DRUG DETERMINATION POLICY

Title: DDP-11 Interleukin Inhibitors

Effective Date: 05/31/2019

Physicians Health Plan
PHP Insurance Company
PHP Service Company

Important Information - Please Read Before Using This Policy

The following policy applies to health benefit plans administered by PHP and may not be covered by all PHP plans. Please refer to the member's benefit document for specific coverage information. If there is a difference between this general information and the member's benefit document, the member's benefit document will be used to determine coverage. For example, a member's benefit document may contain a specific exclusion related to a topic addressed in a coverage policy.

Benefit determinations for individual requests require consideration of:

1. The terms of the applicable benefit document in effect on the date of service.
2. Any applicable laws and regulations.
3. Any relevant collateral source materials including coverage policies.
4. The specific facts of the particular situation.

Contact PHP Customer Service to discuss plan benefits more specifically.

1.0 Policy:

This policy describes the determination process for coverage of specific drugs.

This policy does not guarantee or approve benefits. Coverage depends on the specific benefit plan. Drug Determination Policies are not recommendations for treatment and should not be used as treatment guidelines.

2.0 Background or Purpose:

Preferred Interleukin Inhibitors are specialty drugs indicated for a number of diagnoses and are associated with significant toxicity. These medications include, but are not limited to: Actemra (tocilizumab), Cosentyx (secukinumab), and Stelara (ustekinumab).These criteria for prior approval (PA) were developed and implemented to ensure appropriate use for the intended diagnoses and mitigation of toxicity, if possible.

3.0 Clinical Determination Guidelines:

Document the following with chart notes:

I. Inflammatory bowel disease (IBD)

A. Crohn's disease (CD)

1. Age: ≥18 years.
2. Prescriber: gastroenterologist.
3. Diagnosis and severity: Moderate to severe active CD disease.
4. Other therapies: contraindicated, failed or significant adverse effects (one of two below):
   a. Conventional therapies (4 months.): mesalamine, metronidazole.
   b. DMARD (4 months.): thiopurines (azathioprine/6-MP), methotrexate.
5. Dosage regimen:
   a. Stelara IV and SC (ustekinumab): load: ≤55Kg - 260mg; >55-85Kg - 390mg; >85Kg - 520mg IV times one, then 90 mg SC every eight weeks.

6. Approval
    a. Initial: six months.
    b. Re-approval: one year.
7. Exceptions: skipping the requirements of "*2. Other therapies"* are allowed if patient exhibits severe or fulminant disease (See Appendix III).

II. Rheumatology

A. Rheumatoid Arthritis (RA)

1. Age: ≥18 years.
2. Prescriber: rheumatologist.
3. Diagnosis and severity: moderate - severe RA.
4. Other therapies: contraindicated, failed or had significant adverse events with two therapies with different mechanisms of action: chronic DMARD (four months): leflunomide or methotrexate, hydroxychloroquine, sulfasalazine.
5. Dosage regimen.
    a. Actemra IV (tocilzumab): 4mg/Kg q four weeks; increase to 8mg per Kg with inadequate response (max. 800mg).
6. Exclude: Actemra subcutaneous (tocilzumab) and Kevzara SC (sarilumab).
    a. All preferred products are contraindicated, failed or resulted in significant adverse effects.
    b. Required site of care determined by the Health Plan.

B. Psoriatic Arthritis (PA)

1. Age: ≥18years.
2. Prescriber: rheumatologist.
3. Diagnosis and severity: active PA with at least five swollen and at least five tender joints.
4. Other therapies: contraindicated, failed or to significant adverse effects from two of the appropriate category below:
    a. Peripheral disease: DMARD therapy (four months) - methotrexate, leflunomide, sulfasalazine.
    b. Axial disease, enthesitis, dactylitis and uveitis: NSAIDs (four months).
5. Exclude: Taltz SC (ixekizumab).
    a. All preferred products are contraindicated, failed or resulted in significant adverse effects.
    b. Required site of care determined by the Health Plan.
6. Dosage regimen:
    a. Cosentyx SC (secukinumab): 300 mg weekly times five, then 150-300 mg every four weeks.
    b. Stelara SC (ustekinumab):
        i. Standard: 45 mg week 0 and 4, then 45 mg every 12 weeks.
        ii. Co-morbid moderate to severe PP (>100 kg): 90 mg week 0 and 4, then 90 mg every 12 weeks.

7. Approval:
    a. Initial: six months.
    b. Re-approval: one year (decreased or sustained reduction in disease activity, as shown by less joints affected).

C. Ankylosing Spondylitis (AS)

1. Age: ≥18years.
2. Prescriber: rheumatologist.
3. Diagnosis and severity: Active AS.
4. Other therapies: contraindicated, failed or had significant adverse effects (two below):
    a. DMARD (four months.): MTX, leflunomide, sulfasalazine.
5. Dosage regimen:
    a. Cosentyx SC (secukinumab): 150 mg weekly times five, then 150 mg every four weeks.
6. Approval
    a. Initial: six months.
    b. Re-approval: one year (decreased or sustained reduction in disease activity, as shown by less joints affected).

III. Dermatology

A. Plaque Psoriasis (PP)

1. Age: at least 18 years.
2. Prescriber: dermatologist, allergist.
3. Diagnosis and severity: moderate to severe chronic PP.
    a. Duration: chronic PP greater than 6 months.
    b. Severity.
        i. Body Surface area (BSA): ≥10% OR
        ii. Severe at localized sites and associated with significant functional impairment (e.g., involvement of high-impact and difficult to treat sites such as the face, scalp, palms, soles, flexures and genitals).
4. Other therapies: contraindicated, failed or significant adverse effects with two of category a and one of b:
    a. Local therapies (four months.): topical (steroids, vitamin D analogues, coal tar, dithranol), phototherapy, photochemotherapy.
    b. Systemic therapy (four months.): Cyclosporine, methotrexate.
5. Exclude: Taltz SC (ixekizumab), Siliq SC (brodalumab), Tremfya SC (guselkumab) and Ilumya SC (tildrakizumab).
    a. All preferred products are contraindicated, failed or resulted in significant adverse effects.
    b. Required site of care determined by the Health Plan.
6. Dosing regimen

a. Cosentyx SC (secukinumab): 300mg weekly times five, then 150-300mg every four weeks.

b. Stelara SC (ustekinumab):

i. ≤100 kg: 45 mg week 0 and 4, then 45 mg every 12 weeks.

ii. >100 kg: 90 mg week 0 and 4, then 90 mg every 12 weeks.

7. Approval

a. Initial: six months.

b. Re-approval: one year (decreased or sustained reduction in disease activity, as shown by less joints affected).

4.0 Coding:

AFFECTED CODES			
Code	**Brand name**	**Generic name**	**Billing units (Iu)**
J3358	Stelara		1mg
J3262	Actemra IV		1mg
0078-0069-98	Cosentyx 2-pack syringe		NA

NON-COVERED CODES	
Code	**Description**
	Taltz

5.0 References, Citations & Resources:

1. Lexicomp Online® , Lexi-Drugs® , Hudson, Ohio: Lexi-Comp, Inc.; Cosentyx, Stelara, Actemra, accessed Jan, 2019.

2. Secukinumab in Plaque Psoriasis – results of two phase 3 trials. NEJM 2014; 371:326-338.

3. Ustekinumab induction and maintenance therapy in refractory Crohn's disease. NEJM 2012;367:1519-1528.

4. Comparison of ustekinumab and etanercept for moderate-to-severe psoriasis. NEJM 2010; 362(2):118-28.

5. Ustekinumab inhibits radiographic progression in patients with active psoriatic arthritis: results from the phase 3 PSUMMIT-1 and PSUMMIT-2 trials. Ann Rheum Dis. 2014;73(6):1000-6.

6. 3rd European evidence-based consensus on the diagnosis and management of Crohn's disease 2016: Part 1: Diagnosis and medical management. Journal of Crohn's and Colitis. 2017;11:3-25.

7. British Association of Dermatologists guidelines for the biological therapy for psoriasis 2017;177(3):628-36.

10. Clinical Practice Guidelines for the treatment of patients with axial spondyloarthritis and psoriatic arthritis. Madrid, (Spain): Spanish Society of Rheumatology (SER);2015.

6.0 Appendices:

Appendix I: FDA Approved Indications

FDA Approved Indications	Plaque Psoriasis (PP)	Crohn's Disease (CD)	Rheumatoid Arthritis (RA)	Psoriatic Arthritis (PA)	Ankylosing Spondylitis (AS)
Preferred Interleukin Inhibitors					
Actemra IV			X		
Cosentyx SC	X			X	X
Stelara IV/SC	X	X		X	
Excluded Interleukin Inhibitors					
Actemra SC			X		
Kevzara SC			X		
Siliq SC	X				
Talltz SC	X			X	
Tremfya SC	X				
Ilumya SC	X				

Appendix II: Monitoring & Patient Safety

Drug	Adverse Reactions	Monitoring	REMS
Stelara Ustekinumab IV/SC	• CNS: HA (5%) • Resp.: naso-pharyngitis (27-72%) • Other: antibody development (6%) • Preg. risk factor: B	• Infection: TB- Test prior to treatment; watch for signs and symptoms • Misc: signs and symptoms of skin CA (esp w elderly, long therapy, history of PUVA treatment	• Med. guide must be dispensed with med
Cosentyx secukinumab	• Infection: nasopharyngitis, Candida, herpes, staph skin (29-48%) • Preg. Risk factor: B	• GI: Crohn's flare (0.09%) • Infections: TB Test - pre-treatment; watch for signs and symptoms	• Med. guide must be dispensed with med
Actemra Tocilizumab IV/SC	• Endo/metab: ↑ cholesterol (19-20%) • Hepatic: ↑ ALT (≤34%); ↑ AST (≤22%) • Misc: infusion related Rx (4-16%) • Preg.: adverse events observed in some animal studies	• CNS: signs and symptoms of deylinating disorder • GI: perforation • Infections: TB test – pre-treatment • Labs: ALT/AST - pre, 4-8 weeks during, then q 3 months; lipids - pre, 4-8 weeks during, then q 6 weeks)	• Med. guide must be dispensed with med

7.0 Revision History:

Original Effective Date: June 24, 2015

Last Approval Date: 05/31/2019

Next Review Date: 05/31/2020

Revision Date	Reason for Revision
4/19	Moving to new format