



Drug Coverage Policy

Effective Date09/15/2026
Coverage Policy Number..... DQM039
Policy Title.....Skyrizi Subcutaneous
Drug Quantity Management Policy – Per
Days

Inflammatory Conditions – Skyrizi Subcutaneous Drug Quantity Management Policy – Per Days

- Skyrizi® (risankizumab-rzaa subcutaneous injection – Abbvie)

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

Skyrizi subcutaneous (SC), an interleukin (IL)-23 blocker, is indicated for the following uses:¹

- **Crohn's disease**, for treatment of adults with moderate to severe active disease.
- **Plaque psoriasis**, for the treatment of adults and pediatric patients ≥ 6 years of age with moderate to severe disease who are candidates for systemic therapy or phototherapy.
- **Psoriatic arthritis**, in adults and pediatric patients ≥ 6 years of age with active disease.
- **Ulcerative colitis**, for treatment of adults with moderately to severely active disease.

Dosing

Crohn's Disease

The recommended induction dose of Skyrizi is 600 mg administered by intravenous (IV) infusion at Week 0, Week 4, and Week 8.¹ Then, the recommended maintenance dose is 180 mg or 360 mg administered by SC injection at Week 12 and every 8 weeks thereafter. Use the lowest effective dosage needed to maintain therapeutic response.

Plaque Psoriasis and Psoriatic Arthritis

The recommended dose of Skyrizi for adults is 150 mg at Week 0, Week 4, and then once every 12 weeks thereafter.¹

Pediatric Patients 6 Years of Age and Older The recommended dosage for pediatric patients 6 years of age and older is based on body weight (see Table 1) and administered by subcutaneous injection at Week 0, Week 4, and every 12 weeks thereafter.¹

Table 1. Recommended Dose of Skyrizi for Pediatric Patients 6 Years of Age and Older with Moderate-to-Severe Plaque Psoriasis or Active Psoriatic Arthritis.¹

Body Weight	Recommended Dose
Less than 40kg	55mg
40kg or greater	150mg

Ulcerative Colitis

The recommended induction dose of Skyrizi is 1,200 mg administered by intravenous (IV) infusion at Week 0, Week 4, and Week 8.¹ Then, the recommended maintenance dose is 180 mg or 360 mg administered by SC injection at Week 12 and every 8 weeks thereafter. Use the lowest effective dosage needed to maintain therapeutic response.

Availability

Skyrizi SC is available in the following forms:

- 55 mg/0.37 mL single-dose prefilled syringe
- 150 mg/mL prefilled syringes (each carton contains one syringe)
- 150 mg/mL single-dose prefilled pens (each carton contains one pen)
- 180 mg/1.2 mL (150 mg/mL) single-dose prefilled cartridge with on-body injector
- 360 mg/2.4 mL (150 mg/mL) single-dose prefilled cartridge with on-body injector

Of note, Skyrizi IV administration is available as a 600 mg/10 mL (60 mg/mL) vial. However, the IV vial is not targeted in this policy.

Coverage Policy

POLICY STATEMENT

This Drug Quantity Management program has been developed to promote the safe, effective, and economic use of Skyrizi SC, and to manage potential premature dose escalation. If the Drug Quantity Management rule is not met at the point of service, coverage will be determined by the Criteria below. "One-time" approvals are provided for 30 days. Meeting Drug Quantity Management Program Criteria does not satisfy any other prior authorization or medical necessity criteria requirements.

Drug Quantity Limits

Product	Strength and Form	Retail and Home Delivery Maximum Quantity Per Days
Skyrizi® (risankizumab- rzaa subcutaneous injection)	55 mg/0.37 ml prefilled syringe	55 mg (1 syringe) per 84 days
	150 mg/mL prefilled syringe	150 mg (1 syringe) per 84 days
	150 mg/mL prefilled pen	
	180 mg/1.2 mL (150 mg/mL) prefilled cartridge	1.2 mL (1 prefilled cartridge) per 56 days
	360 mg/2.4 mL (150 mg/mL) prefilled cartridge	2.4 mL (1 prefilled cartridge) per 56 days

Exceptions to the quantity limits listed above are covered as medically necessary when the following criteria are met. Any other exception is considered not medically necessary.

CRITERIA

Skyrizi 55 mg prefilled syringes

1. If the patient is initiating treatment for plaque psoriasis or psoriatic arthritis or requires additional induction dosing for plaque psoriasis or psoriatic arthritis, as verified by the absence of claims for Skyrizi in the past 130 days, approve a one-time override for 110 mg (2 syringes) at retail or home delivery.

Note: The approval quantity is the number of mg of Skyrizi the patient has received in the past 84 days plus 110 mg at retail and home delivery.

Skyrizi 150 mg prefilled pens and prefilled syringes

2. If the patient is initiating treatment for plaque psoriasis or psoriatic arthritis or requires additional induction dosing for plaque psoriasis or psoriatic arthritis, as verified by the absence of claims for Skyrizi in the past 130 days, approve a one-time override for 300 mg (2 pens or syringes) at retail or home delivery.

Note: The approval quantity is the number of mg of Skyrizi the patient has received in the past 84 days plus 300 mg at retail and home delivery.

Skyrizi 180 mg/1.2 mL prefilled cartridge

No overrides.

Skyrizi 360 mg/2.4 mL prefilled cartridge

No overrides.

References

- 1. Skyrizi® subcutaneous injection [prescribing information]. North Chicago, IL: AbbVie; September 2025.

Revision Details

Summary of Changes	Review Date	Effective Date
New policy.	07/23/2026	09/15/2026

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

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