



Drug Coverage Policy

Effective Date09/15/2026

Coverage Policy Number..... DQM040

Policy Title.....Taltz Drug Quantity
Management Policy – Per Days

Inflammatory Conditions – Taltz Drug Quantity Management Policy – Per Days

- Taltz® (ixekizumab subcutaneous injection – Eli Lilly)

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

Taltz, an interleukin (IL)-17A antagonist, is indicated for the following uses:¹

- **Ankylosing spondylitis**, in adults with active disease.
- **Non-radiographic axial spondyloarthritis**, in adults with active disease and objective signs of inflammation.
- **Plaque psoriasis**, in patients ≥ 6 years of age with moderate to severe disease who are candidates for systemic therapy or phototherapy.
- **Psoriatic arthritis**, in adults with active disease.

Dosing

Taltz is administered as a subcutaneous (SC) injection.¹ The recommended dose varies by indication:

- **Adult Plaque Psoriasis:** 160 mg (two 80 mg injections) at Week 0, followed by 80 mg at Weeks 2, 4, 6, 8, 10, and 12, then 80 mg once every 4 weeks.

- **Pediatric Plaque Psoriasis (patients 6 to < 18 years of age):**

Patient's Weight	Starting Dose (Week 0)	Dose Every 4 Weeks Thereafter
> 50 kg	160 mg (two 80 mg injections)	80 mg
25 to 50 kg	80 mg	40 mg
< 25 kg	40 mg	20 mg

- **Psoriatic Arthritis:** 160 mg (two 80 mg injections) at Week 0, followed by 80 mg once every 4 weeks. For psoriatic arthritis patients with coexistent moderate-to-severe plaque psoriasis, use the dosing regimen for plaque psoriasis.
- **Ankylosing Spondylitis:** 160 mg (two 80 mg injections) at Week 0, followed by 80 mg once every 4 weeks.
- **Non-radiographic Axial Spondyloarthritis:** 80 mg once every 4 weeks.

Availability

Taltz is available as an 80 mg/mL solution in a single-dose, prefilled auto-injector supplied in cartons of one, two, or three auto-injectors. It is also available as 20 mg/0.25 mL, 40 mg/0.5 mL, and 80 mg/mL single-dose prefilled syringes supplied in cartons containing one syringe each.

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POLICY STATEMENT

This Drug Quantity Management program has been developed to manage potential premature dose escalation of Taltz. If the Drug Quantity Management rule is not met at the point of service, coverage will be determined by the Criteria below. Approvals are provided for 1 year in duration, unless otherwise noted below. "One-time" approvals are provided for 30 days in duration. 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 Maximum Quantity per 28 Days	Home Delivery Maximum Quantity per 84 Days
Taltz® (ixekizumab subcutaneous injection)	20 mg/0.25 mL prefilled syringe	1 mL (4 syringes)	3 mL (12 syringes)
	40 mg/0.5 mL prefilled syringe	1 mL (2 syringes)	3 mL (6 syringes)
	80 mg/mL prefilled syringe	1 mL (1 syringe)	3 mL (3 syringes)
	80 mg/mL prefilled auto-injector	1 mL (1 autoinjector)	3 mL (3 autoinjectors)

Exceptions to the quantity limits listed above are covered as medically necessary when ONE of the following criteria is met (1, 2, 3, or 4). Any other exception is considered not medically necessary.

CRITERIA

Taltz 20 mg/0.25 mL prefilled syringes

No overrides.

Taltz 40 mg/0.5 mL prefilled syringes

No overrides.

Taltz 80 mg/mL prefilled syringes and auto-injectors

1. If the patient is ≥ 18 years of age and is initiating treatment for psoriatic arthritis or ankylosing spondylitis or requires additional induction dosing for psoriatic arthritis or ankylosing spondylitis, as verified by the absence of claims for Taltz in the past 130 days, approve a one-time override for 2 mL (2 syringes or 2 auto-injectors) at retail or 4 mL (4 syringes or 4 auto-injectors) at home delivery.
2. If the patient is ≥ 18 years of age and is initiating treatment for plaque psoriasis or requires additional induction dosing for plaque psoriasis, as verified by the absence of claims for Taltz in the past 130 days, approve a one-time override for 4 mL (4 syringes or 4 auto-injectors), followed by an approval of 2 mL (2 syringes or 2 auto-injectors) per 28 days for 84 days at retail or a one-time override for 8 mL (8 syringes or 8 auto-injectors) at home delivery.
3. If the patient is ≥ 18 years of age and is currently completing induction dosing for plaque psoriasis, approve 2 mL (2 syringes or 2 auto-injectors) per 28 days for 84 days at retail or a one-time override for 8 mL (8 syringes or 8 auto-injectors) at home delivery.
4. If the patient is < 18 years of age, weighs > 50 kg, and is initiating treatment for plaque psoriasis or requires additional induction dosing for plaque psoriasis, as verified by the absence of claims for Taltz in the past 130 days, approve a one-time override for 2 mL (2 syringes or 2 auto-injectors) at retail or 4 mL (4 syringes or 4 autoinjectors) at home delivery.

References

- 1. Taltz® subcutaneous injection [prescribing information]. Indianapolis, IN: Eli Lilly; August 2024.

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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