

# Otezla Prior Authorization with Quantity Limit Program Summary

## POLICY REVIEW CYCLE

**Effective Date**

03-01-2026

**Date of Origin**

## POLICY AGENT SUMMARY PRIOR AUTHORIZATION

Target Brand Agent(s)	Target Generic Agent(s)	Strength	Targeted MSC	Available MSC	Final Age Limit	Preferred Status
Otezla ; Otezla xr ; Otezla/otezla xr 28 day t	apremilast tab ; apremilast tab er ; apremilast tab start pack ; apremilast tab starter therapy pack	10 & 20 & 30 MG ; 10&20&30&(ER)75 MG ; 20 MG ; 30 MG ; 4 x 10 & 51 x20 MG ; 75 MG	M ; N ; O ; Y	N		

## POLICY AGENT SUMMARY QUANTITY LIMIT

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	QL Amount	Dose Form	Day Supply	Duration	Addtl QL Info	Allowed Exceptions	Targeted NDCs When Exclusions Exist
Otezla	apremilast tab	20 MG	60	Tablets	30	DAYS			
Otezla	Apremilast Tab 30 MG	30 MG	60	Tablets	30	DAYS			
Otezla	apremilast tab starter therapy pack	4 x 10 & 51 x20 MG	1	Pack	180	DAYS	55 tablets = 1 kit		
Otezla	Apremilast Tab Starter Therapy Pack 10 MG & 20 MG & 30 MG	10 & 20 & 30 MG	1	Pack	180	DAYS	55 tablets = 1 kit		
Otezla xr	apremilast tab er	75 MG	30	Tablets	30	DAYS			
Otezla/otezla xr 28 day t	apremilast tab start pack	10&20&30&(ER)75 MG	1	Pack	180	DAYS	41 tablets = 1 pack		

## ADDITIONAL QUANTITY LIMIT INFORMATION

Wildcard	Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Additional QL Information	Targeted NDCs When Exclusions Exist	Effective Date	Term Date
6670001500B710	Otezla	apremilast tab starter therapy pack	4 x 10 & 51 x20 MG	55 tablets = 1 kit		08-26-2024	
6670001500B720	Otezla	Apremilast Tab Starter Therapy Pack 10 MG & 20 MG & 30 MG	10 & 20 & 30 MG	55 tablets = 1 kit			

Wildcard	Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Additional QL Information	Targeted NDCs When Exclusions Exist	Effective Date	Term Date
6670001500B740	Otezla/otezla xr 28 day t	apremilast tab start pack	10&20&30&(ER)75 MG	41 tablets = 1 pack		10-20-2025	

### CLIENT SUMMARY – PRIOR AUTHORIZATION

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Otezla ; Otezla xr ; Otezla/otezla xr 28 day t	apremilast tab ; apremilast tab er ; apremilast tab start pack ; apremilast tab starter therapy pack	10 & 20 & 30 MG ; 10&20&30&(ER)75 MG ; 20 MG ; 30 MG ; 4 x 10 & 51 x20 MG ; 75 MG	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL HMO Performance Quarterly ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods

### CLIENT SUMMARY – QUANTITY LIMITS

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Otezla	apremilast tab	20 MG	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL HMO Performance Quarterly ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Otezla	Apremilast Tab 30 MG	30 MG	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL HMO Performance Quarterly ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ;

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Otezla	apremilast tab starter therapy pack	4 x 10 & 51 x20 MG	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL HMO Performance Quarterly ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Otezla	Apremilast Tab Starter Therapy Pack 10 MG & 20 MG & 30 MG	10 & 20 & 30 MG	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL HMO Performance Quarterly ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Otezla xr	apremilast tab er	75 MG	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL HMO Performance Quarterly ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Otezla/otezla xr 28 day t	apremilast tab start pack	10&20&30&(ER)75 MG	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL HMO Performance Quarterly ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods

## PRIOR AUTHORIZATION CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
PA	<p><b>Initial Evaluation</b></p> <p><b>Target Agent(s)</b> will be approved when the ALL of the following are met:</p> <ol style="list-style-type: none"> <li>1. ONE of the following: <ol style="list-style-type: none"> <li>A. The requested agent is eligible for continuation of therapy AND the following: <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p style="text-align: center;"><b>Agents Eligible for Continuation of Therapy</b></p> <p style="text-align: center;">All target agents are eligible for continuation of therapy</p> </div> </li> <li>1. The prescriber states the patient has been treated with the requested agent (starting on samples is not approvable) within the past 90 days AND is at risk if therapy is changed <b>OR</b></li> </ol> </li> <li>B. BOTH of the following: <ol style="list-style-type: none"> <li>1. ONE of the following: <ol style="list-style-type: none"> <li>A. The patient has a diagnosis of active psoriatic arthritis (PsA) AND BOTH of the following: <ol style="list-style-type: none"> <li>1. If the patient is a pediatric patient 6 years of age or older, then ONE of the following: <ol style="list-style-type: none"> <li>A. The requested agent is Otezla AND the patient weighs at least 20 kg <b>OR</b></li> <li>B. The requested agent is Otezla XR AND the patient weighs at least 50 kg <b>AND</b></li> </ol> </li> <li>2. ONE of the following: <ol style="list-style-type: none"> <li>A. The patient has ONE of the following: <ol style="list-style-type: none"> <li>1. Tried and had an inadequate response to ONE conventional agent (i.e., cyclosporine, leflunomide, methotrexate, sulfasalazine) used in the treatment of PsA after at least a 3-month duration of therapy <b>OR</b></li> <li>2. An intolerance or hypersensitivity to ONE conventional agent used in the treatment of PsA <b>OR</b></li> </ol> </li> </ol> </li> </ol> </li> </ol> </li> </ol> </li></ol>

Module	Clinical Criteria for Approval
	<p style="text-align: center;">3. An FDA labeled contraindication to ALL conventional agents used in the treatment of PsA <b>OR</b></p> <p>B. The patient's medication history (excluding sample use) indicates use of a biologic immunomodulator agent or a systemic targeted synthetic small molecule drug (e.g., oral JAK inhibitor) that is FDA labeled or supported in compendia for the treatment of PsA <b>OR</b></p> <p>B. The patient has a diagnosis of plaque psoriasis (PS) AND BOTH of the following:</p> <ol style="list-style-type: none"> <li>1. If the patient is a pediatric patient 6 years of age or older, then BOTH of the following: <ol style="list-style-type: none"> <li>A. The patient has moderate to severe plaque psoriasis <b>AND</b></li> <li>B. ONE of the following: <ol style="list-style-type: none"> <li>1. The requested agent is Otezla AND the patient weighs at least 20 kg <b>OR</b></li> <li>2. The requested agent is Otezla XR AND the patient weighs at least 50 kg <b>AND</b></li> </ol> </li> </ol> </li> <li>2. ONE of the following: <ol style="list-style-type: none"> <li>A. The patient has ONE of the following: <ol style="list-style-type: none"> <li>1. Tried and had an inadequate response to ONE conventional agent (i.e., acitretin, calcipotriene, calcitriol, coal tar, cyclosporine, methotrexate, pimecrolimus, PUVA [phototherapy], tacrolimus, tazarotene, topical corticosteroids) used in the treatment of PS after at least a 3-month duration of therapy <b>OR</b></li> <li>2. An intolerance or hypersensitivity to ONE conventional agent used in the treatment of PS <b>OR</b></li> <li>3. An FDA labeled contraindication to ALL conventional agents used in the treatment of PS <b>OR</b></li> </ol> </li> <li>B. The patient's medication history (excluding sample use) indicates use of a biologic immunomodulator agent or a systemic targeted synthetic small molecule drug (e.g., oral JAK inhibitor) that is FDA labeled or supported in compendia for the treatment of PS <b>OR</b></li> </ol> </li> </ol> <p>C. The patient has a diagnosis of Behcet's disease (BD) AND ALL of the following:</p> <ol style="list-style-type: none"> <li>1. The patient has active oral ulcers associated with BD <b>AND</b></li> <li>2. The patient has had at least 3 occurrences of oral ulcers in the last 12-months <b>AND</b></li> <li>3. ONE of the following: <ol style="list-style-type: none"> <li>A. BOTH of the following: <ol style="list-style-type: none"> <li>1. ONE of the following: <ol style="list-style-type: none"> <li>A. The patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer <b>OR</b></li> <li>B. The patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer [chart notes required] <b>AND</b></li> </ol> </li> <li>2. The use of the requested agent is consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed,</li> </ol> </li> </ol> </li> </ol>

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	<p>evidence-based literature; and approved by the United States Food and Drug Administration <b>OR</b></p> <p>B. The patient has ONE of the following:</p> <ol style="list-style-type: none"> <li>1. Tried and had an inadequate response to ONE conventional agent (i.e., topical oral corticosteroids [i.e., triamcinolone dental paste], colchicine, azathioprine) used in the treatment of BD <b>OR</b></li> <li>2. An intolerance or hypersensitivity to ONE conventional agent used in the treatment of BD <b>OR</b></li> <li>3. An FDA labeled contraindication to ALL conventional agents used in the treatment of BD <b>OR</b></li> </ol> <p>C. The patient's medication history (excluding sample use) indicates use of a biologic immunomodulator agent or a systemic targeted synthetic small molecule drug (e.g., oral JAK inhibitor) that is FDA labeled or supported in compendia for the treatment of BD <b>OR</b></p> <p>D. The patient has another FDA labeled indication for the requested agent and route of administration <b>AND</b></p> <p>2. If the patient has an FDA labeled indication, then ONE of the following:</p> <ol style="list-style-type: none"> <li>A. The patient's age is within FDA labeling for the requested indication for the requested agent <b>OR</b></li> <li>B. There is support for using the requested agent for the patient's age for the requested indication <b>OR</b></li> </ol> <p>C. The patient has another indication that is supported in compendia for the requested agent and route of administration <b>AND</b></p> <p>2. ONE of the following (Please refer to "Agents NOT to be used Concomitantly" table):</p> <ol style="list-style-type: none"> <li>A. The patient will NOT be using the requested agent in combination with another immunomodulatory agent (e.g., TNF inhibitors, JAK inhibitors, IL-4 inhibitors) <b>OR</b></li> <li>B. The patient will be using the requested agent in combination with another immunomodulatory agent <b>AND BOTH</b> of the following: <ol style="list-style-type: none"> <li>1. The prescribing information for the requested agent does NOT limit the use with another immunomodulatory agent <b>AND</b></li> <li>2. There is support for the use of combination therapy (submitted copy of clinical trials, phase III studies, or guidelines required) <b>AND</b></li> </ol> </li> </ol> <p>3. ONE of the following:</p> <ol style="list-style-type: none"> <li>A. The patient has a diagnosis of mild severity plaque psoriasis <b>OR</b></li> <li>B. The prescriber is a specialist in the area of the patient's diagnosis (e.g., dermatologist, rheumatologist), or the prescriber has consulted with a specialist in the area of the patient's diagnosis <b>AND</b></li> </ol> <p>4. The patient does NOT have any FDA labeled contraindications to the requested agent</p> <p><b>Compendia Allowed:</b> AHFS, DrugDex 1, 2a, or 2b level of evidence, or NCCN 1, 2a, or 2b recommended use</p> <p><b>Length of Approval:</b></p> <p>BCBSOK: 36 months</p> <p>BCBSIL and BCBSMT: Approve for 12 months (if approving starter pack that has separate GPI-14, approve both starter pack and maintenance product for 12 months each)</p> <p>ALL other plans: 12 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.</p>

Module	Clinical Criteria for Approval
	<p><b>The requested agent will also be approved when the following are met:</b></p> <ol style="list-style-type: none"> <li>1. The member resides in Ohio <b>AND</b></li> <li>2. The plan is Fully Insured or HIM Shop (SG) <b>AND</b> BOTH of the following <ol style="list-style-type: none"> <li>A. The patient does NOT have any FDA labeled contraindications to the requested agent <b>AND</b></li> <li>B. ONE of the following: <ol style="list-style-type: none"> <li>1. The patient has another FDA labeled indication for the requested agent and route of administration <b>OR</b></li> <li>2. The patient has another indication that is supported in compendia for the requested agent and route of administration <b>OR</b></li> <li>3. The prescriber has submitted TWO articles from major peer-reviewed professional medical journals [e.g., Journal of American Medical Association (JAMA), New England Journal of Medicine (NEJM), Lancet] supporting the proposed use(s) as generally safe and effective. Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. NOTE: Case studies are not acceptable [journal articles required]</li> </ol> </li> </ol> </li> </ol> <p><b>Non-oncology compendia allowed:</b> DrugDex level 1, 2A or 2B, AHFS-DI (narrative text must be supportive)</p> <p><b>Oncology compendia allowed:</b> NCCN 1 or 2A, AHFS-DI (narrative text must be supportive), DrugDex level 1, 2A, or 2B, or Clinical Pharmacology (narrative text must be supportive), Lexi-Drugs evidence level A, peer-reviewed medical literature</p> <p><b>Length of Approval:</b></p> <p>BCBSOK: 36 months</p> <p>ALL other plans: 12 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.</p> <p><b>Renewal Evaluation</b></p> <p><b>Target Agent(s)</b> will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> <li>1. The patient has been previously approved for the requested agent through the plan's Prior Authorization process (Note: patients not previously approved for the requested agent will require initial evaluation review) <b>AND</b></li> <li>2. The patient has had clinical benefit with the requested agent <b>AND</b></li> <li>3. ONE of the following (Please refer to "Agents NOT to be used Concomitantly" table): <ol style="list-style-type: none"> <li>A. The patient will NOT be using the requested agent in combination with another immunomodulatory agent (e.g., TNF inhibitors, JAK inhibitors, IL-4 inhibitors) <b>OR</b></li> <li>B. The patient will be using the requested agent in combination with another immunomodulatory agent <b>AND</b> BOTH of the following: <ol style="list-style-type: none"> <li>1. The prescribing information for the requested agent does NOT limit the use with another immunomodulatory agent <b>AND</b></li> <li>2. There is support for the use of combination therapy (submitted copy of clinical trials, phase III studies, or guidelines required) <b>AND</b></li> </ol> </li> </ol> </li> <li>4. ONE of the following: <ol style="list-style-type: none"> <li>A. The patient has a diagnosis of mild severity plaque psoriasis <b>OR</b></li> <li>B. The prescriber is a specialist in the area of the patient's diagnosis (e.g., dermatologist, rheumatologist), or the prescriber has consulted with a specialist in the area of the patient's diagnosis <b>AND</b></li> </ol> </li> </ol>

Module	Clinical Criteria for Approval
	<p>5. The patient does NOT have any FDA labeled contraindications to the requested agent</p> <p><b>Length of Approval:</b></p> <p>BCBSOK: 36 months</p> <p>ALL other plans: 12 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.</p>

### QUANTITY LIMIT CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	<p><b>Quantity Limit for the Target Agent(s)</b> will be approved when ONE of the following is met:</p> <ol style="list-style-type: none"> <li>1. The requested quantity (dose) does NOT exceed the program quantity limit <b>OR</b></li> <li>2. The requested quantity (dose) exceeds the program quantity limit AND ONE of the following: <ol style="list-style-type: none"> <li>A. BOTH of the following: <ol style="list-style-type: none"> <li>1. The requested agent does NOT have a maximum FDA labeled dose for the requested indication <b>AND</b></li> <li>2. There is support for therapy with a higher dose for the requested indication (submitted copy of clinical trials, phase III studies, or guidelines required) <b>OR</b></li> </ol> </li> <li>B. BOTH of the following: <ol style="list-style-type: none"> <li>1. The requested quantity (dose) does NOT exceed the maximum FDA labeled dose for the requested indication <b>AND</b></li> <li>2. The requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does not exceed the program quantity limit <b>OR</b></li> </ol> </li> <li>C. BOTH of the following: <ol style="list-style-type: none"> <li>1. The requested quantity (dose) exceeds the maximum FDA labeled dose for the requested indication <b>AND</b></li> <li>2. There is support of therapy with a higher dose for the requested indication (submitted copy of clinical trials, phase III studies, or guidelines required)</li> </ol> </li> </ol> </li> </ol> <p><b>Length of Approval:</b> 12 months</p>

### CONTRAINDICATION AGENTS

Contraindicated as Concomitant Therapy
<p><b>Agents NOT to be used Concomitantly</b></p> <p>Abrilada (adalimumab-afzb)</p> <p>Actemra (tocilizumab)</p> <p>Adalimumab</p> <p>Adbry (tralokinumab-ldrm)</p> <p>Amjevita (adalimumab-atto)</p> <p>Arcalyst (rilonacept)</p> <p>Avsola (infliximab-axxq)</p> <p>Avtozma (tocilizumab-anoh)</p> <p>Benlysta (belimumab)</p> <p>Bimzelx (bimekizumab-bkzx)</p> <p>Cibinqo (abrocitinib)</p> <p>Cimzia (certolizumab)</p> <p>Cinqair (reslizumab)</p> <p>Cosentyx (secukinumab)</p> <p>Cyltezo (adalimumab-adbm)</p> <p>Dupixent (dupilumab)</p>

**Contraindicated as Concomitant Therapy**

Ebglyss (lebrikizumab-lbkz)  
Enbrel (etanercept)  
Entyvio (vedolizumab)  
Fasenra (benralizumab)  
Hadlima (adalimumab-bwwd)  
Hulio (adalimumab-fkjp)  
Humira (adalimumab)  
Hyrimoz (adalimumab-adaz)  
Idacio (adalimumab-aacf)  
Ilaris (canakinumab)  
Ilumya (tildrakizumab-asmn)  
Imuldosa (ustekinumab-srlf)  
Inflixtra (infliximab-dyyb)  
Infliximab  
Kevzara (sarilumab)  
Kineret (anakinra)  
Leqselvi (deuruxolitinib)  
Litfulo (ritlecitinib)  
Nemludio (nemolizumab-ilto)  
Nucala (mepolizumab)  
Olumiant (baricitinib)  
Omyclo (omalizumab-igec)  
Omvoh (mirikizumab-mrkz)  
Opzelura (ruxolitinib)  
Orencia (abatacept)  
Otezla (apremilast)  
Otezla XR (apremilast extended-release)  
Otulfi (ustekinumab-aaaz)  
Pyzchiva (ustekinumab-ttwe)  
Remicade (infliximab)  
Renflexis (infliximab-abda)  
Rhapsido (remibrutinib)  
Riabni (rituximab-arrx)  
Rinvoq (upadacitinib)  
Rituxan (rituximab)  
Rituxan Hycela (rituximab/hyaluronidase human)  
Ruxience (rituximab-pvvr)  
Saphnelo (anifrolumab-fnia)  
Selarsdi (ustekinumab-aekn)  
Siliq (brodalumab)  
Simlandi (adalimumab-ryvk)  
Simponi (golimumab)  
Simponi ARIA (golimumab)  
Skyrizi (risankizumab-rzaa)  
Sotyktu (deucravacitinib)  
Spevigo (spesolimab-sbzo) subcutaneous injection  
Starjemza (ustekinumab-hmny)  
Stelara (ustekinumab)  
Steqeyma (ustekinumab-stba)  
Taltz (ixekizumab)  
Tezspire (tezepelumab-ekko)  
Tofidence (tocilizumab-bavi)  
Tremfya (guselkumab)  
Truxima (rituximab-abbs)  
Tyenne (tocilizumab-aazg)  
Tyruko (natalizumab-sztn)  
Tysabri (natalizumab)  
Ustekinumab  
Velsipity (etrasimod)  
Wezlana (ustekinumab-auub)  
Xeljanz (tofacitinib)  
Xeljanz XR (tofacitinib extended release)

**Contraindicated as Concomitant Therapy**

Xolair (omalizumab)  
Yesintek (ustekinumab-kfce)  
Yuflyma (adalimumab-aaty)  
Yusimry (adalimumab-aqvh)  
Zeposia (ozanimod)  
Zymfentra (infliximab-dyyb)