MEDICATION POLICY

Generic Name: Apremilast

Therapeutic Class or Brand Name: Otezla®

Applicable Drugs (if Therapeutic Class)**:** N/A

Date of Origin: 8/25/16 **Date Last Reviewed/Revised:** 11/21/17

GPI Code: 6670001500

Prior Authorization Criteria (may be considered medically necessary when criteria I through IV are met):

I. Documented diagnosis of one of the following conditions A through B AND must meet criteria listed under applicable diagnosis:
   A. Moderate to severe plaque psoriasis and both criteria 1 and 2 are met:
      1. History of treatment failure, intolerance, or contraindication with phototherapy or photochemotherapy.
      2. History of treatment failure, intolerance, or contraindication with at least one systemic non-biologic agent (i.e. cyclosporine, methotrexate, acitretin, etc.).
   B. Active Psoriatic Arthritis.

II. Documented failure, intolerance, or contraindication to at least one preferred tumor necrosis factor (TNF) inhibitor (refer to plan document for the list of preferred products).

III. Minimum age requirement: 18 years old.

IV. Diagnosis must be established by a rheumatologist or dermatologist.

Exclusion Criteria:

- Coadministration of Otezla® with cytochrome P450 enzyme inducers (i.e. rifampin, phenobarbital, carbamazepine, phenytoin).
- Coadministration of Otezla® with biologic DMARDs or Xeljanz®/ XR (tofacitinib). Examples of biologic DMARDs include the following:
  - Actemra® (tocilizumab)
  - Cosentyx® (secukinumab)
  - Entyvio® (vedolizumab)
  - Kevzara® (sarilumab)

- Kineret® (anakinra)
- Orencia® (abatacept)
- Rituxan® (rituximab)
- Siliq™ (brodalumab)
- Stelara® (ustekinumab)
- Taltz® (Ixekizumab)
- TNF inhibitors [Cimzia® (certolizumab pegol), Enbrel® (etanercept), Humira® (adalimumab), Inflectra® (infliximab-dyyb), Remicade® (infliximab), Renflexis™ (infliximab-abda), Simponi®/Simponi® Aria® (golimumab)]
- Tremfya™ (guselkumab)
- Tysabri® (natalizumab)

Other Criteria:

- N/A

Quantity/Days Supply Restrictions:

- Quantities of up to 60 tablets per 30 days.

Approval Length:

- **Authorization:** 1 year.
- **Re-Authorization:** An updated letter of medical necessity or progress notes showing current medical necessity criteria are met and that the medication is effective.

Appendix:

N/A

References:

1. http://www.celgene.com/content/uploads/otezla-pi.pdf.
2. Medi-Span.

MEDICATION POLICY

Historical Tracking Of Changes Made To Policy	
11/21/2017	1. **Added** "Kevzara® (sarilumab)"**,** "Siliq™ (brodalumab)"**, and** "Tremfya™ (guselkumab)" **to list under Exclusion Criteria**. 2. **Added** "Inflectra® (infliximab-dyyb)" **and** "Renflexis™ (infliximab-abda)" **following TNF Inhibitors to list under Exclusion Criteria**.
12/2/2016	1. **Changed** "1. A. 2. History of treatment failure, intolerance, or contraindication with at least one appropriate systemic agent (i.e. cyclosporine, methotrexate, acitretin, etc.)" **to** "I. A. 2. History of treatment failure, intolerance, or contraindication with at least one systemic non-biologic agent (i.e. cyclosporine, methotrexate, acitretin, etc.)" **under Prior Authorization Criteria**. 2. **Changed** "II. Documented failure, intolerance, or contraindication to two preferred biologic products (refer to plan document for the list of preferred products)" **to** "II. Documented failure, intolerance, or contraindication to at least one preferred tumor necrosis factor (TNF) inhibitor (refer to plan document for the list of preferred products)" **under Prior Authorization Criteria**.