



AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Siliq	Page:	1 of 4
Effective Date:	7/31/2026	Last Review Date:	6/18/2026
Applies to:	☒ Florida Kids ☒ Pennsylvania Kids		

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Siliq under the patient's prescription drug benefit.

Description:

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-approved Indications

Treatment of moderate to severe plaque psoriasis (PsO) in adult patients who are candidates for systemic therapy or phototherapy and have failed to respond or have lost response to other systemic therapies.

All other indications are considered experimental/investigational and not medically necessary.

Applicable Drug List:

Non-Preferred: Siliq

Policy/Guideline:

Documentation for all indications:

The patient is unable to take THREE preferred products, where indicated, for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication. Documentation is required for approval.

THREE preferred products:

- Cosentyx
- A preferred adalimumab product OR Enbrel
- One of the following:
 - A preferred ustekinumab product
 - Otezla

Documentation

Submission of the following information is necessary to initiate the prior authorization review:

Initial requests

- Chart notes or medical record documentation of affected area(s) and body surface area (BSA) affected (if applicable).



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- Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.

Continuation requests

Chart notes or medical record documentation of decreased body surface area (BSA) affected and/or improvement in signs and symptoms.

Prescriber Specialties

This medication must be prescribed by or in consultation with a dermatologist.

Coverage Criteria

Plaque psoriasis (PsO)

Authorization of 12 months may be granted for adult members who have previously received a biologic or targeted synthetic drug (e.g., Sotyktu, Otezla) indicated for treatment of moderate to severe plaque psoriasis.

Authorization of 12 months may be granted for adult members for treatment of moderate to severe plaque psoriasis when ANY of the following criteria is met:

- Crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected.
- At least 10% of body surface area (BSA) is affected.
- At least 3% of body surface area (BSA) is affected and the member meets either of the following criteria:
 - Member has had an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin.
 - Member has a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin (see Appendix).

Continuation of Therapy

Authorization of 12 months may be granted for all adult members (including new members) who are using the requested medication for moderate to severe plaque psoriasis and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when EITHER of the following criteria is met:

- Reduction in body surface area (BSA) affected from baseline
- Improvement in signs and symptoms from baseline (e.g., itching, redness, flaking, scaling, burning, cracking, pain)

Other

			
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Member has been evaluated for tuberculosis (TB) infection prior to initiation of treatment with a biologic or targeted synthetic drug associated with an increased risk of TB.

Member cannot use the requested medication concomitantly with any other biologic drug or targeted synthetic drug for the same indication.

Dosage and Administration

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Appendix

Examples of Clinical Reasons to Avoid Pharmacologic Treatment with Methotrexate, Cyclosporine, or Acitretin

- Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease
- Drug interaction
- Risk of treatment-related toxicity
- Pregnancy or currently planning pregnancy
- Breastfeeding
- Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension)
- Hypersensitivity
- History of intolerance or adverse event

Approval Duration and Quantity Restrictions:

Approval:

Initial and Renewal Approval: 12 months

Quantity Level Limit:

- Siliq (brodalumab) 210 mg/1.5 mL prefilled syringe:
 - 2 syringes per 28 days
 - Exception limit: 4 syringes per 28 days

References:

1. Siliq [package insert]. Bridgewater, NJ: Bausch Health US, LLC; February 2026.
2. Lebwohl M, Strober B, Menter A, et al. Phase 3 studies comparing brodalumab with ustekinumab in psoriasis. *N Engl J Med*. 2015;373(14):1318-1328.
3. Menter A, Korman NJ, Elmets CA, et al. 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;65(1):137-174.



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5. Coates LC, Soriano ER, Corp N, et al. Group for Research and Assessment of Psoriasis and Psoriatic Arthritis (GRAPPA): updated treatment recommendations for psoriatic arthritis 2021. Nat Rev Rheumatol. 2022;18(8):465-479.
6. Menter A, Gelfand JM, Connor C, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management of psoriasis with systemic nonbiologic therapies. J Am Acad Dermatol. 2020;82(6):1445-1486. doi:10.1016/j.jaad.2020.02.044.