitis

-AND-

(2) **One** of the following:

(a) Patient has been established on therapy with the requested ustekinumab product under an active UnitedHealthcare medical benefit prior

authorization for treatment of moderately to severely active ulcerative colitis

-OR-

(b) **Both** of the following:

i. Patient is currently on the requested ustekinumab product therapy for moderately to severely active ulcerative colitis as documented by claims history or submission of medical records (Document date and duration of therapy):

-AND-

ii. Patient has **not** received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from a manufacturer sponsored program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of the requested ustekinumab product *

-AND-

(3) Patient is not receiving the requested ustekinumab product in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Skyrizi (risankizumab)]

-AND-

(4) Prescribed by or in consultation with a gastroenterologist

* Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from a manufacturersponsored program **shall be required** to meet initial authorization criteria as if patient were new to therapy.

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Ustekinumab** will be approved based on **all** of the following criteria:

(1) Documentation of positive clinical response to the requested ustekinumab therapy

-AND-

(2) Patient is not receiving the requested ustekinumab product in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia

(certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Skyrizi (risankizumab)]

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.
[b] For Connecticut, Kentucky and Mississippi business only a 30-day trial will be required.

**Otulfi (ustekinumab-aauz), Pyzchiva (ustekinumab-ttwe), Selarsdi (ustekinumab-aekn), Stelara (ustekinumab), and Ustekinumab-ttwe are excluded from coverage for the majority of our benefits.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.
- The intravenous infusion is typically covered under the medical benefit. Please refer to the UnitedHealthcare Drug Policy for Ustekinumab.

4. Reference:

1. Stelara [package insert]. Horsham, PA: Janssen Biotech Inc.; March 2024.
2. Menter A, Gottlieb A, Feldman SR, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis: Section 1. Overview of psoriasis and guidelines of care for the treatment of psoriasis with biologics. J Am Acad Dermatol 2008; 58(5):826-50.
3. Gottlieb A, Korman NJ, Gordon KB, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Psoriatic arthritis: Overview and guidelines of care for treatment with an emphasis on the biologics. J Am Acad Dermatol 2008;58(5):851-64.
4. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Section 3. Guidelines of care for the management and treatment of psoriasis with topical therapies. J Am Acad Dermatol 2009;60(4):643-59.
5. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Guidelines of care for the treatment of psoriasis with phototherapy and photochemotherapy. J Am Acad Dermatol 2010;62(1):114-35.
6. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Guidelines of care for the management and treatment of psoriasis with traditional systemic agents. J Am Acad Dermatol 2009;61(3):451-85.
7. Menter A, Korman NJ, Elmets CA,Feldman SR, Gelfand JM, Gordon KB, Guidelines of care for the management of psoriasis and psoriatic arthritis: section 6. Guidelines of care for the treatment of psoriasis and psoriatic arthritis: case-based presentations and evidence-based conclusions. J Am Acad Dermatol. 2011 Jul;65(1):137-74.
8. Feuerstein JD, Isaacs KL, Schneider Y, et al. AGA clinical practice guidelines on the management of moderate to severe ulcerative colitis. Gastroenterology. 2020; 158(5):1450-61.
9. Lichtenstein GR, Loftus EV, Isaacs KL, et al ACG clinical guideline: management of Crohn's disease in adults. Am J Gastroenterol. 2018; 113:481-517.

10. 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;80:1029-72.
11. Steqeyma [package insert]. Jersey City, NJ: Celltrion USA, Inc.; December 2024.
12. Yesintek [package insert]. Cambridge, MA: Biocon Biologics Inc.; November 2024.
13. Selarsdi [package insert], Boston, MA: argenx US, Inc.; June 2025.
14. Otulfi [package insert], Lake Zurich, IL: Fresenius Kabi USA, LLC; September 2024.
15. Pyzchiva [package insert], Princeton, NJ: Sandoz Inc.; December 2024.
16. Wezlana [package insert]. Thousand Oaks, CA: Amgen Inc. for Nuvaila; January 2025.

Program	Prior Authorization/Medical Necessity - Ustekinumab: **Otulfi (ustekinumab-aauz), **Pyzchiva (ustekinumab-ttwe), **Selarsdi (ustekinumab-aekn), **Stelara (ustekinumab), Steqeyma (ustekinumab-stba), **Ustekinumab-ttwe, Wezlana (ustekinumab-auub), and Yesintek (ustekinumab-kfce)
Change Control	
5/2020	New program
5/2021	Annual review. Removed preceding month requirement from failure criteria. Removed prescriber requirement from reauthorization criteria. Updated UC coverage criteria to align with other Med Nec programs. Removed drug documentation where only one drug is required. References and background updated.
6/2021	Added coverage criteria for patients previously treated with a biologic DMARD. Added clarification that submission of medical records is required documenting previous or current therapy with a biologic DMARD in order to bypass step through non-biologic therapies if claim history not available.
12/2021	Updated conventional DMARD bypass language for psoriasis, psoriatic arthritis and ulcerative colitis with no change to clinical intent. Updated initial authorization duration to 12 months for ulcerative colitis. Updated CT/KY footnote.
9/2022	Updated background to include patients 6 years and older with active psoriatic arthritis. Added Mississippi to state mandate footnote. Updated reference.
3/2023	Removed step through conventional therapy for CD and UC. Replaced with verbiage that patient has been established on therapy with Stelara under an active UnitedHealthcare prior authorization. Added Rinvoq as a JAKI example. Changed Humira examples to adalimumab. Updated reference.
7/2023	Updated not receiving in combination language to targeted immunomodulator and updated examples.
10/2024	Annual review. Updated criteria for Crohn's disease and ulcerative colitis for establishment of therapy on the medical benefit without change to clinical coverage intent. Updated reference and state mandate footnote.
3/2025	Added Steqeyma and Yesintek to all coverage criteria in parity with Stelara. Updated background and reference.

5/2025	Renamed program to Ustekinumab. Added Otulfi (ustekinumab-aauz), Pyzchiva (ustekinumab-ttwe), Selarsdi (ustekinumab-aekn), Ustekinumab-ttwe, and Wezlana (ustekinumab-auub) to the program. Added notation stating some products are excluded from coverage for the majority of our benefits. Updated Stelara, Steqeyma, or Yesintek to Ustekinumab throughout the program. Updated references.
9/5/2025	Administrative change to add Wezlana into coverage.