BOSTON MEDICAL CENTER HEALTHNet PLAN

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Pharmacy Policy

Otezla

Policy Number: 9.127
Version Number: 2.0
Version Effective Date: 1/1/2022

Product Applicability	☐ **All Plan[+] Products**
Well Sense Health Plan ☐ New Hampshire Medicaid	**Boston Medical Center HealthNet Plan** ☐ MassHealth - MCO ☐ MassHealth - ACO ☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☐ Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Prior Authorization Policy

Products Affected:

- Otezla (apremilast) Tablet
- Otezla (apremilast) Tablet Therapy Pack

The Plan may authorize coverage of the above products for members meeting the following criteria:

Covered Use	All FDA approved indications not otherwise excluded
Required Medical Information	Diagnosis of one of the following: 1. Active psoriatic arthritis (PsA); ***AND*** a. An inadequate response or adverse reaction to at least a 3 consecutive month trial of 1 non-biologic DMARD or contraindication to ALL non-biologic DMARDs; **OR** b. An inadequate response or adverse reaction to at least a 3

[+] *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

	consecutive month trial of one biologic DMARD that is FDA-approved for psoriatic arthritis. 2. Moderate to severe Plaque Psoriasis; ***AND*** a. One of the following: i. Involvement of at least 3% of total body surface area; **OR** ii. Hands, feet, scalp, face, or genital area affected; **AND** b. One of the following: i. An inadequate response or adverse reaction to TWO conventional therapies in any one of the following combinations for a trial of at least 3 consecutive months (please note: these combinations DO NOT have to be used concurrently) or a contraindication to all: 1. One topical agent plus one systemic agent; ***OR*** 2. 2. One topical agent plus one phototherapy; ***OR*** 3. One systemic agent plus one phototherapy; ***OR*** 4. Two systemic agents **OR** ii. A contraindication to methotrexate, as determined by the prescriber. **OR** iii. An inadequate response or adverse reaction to at least a 3 consecutive month trial of one biologic DMARD that is FDA approved for plaque psoriasis. 3. Behçet's Disease; **AND** a. Active oral ulcers; ***AND*** b. An inadequate response, intolerance, or contraindication to **one** topical glucocorticoid (ex: triamcinolone); ***AND*** c. An inadequate response, intolerance, or contraindication to ONE systemic therapy: Examples of systemic therapies include colchicine, systemic corticosteroids, azathioprine, thalidomide, interferon alpha, tumor necrosis factor inhibitors (e.g., adalimumab [e.g., Humira, biosimilars], etanercept [e.g., Enbrel, biosimilars], certolizumab pegol [Cimzia], golimumab [Simponi/Aria], or infliximab products [e.g., Remicade, biosimilars]).
Age Restrictions	18 years of age or older
Prescriber Restriction	PsA: Prescribed by or in consultation with a rheumatologist Ps: Prescribed by or in consultation with a dermatologist BD: Prescribed by or in consultation with a rheumatologist or dermatologist
Coverage Duration	1 year

Other criteria	Reauthorization: 1. Initial criteria are met; **AND** 2. Member's clinical condition has improved or stabilized

Appendix

Diagnosis	Non-Biologic DMARD Treatment Options
Plaque Psoriasis	Methotrexate Azathioprine Cyclosporine
Psoriatic Arthritis	Methotrexate Leflunomide Sulfasalazine Azathioprine

Note: other trials may be considered on a case-by-case basis

Applicable Coding:

None

Clinical Background Information and References

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Original Approval Date	Original Effective Date	Policy Owner	Approved by
12/1/2020	1/1/2021	Pharmacy Services	Pharmacy & Therapeutics (P&T) Committee

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
12/1/2020	9.190 Otezla Policy retired; new policy created; removed trial and failure with Humira and Enbrel since Otezla will be preferred agent	1/1/2021	P&T Committee
5/24/2021	Addition of Otezla (apremilast) Tablet Therapy Pack, 10 & 20 & 30 mg (55ea) to the formulary and policy. Same clinical criteria applies.	7/1/2021	P&T Committee
8/12/2021	P&T Annual Review: Addition of specific criteria for each indication to align with ESI ICCV policy including: addition of one biologic DMARD trial for trial requirements of RA and Ps; Contraindication of MTX only for Ps; Addition of diagnostic criteria for Ps; Addition of expanded trial options for BD.	1/1/2022	P&T Committee

Next Review Date

8/2022

Other Applicable Policies

Reference to Applicable Laws and Regulations, If Any

Disclaimer Information

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.