Enbrel (etanercept)

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<th>Line(s) of Business:</th>
<th>Original Effective Date:</th>
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<td>HMO; PPO; QUEST Integration</td>
<td>10/01/2015</td>
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**Original Effective Date:** 10/01/2015

**Current Effective Date:** 10/01/2016

**POLICY**

A. **INDICATIONS**

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**

- Moderately to severely active rheumatoid arthritis
- Moderately to severely active polyarticular juvenile idiopathic arthritis
- Active psoriatic arthritis
- Active ankylosing spondylitis
- Moderate to severe chronic plaque psoriasis

**Compendial Uses**

- Axial spondyloarthritis
- Hidradenitis suppurativa
- Reactive arthritis

B. **REQUIRED DOCUMENTATION**

The following information is necessary to initiate the prior authorization review:

- For psoriasis, the following documentation is required:
  - For new starts on therapy
    - Documentation supporting a history of plaque psoriasis for longer than six months
    - Percent of body surface area involvement
    - Results of treatment with methotrexate (MTX) such as ineffective treatment or intolerance, or documentation that MTX is contraindicated
  - For continuation of therapy, documentation in member’s chart or medical record supporting a decrease in percent of body surface area involvement when compared to baseline must be submitted
C. CRITERIA FOR INITIAL APPROVAL

1. Moderately to severely active rheumatoid arthritis (RA)
   Initial authorization of 6 months may be granted for members with RA who have tried a disease modifying anti-rheumatic drug (DMARD).

2. Moderate to severe chronic plaque psoriasis
   Initial authorization of 6 months may be granted for members who meet ALL of the following criteria:
   i. Treatment with Enbrel was recommended by a dermatologist
   ii. Member has been diagnosed with moderate to severe chronic plaque psoriasis defined as the following
      a) At least 10% of body surface area (BSA) is affected, or crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected, and
      b) History of psoriasis 6 months or longer
   iii. Plaque psoriasis is characterized by well-defined patches of red and raised skin
   iv. Member has tried MTX for at least 3 months at a therapeutic dose and found it to be ineffective, or the member exhibited intolerance or allergy, or the use of MTX is contraindicated.
      a) Ineffective treatment is defined as symptoms and/or signs that are not resolved after completion of treatment at the recommended therapeutic dose and duration. If there is no recommended treatment time, the member must have had a meaningful trial.
      b) Intolerance is defined as having a recognized and reproducible or repeated adverse reaction that is clearly associated with taking the medication.
      c) Allergy is defined as a state of hypersensitivity produced by exposure to a particular antigen resulting in harmful immunologic reactions on subsequent exposures. The most common symptoms are skin rash or anaphylaxis.

3. Active psoriatic arthritis (PsA)
   Initial authorization of 6 months may be granted for members who meet the following criteria:
   i. Member has been diagnosed with active PsA, and meets ANY of the following:
      a) Member has tried at least 2 of the following drugs for PsA: MTX, sulfasalazine, and leflunomide experienced an inadequate response to MTX.
   ii. Member has a history of intolerance to MTX, sulfasalazine, or leflunomide.
   c) Member has a contraindication to MTX, sulfasalazine AND leflunomide.

4. Active ankylosing spondylitis (AS) and axial spondyloarthritis
   Initial authorization of 6 months may be granted for members with active AS/axial spondyloarthritis who have tried a disease modifying anti-rheumatic drug (DMARD) meet ANY of the following criteria:
   i. Member has experienced an inadequate response to treatment with an NSAID over a 4-week period in total at the maximum recommended or tolerated anti-inflammatory dose
   ii. Member has experienced intolerance to NSAID therapy
   iii. Member has a contraindication to all NSAIDs
      Intolerance and contraindications to NSAIDs — Examples:
      a) History of intolerance or adverse event
      b) Asthma
      c) Urticaria
      d) Allergic-type reaction following aspirin or other NSAID administration
e) Gastrointestinal bleeding
f) Significant drug interaction
g)

5. Active polyarticular juvenile idiopathic arthritis (pJIA)
   Initial authorization of 6 months may be granted for members with active pJIA who have tried a disease modifying anti-rheumatic drug (DMARD).
6. **Hidradenitis suppurativa**
   Initial authorization of 6 months may be granted for members who have severe hidradenitis suppurative that is refractory to standard first-line treatment (eg, antibiotics).

7. **Reactive arthritis**
   Initial authorization of 6 months may be granted for members who have severe reactive arthritis that is refractory to standard first-line treatment.

D. **RE-AUTHORIZATION/CONTINUATION OF THERAPY**
   Members who have had Enbrel previously authorized by HMSA/CVS are subject to the continuation criteria below for approval. Members without previous authorization are required to meet criteria for initial authorization in section C. above.

   **Chronic plaque psoriasis**
   To receive authorization for an additional 6 months of therapy for chronic plaque psoriasis, documentation supporting a decrease in percent of body surface area involvement when compared to baseline must be submitted. Thereafter, authorization of 12 months may be granted.

   **All other indications**
   Authorization of 12 months may be granted for members who achieve or maintain positive clinical response as evidenced by low disease activity, improvement in signs and symptoms or maintenance of improvement in signs and symptoms.

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

F. **IMPORTANT REMINDER**
   The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended to discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.

   Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

   This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii’s Patients’ Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), generally accepted standards of medical practice and review of medical literature and government approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with HMSA’s determination as to medical necessity in a given case, the physician may request that CVS/caremark reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.
G. REFERENCES


Revised: December 2015 April 2016.