Enbrel (etanercept)

**Line(s) of Business:**
HMO; PPO; QUEST Integration

**Original Effective Date:**
10/01/2015

**Current Effective Date:**
10/01/2018

**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:
  - Initial therapy
    - Documentation supporting a history of plaque psoriasis for longer than six months
    - Percent of body surface area involvement
    - Documentation of crucial body areas affected (e.g. hands, feet, face, neck, scalp, etc.) if present
    - Results of treatment with methotrexate such as ineffective treatment or intolerance, or documentation that methotrexate is contraindicated
  - 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
C. CRITERIA FOR 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. Moderately to severely 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).

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 experienced an inadequate response to methotrexate.
      b) Member has a history of intolerance to methotrexate.
      c) Member has a contraindication to methotrexate.

4. Active ankylosing spondylitis (AS) and axial spondyloarthritis
   Initial authorization of 6 months may be granted for members with active AS/axial spondyloarthritis who 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

5. 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 methotrexate 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 methotrexate 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.
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. **CONTINUATION OF THERAPY**
   1. **No previous authorization/precertification:**
      All members (including new members and members currently receiving treatment without prior authorization) must meet criteria for initial approval in section C.
   2. **Reauthorization:**
      a. **Chronic plaque psoriasis**
         Authorization of an additional 6 months may be granted to members requesting authorization for continuation of therapy who are benefitting from Enbrel therapy as evidenced by a decrease in percent of body surface area involvement when compared to baseline, and were previously authorized by HMSA/CVS. Thereafter, authorization of an additional 12 months may be granted.
      b. **All other indications**
         Authorization of an additional 12 months may be granted to members requesting authorization for continuation of therapy who are benefitting from Enbrel therapy as evidenced by low disease activity, improvement in signs and symptoms or maintenance of improvement in signs and symptoms, and were previously authorized by HMSA/CVS.

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. **ADMINISTRATIVE GUIDELINES**
   Precertification is required. Please refer to the [HMSA medical policy web site](#) for the fax form.

G. **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/CVS’s determination as to medical necessity in a given case, the physician may request that HMSA reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.

H. REFERENCES

Document History

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