Washington State Health Care Authority

Cytokine and CAM Antagonists: T-Lymphocyte Inhibitors

Medical policy no. 66.27.00.AG-4 Effective Date: Month, 1, Year

Related medical policies:

Policy Number	Policy Name
66.27.00.AA	Cytokine and CAM Antagonists: Tumor Necrosis Factor (TNF) Inhibitors
66.27.00.AB	Cytokine and CAM Antagonists: IL-4/IL-13 Inhibitors
66.27.00.AC	Cytokine and CAM Antagonists: IL-6 Inhibitors
66.27.00.AD	Cytokine and CAM Antagonists: IL-12/IL-23 Inhibitors
66.27.00.AE	Cytokine and CAM Antagonists: IL-17 Inhibitors
66.27.00.AF	Cytokine and CAM Antagonists: Oral PDE-4 Inhibitors
66.27.00.AH	Cytokine and CAM Antagonists: Janus Associated Kinase (JAK) Inhibitors
66.27.00.AI	Cytokine and CAM Antagonists: IL-1 Inhibitors
66.27.00.AJ	Cytokine and CAM Antagonists: Integrin Receptor Antagonists
66.27.00.AK	Cytokine and CAM Antagonists: S1-P Receptor Modulator

Note: *New-to-market drugs included in this class based on the Apple Health Preferred Drug List are non-preferred and subject to this prior authorization (PA) criteria. Non-preferred agents in this class require an inadequate response or documented intolerance due to severe adverse reaction or contraindication to at least TWO preferred agents. If there is only one preferred agent in the class documentation of inadequate response to ONE preferred agent is needed. If a drug within this policy receives a new indication approved by the Food and Drug Administration (FDA), medical necessity for the new indication will be determined on a case-by-case basis following FDA labeling.*

To see the list of the current Apple Health Preferred Drug List (AHPDL), please visit: https://www.hca.wa.gov/assets/billers-and-providers/apple-health-preferred-drug-list.xlsx

Medical necessity

Drug	Medical Necessity
abatacept (Orencia)	**Abatacept (Orencia)** may be considered medically necessary in patients who meet the criteria described in the clinical policy below. If all criteria are not met, the clinical reviewer may determine there is a medically necessary need and approve on a case-by-case basis. The clinical reviewer may choose to use the reauthorization criteria when a patient has been previously established on therapy and is new to Apple Health.

Clinical policy:

Clinical Criteria	
Polyarticular Juvenile Idiopathic Arthritis (PJIA)	Abatacept (Orencia) may be approved when all of the following documented criteria are met: 1. Patient meets the appropriate age limit for the requested product: a. For subcutaneous abatacept: Patient is 2 to 17 years of age; **OR** b. For intravenous abatacept: Patient is 6 to 17 years of age; **AND** 2. Prescribed by, or in consultation with a rheumatologist; **AND** 3. Not used in combination with another Cytokine and CAM medication; **AND** 4. Diagnosis of Polyarticular Juvenile Idiopathic Arthritis (PJIA); **AND** 5. Documentation of current weight is provided; **AND** 6. Treatment with at least one non-Cytokine and CAM DMARD (e.g., methotrexate, sulfasalazine, leflunomide, hydroxychloroquine, azathioprine, cyclosporine) has been ineffective unless all are contraindicated or not tolerated [minimum trial of 3 months]; **AND** 7. Treatment with two preferred Cytokine & CAM Apple Health Preferred Drug List (AHPDL) medications has each been ineffective unless all are contraindicated or not tolerated [minimum trial of 12 weeks]. If ALL criteria are met, the request will be authorized for **6 months.**
	Criteria (Reauthorization) Abatacept (Orencia) may be approved when all of the following documented criteria are met: 1. Not used in combination with another Cytokine and CAM medication; **AND** 2. Documentation is submitted demonstrating disease stability or a positive clinical response (e.g., improvement in joint pain, swelling, activities of daily living, reduction in diseases flares, etc.). If ALL criteria are met, the request will be authorized for **12 months.**
Psoriatic Arthritis (PsA)	Abatacept (Orencia) may be approved when all of the following documented criteria are met: 1. Patient is two years of age or older, **AND** 2. Prescribed by, or in consultation with a rheumatologist or dermatologist; **AND** 3. Not used in combination with another Cytokine and CAM medication; **AND** 4. Diagnosis of Psoriatic Arthritis (PsA); **AND** 5. For pediatric and intravenous formulation requests: Documentation of current weight is provided; **AND** 6. Patient meets one of the following:

	a. Treatment with at least one non-Cytokine and CAM DMARD (e.g., methotrexate, sulfasalazine, leflunomide, cyclosporine) has been ineffective unless all are contraindicated or not tolerated [minimum trial of 3 months]; **OR** b. Presence of active, severe disease as indicated by provider assessment and the presence of at least ONE of the following: i. Erosive disease; **OR** ii. Elevated C-reactive protein (CRP) or erythrocyte sedimentation rate (ESR); **OR** iii. Long-term damage interfering with function (e.g., joint deformities, vision loss); **OR** iv. Major impairment of quality of life due to high disease activity at many sites (including dactylitis, enthesitis) or functionally limiting arthritis at a few sites; **AND** 7. For adult requests, treatment with two preferred Cytokine & CAM Apple Health Preferred Drug List (AHPDL) medications has been ineffective unless all are contraindicated or not tolerated [minimum trial of 12 weeks]. If ALL criteria are met, the request will be authorized for **6 months.**
	Criteria (Reauthorization) Abatacept (Orencia) may be approved when all of the following documented criteria are met: 1. Not used in combination with another Cytokine and CAM medication; **AND** Documentation is submitted demonstrating disease stability or a positive clinical response (e.g., improvement in joint pain, swelling, activities of daily living, reduction in diseases flares, etc.). If ALL criteria are met, the request will be authorized for **12 months.**
Rheumatoid Arthritis (RA)	Abatacept (Orencia) may be approved when all of the following documented criteria are met: 1. Patient is 18 years of age or older, **AND** 2. Prescribed by, or in consultation with a rheumatologist; **AND** 3. Not used in combination with another Cytokine and CAM medication; **AND** 4. Diagnosis of Rheumatoid Arthritis (RA); **AND** 5. For intravenous formulation requests: Documentation of current weight is provided; **AND** 6. Baseline assessments are included (e.g., Disease Activity Score for 28 joints (DAS28) with the CRP, DAS28 with ESR, Simplified Disease Activity Index (SDAI), Clinical Disease Activity Index (CDAI), Routine Assessment of Patient Index Data 3 (RAPID3), Patient Activity Scale (PAS) II; **AND**

	7. Treatment with at least one non-Cytokine and CAM DMARD (e.g., methotrexate, sulfasalazine, hydroxychloroquine, leflunomide, cyclosporine, azathioprine) has been ineffective unless all are contraindicated or not tolerated [minimum trial of 3 months]; **AND** 8. Treatment with two preferred Cytokine & CAM Apple Health Preferred Drug List (AHPDL) medications has each been ineffective unless all are contraindicated or not tolerated [minimum trial of 12 weeks]. If ALL criteria are met, the request will be authorized for **6 months.**
	Criteria (Reauthorization) Abatacept (Orencia) may be approved when all of the following documented criteria are met: 1. Not used in combination with another Cytokine and CAM medication; **AND** 2. Documentation is submitted demonstrating disease stability or a positive clinical response (e.g. improvement in DAS28 with CRP/ESR, SDAI, CDAI, RAPID3, PAS II scores). If ALL criteria are met, the request will be authorized for **12 months.**
Graft Versus Host Disease (GVHD)	Abatacept (Orencia) (*IV formulation only*) may be approved when all of the following documented criteria are met: 1. Patient is 2 years of age or older, **AND** 2. Prescribed by, or in consultation with, an oncologist or hematologist; **AND** 3. Not used in combination with another Cytokine and CAM medication; **AND** 4. Documentation of current weight is provided; **AND** 5. Patient meets one of the following: a. Patient has received a hematopoietic stem cell transplant (HSCT); **AND** i. Used as additional therapy in combination with corticosteroids for chronic GVHD; **AND** ii. Patient has no response (e.g., steroid-refractory disease) to first-line therapy options; **OR** b. Patient is undergoing a hematopoietic stem cell transplant (HSCT) from a matched or 1 allele-mismatched unrelated-donor; **AND** i. Used for prophylaxis of acute graft versus host disease (aGVHD); **AND** ii. Used in combination with a calcineurin inhibitor and methotrexate; **AND** iii. Patient will receive antiviral prophylactic treatment for Epstein-Barr Virus (EBV) reactivation and prophylaxis will continue for 6 months post-transplantation;

	If ALL criteria are met, the request will be authorized for **6 months.**
	Criteria (Reauthorization)
	Abatacept (Orencia) may not be reauthorized.

Dosage and quantity limits

Drug	Indication	FDA Approved Dosing	Dosage Form and Quantity Limit
Orencia	Polyarticular Juvenile Idiopathic Arthritis (PJIA)	IV: 0, 2, and 4 weeks, and every 4 weeks thereafter based on weight SC: 125 mg once weekly	• Auto-Injector and prefilled syringe: #4 pen or PFS per 28-day supply • 250mg/15mL vial: up to 1,000 mg at weeks 0, 2, & 4, then every 4 weeks thereafter
	Psoriatic Arthritis (PsA)	SC: 125 mg once weekly	• Auto-Injector and prefilled syringe: #4 pen or PFS per 28-day supply • 250mg/15mL vial: up to1,000 mg at weeks 0, 2, & 4, then every 4 weeks thereafter
	Rheumatoid Arthritis (RA)	IV: 0, 2, and 4 weeks, and every 4 weeks thereafter based on weight SC: 125 mg once weekly	• Auto-Injector and prefilled syringe: #4 pen or PFS per 28-day supply • 250mg/15mL vial: up to 1,000 mg at weeks 0, 2, & 4, then every 4 weeks thereafter
	Graft Versus Host Disease (GVHD)	IV: 10 mg/kg IV on the day prior to transplant (day -1), followed by 10 mg/kg IV on days 5, 14, and 28 post-transplant	• 250mg/15mL vial: up to 1,000 mg on the day prior to transplant (day -1) followed by doses up to 1,000 mg on days 5, 14 and 28 post-transplant

Coding:

HCPCS Code	Description
J0129	Injection, abatacept, up to 1,000 mg; 1 billable unit = 10 mg

Background:

Polyarticular Juvenile Idiopathic Arthritis (PJIA)

Juvenile idiopathic arthritis (JIA) is a grouping of inflammatory disorders that affect children. Polyarticular juvenile idiopathic arthritis (PJIA) is a subset of JIA, which is defined by the presence arthritis in five or more joints during the first six months of illness. Other subsets of JIA include ERA, oligoarthritis (less than five joints affected), systemic juvenile idiopathic arthritis (SJIA; fever, rash, hepatic/splenic/lymphatic involvement) and psoriatic arthritis (psoriasis and dactylitis). While these are distinct disease states, their pathogenesis and presentation are similar so there is significant overlap in effective treatments. The 2019 ACR JIA guidelines for non-systemic polyarthritis (PJIA) strongly recommend initial therapy with a DMARD for all patients with JIA and active polyarthritis; methotrexate has the strongest evidence, but sulfasalazine and leflunomide can also be used. Adjunctive therapy with NSAIDs and oral or intra-articular glucocorticoids is common. Regardless of disease activity, initial therapy with a DMARD is recommended over a biologic, though there may be certain situations where a biologic as initial therapy is preferred (i.e., high risk joints such as cervical spine, wrist, or hip involved). ACR notes that while initial treatment with biologics was studied in the TREAT-JIA and ACUTE-JIA studies, results were not deemed conclusive enough to make recommendations for biologics as initial therapy at this time. For patients with continued moderate to high disease activity, the guidelines recommend adding a TNF inhibitor, abatacept, or tocilizumab as second-line. The ACR guidelines make a conditional recommendation for switching to non-TNF inhibitor biologics (tocilizumab and abatacept) in patients receiving a TNF inhibitor with continued moderate or high disease activity.

Psoriatic Arthritis (PsA)

Psoriatic arthritis is an inflammatory musculoskeletal disease associated with psoriasis that was initially considered a variant of rheumatoid arthritis but has emerged as a distinct clinical entity. The 2018 American College of Rheumatology/National Psoriasis Foundation Guideline (ACR) for psoriatic arthritis make a conditional recommendation for starting a TNF inhibitor over an oral small molecule (OSM) as a first-line option for patients who are treatment-naïve with active psoriatic arthritis. This recommendation is based on low- to very-low quality of evidence. Many of the studies in which greater benefit was seen in terms of disease severity or radiographic progression compared methotrexate to TNF inhibitors, however, most patients included in these groups were not truly treatment naïve to OSM medications. Guidelines note that OSM can be used first-line in naïve patients who do not have severe PsA, severe PsO, prefers oral therapy, or has contraindications to TNF inhibitors.

Rheumatoid Arthritis (RA)

The 2021 American College of Rheumatology (ACR) guidelines for rheumatoid arthritis strongly recommend the use of conventional synthetic disease-modifying antirheumatic drug (csDMARD) monotherapy (methotrexate preferred) in patients who are DMARD-naïve with moderate-to-severe RA. Recommended csDMARDs include methotrexate, sulfasalazine, hydroxychloroquine, and leflunomide. Despite moderate evidence in the SELECT-EARLY study noting higher efficacy of upadacitinib over methotrexate in DMARD-naïve patients with moderate-to-severe RA, there is limited long-term safety data to strongly recommend the use of tsDMARDs (e.g., JAK inhibitors) as first line therapy. Therefore, methotrexate monotherapy remains the preferred first-line therapy over tsDMARDs in DMARD-naïve patients based on established safety and efficacy. Additionally, JAK inhibitors are not FDA approved for use in csDMARD-naïve patients. The 2019 European League Against Rheumatism (EULAR) guidelines follow similar recommendations to the 2021 ACR guidelines, and state that patients with highly active RA despite treatment with csDMARDs may receive a biologic DMARD or JAK inhibitor based on high level of evidence.

Graft Versus Host Disease (GVHD)

The intravenous form of abatacept (Orencia) is FDA-approved for the prevention or prophylaxis of acute graft vs. host disease (aGVHD). The FDA-approval of intravenous abatacept (Orencia) in aGVHD was based on two studies; a double-blind, placebo-controlled trial that showed survival benefit over placebo when used in combination with other immunosuppressive drugs; and a registry-based evaluation that compared patients that received abatacept (Orencia) in addition to conventional immunosuppressant therapy vs. conventional immunosuppressive therapy alone. The study observed to abatacept (Orencia) to have a survival benefit when used with conventional immunosuppressive treatments. The FDA-approved dose is 10 mg/kg IV over 60 minutes the day prior to stem cell transplantation, as well as days 5, 14, 28 days after transplantation, which conveniently overlaps with the expected inpatient stay following stem cell transplantation. Accurate dosing may only be achieved with the intravenous formulation. In addition to having unknown safety and efficacy, the self-administered formulation would have a greater injection burden, greater medication waste, and greater cost compared to the intravenous formulation. No other biologic therapies have been evaluated for this condition.

References

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History

Approved Date	Effective Date	Version	Action and Summary of Changes
MM/DD/YYY	MM/DD/YYYY	66.27.00.AG-4	Pending Approval (draft version) - Split 66.27.00 policy into different policies -Added new drug indications when applicable -Update language in medical necessity section
Previous policy changes (relevant from Cytokine & CAM Antagonists Policy)			
Date			**Action and Summary of Changes**
10.21.2021			Removed Hyrimoz from the policy and updated the initial dosing for infliximab.
11.30.2020			Removed Preferred/Non-Preferred listing and added link to AHPDL publication
11.12.2020			Added language in clinical policy section for cases which do not meet policy criteria
09.01.2020			Updated wording in clinical criteria for products with only one preferred option.
08.19.2020			Approved by DUR Board
8.20.2020			Update to dosing and limits section for all products and indications
08.12.2020			Updated policy clinical criteria and dosing & quantity limits to include nonradiographic axial spondyloarthritis
06.01.2020			Added new agents to class; updated age limit for Uveitis indication; updated dosing and quantity limits; updated HCPCS coding
07.31.2019			Updated criteria that trial of preferred biologics only applies to non-preferred biologics
06.07.2019			Updates to TB skin test requirements for apremalist; updates to initial authorization clinical criteria
11.02.2018			Addition of Hyrimoz (adalimumab-adaz)
09.07.2018			Addition of new medication
08.16.2017			New Policy