

POLICY AND PROCEDURE

POLICY NUMBER: *RX.PA.22&E*

REVISION DATE: *06/18*

PAGE NUMBER: 1 of 4

POLICY TITLE: *Otezla[®] (Apremilast)*
DEPARTMENT: *Clinical Pharmacy Services – Utilization Management*
ORIGINAL DATE: *June 2014 (as adopted from UPMC Health Plan)*

Last P & T Committee Approval Date: *June 2018*

Product Applicability: *mark all applicable products below:*

COMMERCIAL	<input type="checkbox"/> HMO <input type="checkbox"/> PPO Products: <input type="checkbox"/> Small Exchange: <input type="checkbox"/> Shop <input checked="" type="checkbox"/> All <input type="checkbox"/> Indiv. <input type="checkbox"/> Indiv. <input type="checkbox"/> Large
OTHER	<input checked="" type="checkbox"/> Self-funded/ASO

PURPOSE

The purpose of this policy is to define the prior authorization process for Otezla[®] (apremilast).

Otezla[®] (apremilast) is indicated for treatment of adult patients with active psoriatic arthritis and for patients with moderate-to-severe plaque psoriasis who are candidates for phototherapy or systemic therapy.

DEFINITIONS

Dactylitis – a painful inflammation of the fingers or toes; a sausage shaped digit associated with psoriatic arthritis

Enthesitis – inflammation of sites where tendons or ligaments insert into the bone. It is also called enthesopathy, or any pathologic condition involving the enthuses. The enthuses are any point of attachment of skeletal muscles to the bone, where recurring stress or inflammatory autoimmune disease can cause inflammation or occasionally fibrosis and calcification.

POLICY

It is the policy of the Health Plan to maintain a prior authorization process that promotes appropriate utilization of specific drugs with potential for misuse or limited indications. This process involves a review using Food and Drug Administration (FDA) criteria to make a determination of Medical Necessity, and approval by the Pharmacy & Therapeutics Committee of the criteria for prior authorization, as described in RX.002 Pharmacy and Therapeutics Committee and RX.003-Prior Authorization Process.

The drug, Otezla® (apremilast), is subject to the prior authorization process.

PROCEDURE

Initial Authorization Criteria:

Must meet all of the criteria listed under the respective diagnosis:

1. Psoriatic arthritis

- Must be prescribed by or in consultation with a rheumatologist or dermatologist
- Must be age 18 years or older
- Must have a diagnosis of active psoriatic arthritis
- Must currently not be using a biologic disease-modifying drug (DMARD) in combination with Otezla

2. Psoriasis

- Must be prescribed by or in consultation with a dermatologist
- Must be age 18 years or older
- Must have a diagnosis of moderate-to-severe plaque psoriasis
- Must have a minimum body surface area involvement of >5% (members with plaque psoriasis of palms, soles, head and neck, or genitalia are not required to have a minimum body surface area involvement)
- Must have an adequate trial of either phototherapy (e.g., UVB or PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin with an inadequate response, intolerance/contraindication, or clinical reason not to use these therapies
- Must currently not be using a biologic disease-modifying drug (DMARD) in combination with Otezla



Reauthorization Criteria:

Authorization may be extended by 1 year based upon chart documentation showing that the member achieved or maintained positive clinical response after at least 4 months of therapy with Otezla as evidenced by low disease activity or improvement in signs and symptoms of the condition.

Limitations:

Length of Authorization (if above criteria met)	
Initial Authorization	Up to 1 year
Reauthorization	Same as initial

If the established criteria are not met, the request is referred to a Medical Director for review.

REFERENCES

1. Otezla [Prescribing Information]. Summit, NJ: Celgene Corporation; September 2014.
2. Celgene Corporation. Apremilast and Psoriatic Arthritis: Summary of Published Data. March 2014. pg 3-14.
3. Menter A, Gottlieb A, Feldman SR, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Section 1. Overview of psoriasis and guidelines of care for the treatment of psoriasis with biologics. *J Am Acad Dermatol*. 2008;58:826-850.
4. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Section 3. Guidelines of care for the management and treatment of psoriasis with topical therapies. *J Am Acad Dermatol*. 2008;1-17.
5. Otezla [medical information]. Summit, NJ: Celgene Corporation; October 1, 2014. Accessed October 6, 2014.
6. Coates LC, Kavanaugh A, Mease PJ, Soriano ER, Laura, Acosta-Felquer M, Armstrong AW, Bautista-Molano W, Boehncke W-H, Campbell W, Caul A, Espinoza LR, FitzGerald O, Gladman DD, Gottlieb A, Helliwell PS, Husn ME, Love TJ, Lubrano E, McHugh N, Nash P, Ogdie A, Orbai A-M, Parkinson A, O’Sullivan D, Rosen C F, Schwartzman S, Siegle EL, Toloza S, Tuong W and Ritchlin CT (2016), Group for Research and Assessment of Psoriasis and Psoriatic Arthritis 2015 Treatment Recommendations for Psoriatic Arthritis. *Arthritis & Rheumatology*, 68:1060-1071

RECORD RETENTION

Records Retention for Evolent Health documents, regardless of medium, are provided within the Evolent Health records retention policy and as indicated in CORP.028.E Records Retention Policy and Procedure.



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REVIEW HISTORY

DESCRIPTION OF REVIEW / REVISION	DATE APPROVED
<i>Annual review</i>	<i>02/16, 02/17, 02/18</i>
<i>Criteria update</i>	<i>10/16, 6/18</i>

