Generic Name: Apremilast

Therapeutic Class or Brand Name: Otezla

Applicable Drugs (if Therapeutic Class): N/A

GPI Code: 6670001500

Preferred: N/A

Non-preferred: N/A

Date of Origin: 8/25/2016

Date Last Reviewed / Revised: 3/27/2019

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 all preferred targeted immunomodulators (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, Olumiuant® (baricitinib) 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)
- Skyrizi™ (risankizumab-rzaa)
- 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
3. https://www.aad.org/practicecenter/quality/clinical-guidelines/psoriasis.
4. https://www.jaad.org/article/S0190-9622(18)33001-9/fulltext

HISTORICAL TRACKING OF CHANGES MADE TO POLICY

Date	Notes/Changes
3/27/2019	1. **Added** Olumiuant® (baricitinib)and Skyrizi™ (risankizumab-rzaa) **under Exclusion Criteria.** **2. Added** "https://www.jaad.org/article/S0190-9622(18)33001-9/fulltext" **under References.** 3. **Removed** "https://tuftshealthplan.com/documents/providers/guidelines/pharmacy-medical-necessity-guidelines/otezla-apremilast" and "https://www.bluecrossnc.com/sites/default/files/document/attachment/services/public/pdfs/formulary/Otezla_criteria.pdf" **under References**.
8/14/2018	1. **Added** https://tuftshealthplan.com/documents/providers/guidelines/pharmacy-medical-necessity-guidelines/otezla-apremilast", https://www.bluecrossnc.com/sites/default/files/document/attachment/services/public/pdfs/formulary/Otezla_criteria.pdf", and https://www.aad.org/practicecenter/quality/clinical-guidelines/psoriasis" **under References**
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**.