Pharmacy Management Drug Policy

SUBJECT: Humira ® (adalimumab) – for Psoriasis, Rheumatoid Arthritis, Juvenile Idiopathic Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, Hidradenitis Suppurativa, Crohn's Disease, Ulcerative Colitis and Panuveitis
POLICY NUMBER: Pharmacy-22
EFFECTIVE DATE: 05/09
LAST REVIEW DATE: 5/2/2019

If the member's subscriber contract excludes coverage for a specific service or prescription drug, it is not covered under that contract. In such cases, medical or drug policy criteria are not applied. Medical or drug policies apply to commercial and Health Care Reform products only when a contract benefit for the specific service exists.

DESCRIPTION:

Humira® (Adalimumab) binds specifically to tumor necrosis factor (TNF)–alpha and blocks its interaction with the p55 and p75 cell surface TNF receptors. Adalimumab also lyses surface TNF-expressing cells in vitro in the presence of a complement. Adalimumab does not bind or inactivate lymphotoxin (TNF-beta). TNF is a naturally occurring cytokine that is involved in normal inflammatory and immune responses.

Humira® is indicated for:

- Reducing signs and symptoms in patients with active ankylosing spondylitis
- Reducing signs and symptoms and inducing and maintaining clinical remission in patients 6 years of age and older with moderately to severely active Crohn's disease who have had an inadequate response to conventional therapy OR for reducing signs and symptoms and inducing clinical remission in these patients if they have also lost response to or are intolerant to infliximab
- Reducing signs and symptoms in patients 2 years of age and older with moderately to severely active polyarticular juvenile idiopathic arthritis alone or in combination with methotrexate
- The treatment of adult patients with moderate to severe chronic plaque psoriasis who are candidates for systemic therapy or phototherapy, and when other systemic therapies are medically less appropriate
- Reducing signs and symptoms of active arthritis, inhibiting the progression of structural damage, and improving physical function in patients with psoriatic arthritis alone or in combination with disease-modifying antirheumatic drugs (DMARDs)
- Reducing signs and symptoms, inducing major clinical response, inhibiting the progression of structural damage, and improving physical function in adult patients with moderately to severely active rheumatoid arthritis (RA) alone or in combination with methotrexate or other DMARDs
- Reducing signs and symptoms and inducing and maintaining clinical remission in adult patients with moderately to severely active ulcerative colitis who have had an inadequate response to immunosuppressants such as corticosteroids, azathioprine or 6-mercaptopurine (6-MP). The effectiveness of Humira® has not been established in patients who have lost response to or were intolerant to TNF blockers.
- Reducing the signs and symptoms and treat moderate to severe hidradenitis suppurativa (HS) in adults. HS is a chronic inflammatory skin disease characterized by recurrent painful abscesses and nodules.

Reducing the signs and symptoms and treat non-infectious intermediate, posterior, and panuveitis in adult patients.

POLICY:
Based upon our assessment and review of the peer-reviewed literature Humira® has been medically proven to be effective and therefore, **medically necessary** for the treatment of the following FDA-approved diagnoses if specific criteria are met:

A. Plaque Psoriasis

1. Member must be followed by a dermatologist or rheumatologist **AND**
2. Member must be at least 18 years of age **AND**
3. Member must have moderate to severe chronic plaque psoriasis that involves at least 10% of their body surface area. Consideration will be given to those who have severe disease of the hands or feet or other areas causing disruption in normal activities, but have less than 10% body surface area involvement. **AND**
4. Member must be a candidate for systemic therapy, i.e. Acitretin, methotrexate, or cyclosporine with a trial period of at least 3 months. If contraindications are present or member had developed severe intolerance to the above mentioned agents before 3 months, a trial of one of the other three criteria listed below must be present **OR**
5. If member does not qualify as stated above in **"4"**, then one of the following must be attempted for a reasonable period of time (at least 3 months):
   a. UVB in combination with a topical therapy such as coal tar, steroids or tazarotene **OR**
   b. PUVA in combination with topical corticosteroids **OR**
   c. Medium/High potency topical steroids in combination with anthralin, calcipotriene, or tazarotene
6. Coverage of Humira in psoriasis patients will be limited to an initial dose of Humira 80mg at week 0, and 40mg one week after initial dosing and every other week thereafter.
   a. #4 injections / 28 days for first fill
   b. #2 injections / 28 days thereafter
7. Dose escalation to 40mg weekly may be considered for patients who have had an inadequate response to 40mg every other week after 24 weeks of therapy.

B. Rheumatoid Arthritis

1. Member must be actively followed by and the drug prescribed by a Rheumatologist **AND**
2. Member must have active moderate to severe rheumatoid arthritis **AND**
3. Member must have failed to respond to and/or is intolerant to approved disease-modifying antirheumatic drug (DMARD) agents, such as methotrexate, azathioprine, sulfasalazine, or hydroxychloroquine, either alone or in combination for a 3 month period **AND**
4. Initial dosing is limited to subcutaneous injections every two weeks (2 injections/ month)
   a. Humira dosing frequency more often than every 2 weeks (4 injections/ month) will require the addition or concurrent use of methotrexate 10-15mg/week
   b. For patients who have a contraindication to methotrexate the addition of an alternative DMARD will be required prior to authorization of Humira 40mg weekly.
5. Low disease activity or remission should be considered treatment targets for members receiving adalimumab. Members with moderate or high disease activity >3 months due to lack of or loss of benefit should discontinue adalimumab and switch to another biologic agent.

6. Members with high disease activity who fail adalimumab therapy due to a serious adverse effect should switch to a non-TNF biologic. Member with moderate or high disease activity who fail adalimumab therapy due to non-serious adverse effects should switch to another TNF-blocker or a non-TNF biologic agent.

C. Juvenile Idiopathic Arthritis

1. Member must be actively followed by a Rheumatologist **AND**
2. Member must be at least 2 years old **AND**
3. Member must have moderately to severely active polyarticular juvenile idiopathic arthritis **AND**
4. Member must have failed to respond to and/or is intolerant to approved disease-modifying antirheumatic drugs (DMARDs) agents, such as methotrexate, NSAIDs, analgesics or corticosteroids either alone or in combination **AND**
5. The recommended dose for pediatric patients ages 2 to 17 years of age is 10mg every other week for patients 10kg to < 15kg, 20mg every other week for patients 15kg to < 30kg, and 40mg every other week for patients weighing ≥ 30kg

D. Psoriatic Arthritis

1. A diagnosis of definitive psoriatic arthritis established by a Rheumatologist or Dermatologist **AND**
2. Member must have some clinical features of psoriatic arthritis such as: involvement of the DIP joints, an asymmetric distribution of joint disease, spondyloarthritis, sausage digits, new bone formation on radiographs, cutaneous findings, and the characteristic nail manifestations of psoriatic arthritis (nail pitting, onycholysis & other lesions, which include leukonychia, red spots in the lunula, and nail plate crumbling) all may be present.
3. Member must be actively followed by and the drug prescribed by a Rheumatologist or Dermatologist **AND**
4. Approved dosing is 40 mg subcutaneously every other week only

E. Ankylosing Spondylitis

1. Member must be actively followed by and the drug prescribed by a Rheumatologist **AND**
2. Member must have ankylosing spondylitis **AND**
3. Presence of refractory disease defined by failure of or intolerance to at least two NSAIDS at maximum strength for at least 1 month each
4. Approved dosing is 40 mg subcutaneously every other week only

F. Crohn's Disease

1. Patient has a diagnosis of moderately to severely active Crohn's disease made by a gastroenterologist **AND**
2. Moderate to severe disease - Crohn's Disease Activity Index (CDAI) score of 220-450, typically described as having more prominent symptoms of fever, significant weight loss, abdominal pain or tenderness, intermittent nausea or vomiting or significant anemia.
3. Patient meets at least one of the following criteria:
    a. Patient continues to experience disease flare despite complete and adequate therapy with a corticosteroid (such as prednisone or budesonide). Typically, response is noted within 14 days of initiating therapy **OR**
    b. Patient is steroid-dependent (unable to taper off of steroids) despite treatment with azathioprine, 6-mercaptopurine or methotrexate **OR**
    c. Documentation is provided that azathioprine, 6-mercaptopurine, or methotrexate is ineffective, contraindicated or not tolerated

4. Authorization period and dosing limitations:
    A. Adults dosing:
        1. Induction dose - At week 0, 160mg (dose can be administered as four 40mg injections in one day or two 40mg injections per day on two consecutive days), followed by 80mg at week 2
        2. Maintenance dose – Starting at week 4, adalimumab 40 mg every other week in patients who respond to the initial induction doses prolongs response and remission.
        3. Dose escalation to 40 mg weekly may be necessary to maintain responses in some patients. 40mg once weekly will only be allowed for people who responded to induction and maintenance therapy but have now lost response
            a. Response to therapy is generally classified as an increase in CDAI of ≥ 70 points
    B. Pediatric dosing (17kg to <40kg)*:
        1. Induction dose – At week 0, 80mg in one day; second dose at week 2 (day 15): 40mg
        2. Maintenance dose – starting at week 4 (day 29), adalimumab 20mg every other week
        * If pediatric patient is equal to or greater than 40kg, please follow adult dosing.

G. Ulcerative Colitis -

1. Patient has a diagnosis of moderate to severe active Ulcerative Colitis as diagnosed by a Gastroenterologist **AND**
2. Tried and failed or has documented intolerance to at least 2 of the following conventional therapies for at least 3 months:
    a. Thiopurines: Azathioprine/6-mercaptopurine (6-MP)
    b. 5-Aminosalicylates: Sulfasalazine, Mesalamine, Olsalazine
    c. Cyclosporine
    d. IV or oral steroids
3. Authorization period and dosing limitations:
    a. At week 0, 160mg (dose can be administered as four 40mg injections in one day or two 40mg injections per day on two consecutive days), followed by 80mg at week 2, followed by a maintenance dose of 40mg every other week beginning at week 4.
    b. Dose escalation to 40mg once weekly may be approvable for patients who initially responded to Humira therapy but have lost response after week 12.

H. Hidradenitis Suppurativa

1. Member must be at least 12 years old and actively followed by and drug prescribed by a Dermatologist **AND**
2. Must have a diagnosis of stage II, stage III, or severe refractory hidradenitis suppurativa with recurrent abscesses
3. Must have had a minimum of a three month trial of systemic antibiotics (such as minocycline, doxycycline, clindamycin, or rifampin) which failed to provide clinical improvement.
4. Approval will be for 160mg week 0, then 80mg week 2 and then 40mg every week thereafter starting at week 4.

I. Non-Infectious Panuveitis

1. Member must be actively followed by and drug prescribed by a Rheumatologist or Ophthalmologist **AND**
2. Member must be at least 2 years old and have a diagnosis of non-infectious intermediate-, posterior- or Pan-uveitis
3. Must have had a previous trial of ALL of the following:
    a. A topical or injected ophthalmologic steroid (unless contraindications are present)

   b. An oral systemic steroid
   c. An adequate trial of an immunosuppressive agent, such as but not limited to, azathioprine, mycophenolate, or methotrexate
4. Coverage of Humira for Panuveitis patients will be limited to an initial dose of Humira 80mg at week 0, and 40mg one week after initial dosing and every other week thereafter.
   a. #4 injections / 30 days for first month
   b. #2 injections / 30 days thereafter

APPROVAL TIME PERIODS:

Line of Business	Rx Initial approval	Rx recertification
Medicaid Managed Care (MMC)/Child Health Plus (CHP)	2 years	2 years
Commercial/Exchange	2 years	2 years

POLICY GUIDELINES:

1. Unless otherwise stated above within the criteria, approval time period will be for 2 years.
   - Continued approval at time of recertification will require documentation that the drug is providing ongoing benefit to the patient in terms of improvement or stability in disease state or condition. Such documentation may include progress notes, imaging or laboratory findings, and other objective or subjective measures of benefit which support that continued use of the requested product is medically necessary. Also, ongoing use of the requested product must continue to reflect the current policy's preferred formulary. Recertification reviews may result in the requirement to try more cost-effective treatment alternatives as they become available (i.e.; generics, biosimilars, or other guideline supported treatment options). Requested dosing must continue to be consistent with FDA-approved or off-label/guideline-supported dosing recommendations
2. Prior authorization is contract dependent.
3. This policy is applicable to drugs that are included on a specific drug formulary. If a drug referenced in this policy is non-formulary, please reference the Coverage Exception Evaluation Policy for All Lines of Business Formularies policy for review guidelines.
4. Humira® is self-administered and therefore falls under the pharmacy benefit.
5. Consideration should be given to initiating therapy with a DMARD such as methotrexate, NSAID, or steroid depending on diagnosis.
6. Involvement of the DIP joints, an asymmetric distribution of joint disease, spondyloarthritis, sausage digits, new bone formation on radiographs, cutaneous findings, and the characteristic nail manifestations of psoriatic arthritis all help to distinguish psoriatic arthritis from other inflammatory arthritis, including RA.
7. A diagnosis of Irritable Bowel Disease associated arthritis will be evaluated using criteria for Ankylosing Spondylitis.
8. Humira® is **not to be used in immunocompromised patients** due to the possible risk of serious infection
9. In clinical trials of all TNF inhibitors, a higher rate of lymphoma was seen compared to the general population; however, the risk of lymphoma may be up to several-fold higher in RA and psoriasis patients. Post-marketing cases of aggressive and fatal hepatosplenic T-cell lymphoma (HSTCL) have occurred in adolescents and young adults receiving Humira for inflammatory bowel disease.

10. Tuberculosis (frequently disseminated or extrapulmonary at clinical presentation), invasive fungal infections, and other opportunistic infections have been observed in patients receiving Humira®. All patients being considered for biologic therapy should be screened for latent tuberculosis infection, regardless of the presence of risk factors. Annual testing is recommended for patients who live, travel, or work in situations where tuberculosis exposure is likely.
11. Use of TNF inhibitors has been associated with reactivation of hepatitis B virus (HBV) in patients who are chronic carriers of this virus. Patients at risk for HBV infection should be evaluated for prior evidence of HBV infection before initiating TNF inhibitor therapy. Patients with plaque psoriasis who are seropositive for hepatitis B surface antigen with inactive disease should undergo a course of antiviral therapy 2 – 4 weeks prior to initiation of anti-TNF therapy.
12. Use of TNF inhibitors has been associated with rare cases of new onset or worsening of neurologic conditions, such as multiple sclerosis (MS), optic neuritis, and Geillain-Barré syndrome. Exercuse caution when using Humira® in patients with preexisting or recent-onset central or peripheral nervous system demyelinating disorders. Consider the discontinuation of Humira if any of these disorders develop.
13. Cases of worsening congestive heart failure (CHF) and new onset CHF have been reported with TNF blockers. Exercise caution when using Humira® in patients who have heart failure and monitor them carefully. Use of anti-TNF agents is not recommended in patients with New York Heart Association class III or IV heart failure that have an ejection fraction of 50% or less.
14. Patients should not receive live attenuated herpes zoster vaccine while receiving anti-TNF therapy.
15. Adalimumab will not be authorized when used in combination with other biologics such as Kineret (anakinra), Orencia (abatacept), Rituxan (rituximab)

UPDATES:

Date	Revision
5/2019	Revised
1/2019	Revised
5/2018	Reviewed
6/2017	Revised
5/2017	P&T Approval
4/2017	Revised
9/15	Revised
5/15	Revised
12/14	Revised
10/14	Revised
12/13	Revised

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