Clinical Policy: Etanercept (Enbrel)

Reference Number: CP.PHAR.250
Effective Date: 08/16
Last Review Date: 08/17
Line of Business: Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Etanercept (Enbrel®) is tumor necrosis factor blocker.

FDA Approved Indication(s)
Enbrel is indicated for the treatment of:

- Rheumatoid arthritis (RA)
- Polyarticular juvenile idiopathic arthritis (PJIA) in patients aged 2 years or older
- Psoriatic Arthritis (PsA)
- Ankylosing spondylitis (AS)
- Plaque psoriasis (PsO) in patients 4 years or older

Policy/Criteria
Provider must submit documentation (which may include office chart notes and lab results) supporting that member has met all approval criteria

It is the policy of health plans affiliated with Centene Corporation® that Enbrel is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Rheumatoid Arthritis (must meet all)**:**

1. Diagnosis of RA per American College of Rheumatology (ACR) criteria (refer to *Appendix B*);
2. Prescribed by or in consultation with a rheumatologist;
3. Age ≥ 18 years;
4. Member meets one of the following (a or b):
   a. Failure of methotrexate (MTX) for ≥ 3 consecutive months unless contraindicated or clinically significant adverse effects are experienced;
   b. If intolerance or contraindication to MTX, failure of sulfasalazine, leflunomide, or hydroxychloroquine for ≥ 3 consecutive months unless contraindicated or clinically significant adverse effect are experienced;
5. Tuberculosis (TB) test within the past 12 months is negative, or if positive, active TB has been ruled out and the patient has received treatment for latent TB infection;
6. Dose does not exceed 50 mg once weekly.

Approval duration: 6 months

B. Polyarticular Juvenile Idiopathic Arthritis (must meet all)**:**

1. Diagnosis of PJIA;
2. Prescribed by or in consultation with a rheumatologist;
3. Age ≥ 2 years;
4. Member meets one of the following (a or b):
   a. Failure of MTX for ≥ 3 consecutive months unless contraindicated or clinically significant adverse effects are experienced;
   b. If intolerance or contraindication to MTX, failure of sulfasalazine or leflunomide for ≥ 3 consecutive months unless contraindicated or clinically significant adverse effects are experienced;
5. TB test within the past 12 months is negative, or if positive, active TB has been ruled out and the patient has received treatment for latent TB infection;
6. Dose does not exceed 50 mg once weekly.

Approval duration: 6 months

C. Psoriatic Arthritis (must meet all)**:**

1. Diagnosis of active PsA;
2. Prescribed by or in consultation with a dermatologist or rheumatologist;
3. Age ≥ 18 years;
4. Member meets one of the following (a or b):
   a. Failure of MTX for ≥ 3 consecutive months unless contraindicated or clinically significant adverse effects are experienced;
   b. If intolerance or contraindication to MTX, failure of sulfasalazine, leflunomide, or cyclosporine for ≥ 3 consecutive months unless contraindicated or clinically significant adverse effects are experienced;
5. TB test within the past 12 months is negative, or if positive, active TB has been ruled out and the patient has received treatment for latent TB infection;
6. Dose does not exceed 50 mg once weekly.

Approval duration: 6 months

D. Ankylosing Spondylitis (must meet all)**:**

1. Diagnosis of active AS;
2. Prescribed by or in consultation with a rheumatologist;
3. Age ≥ 18 years;
4. Failure of at least TWO non-steroidal anti-inflammatory drugs each trialed for ≥ 4 weeks unless contraindicated or clinically significant adverse effects are experienced;
5. TB test within the past 12 months is negative, or if positive, active TB has been ruled out and the patient has received treatment for latent TB infection;
6. Dose does not exceed 50 mg once weekly.

Approval duration: 6 months

E. Plaque Psoriasis (must meet all)**:**

1. Diagnosis of PsO and at least one of the following:
   a. Greater than 5% of body surface area is affected;
   b. Involvement of palms, soles, face/neck, body folds, or genitalia;
2. Prescribed by or in consultation with a dermatologist or rheumatologist;
3. Age ≥ 4 years;

4. Failure of at least one oral systemic therapy for plaque psoriasis (e.g., methotrexate, cyclosporine, acitretin, or thioguanine) in combination with phototherapy or topical therapy (e.g., corticosteroids, calcipotriene, tazarotene) for ≥ 3 consecutive months unless contraindicated or clinically significant adverse effects are experienced;
5. Dose does not exceed 50 mg twice weekly for 3 months, then 50 mg once weekly.

Approval duration: 6 months

F. Other diagnoses/indications

1. Refer to CP.PHAR.57 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy (examples: sign/symptom reduction, no disease progression, no significant toxicity);
3. If request is for a dose increase, new dose does not exceed 50 mg once weekly.

Approval duration: 12 months

B. Other diagnoses/indications (1 or 2)**:**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

Approval duration: Duration of request or 12 months (whichever is less); or

2. Refer to CP.PHAR.57 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PHAR.57 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AS: ankylosing spondylitis
CRP: serum C-reactive protein
CCP: anticyclic citrullinated peptide
DMARD: disease-modifying antirheumatic drug
ESR: erythrocyte sedimentation rate
FDA: Food and Drug Administration
MTX: methotrexate
PJIA: polyarticular juvenile idiopathic arthritis
PsA: psoriatic arthritis
PsO: plaque psoriasis
RA: rheumatoid arthritis
SC: subcutaneous
TB: tuberculosis
TNF: tumor necrosis factor

Appendix B: The 2010 ACR Classification Criteria for RA

Add score of categories A through D; a score of ≥ 6 out of 10 is needed for classification of a patient as having definite RA.

A	**Joint involvement**	Score
	1 large joint	0
	2-10 large joints	1
	1-3 small joints (with or without involvement of large joints)	2
	4-10 small joints (with or without involvement of large joints)	3
	> 10 joints (at least one small joint)	5
B	**Serology (at least one test result is needed for classification)**	
	Negative rheumatoid factor (RF) *and* negative anti-citrullinated protein antibody (ACPA)	0
	Low positive RF *or* low positive ACPA * *Low: < 3 x upper limit of normal*	2
	High positive RF *or* high positive ACPA * *High: ≥ 3 x upper limit of normal*	3
C	**Acute phase reactants (at least one test result is needed for classification)**	
	Normal C-reactive protein (CRP) and normal erythrocyte sedimentation rate (ESR)	0
	Abnormal CRP or normal ESR	1
D	**Duration of symptoms**	
	< 6 weeks	0
	≥ 6 weeks	1

Appendix C: Definition of MTX or DMARD (disease modifying antirheumatic drug) Failure
In RA, failure of MTX or DMARD is defined as ≤ 50% decrease in swollen joint count, ≤ 50% decrease in tender joint count, and ≤ 50% decrease in ESR, or ≤ 50% decrease in CRP.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Adult RA and PsA	50 mg once weekly with or without MTX	50 mg once weekly
AS	50 mg once weekly	50 mg once weekly
Adult PsO	50 mg twice weekly for 3 months followed by 50 mg once weekly	50 mg once weekly
Pediatric PsO and PJIA	0.8 mg/kg weekly	50 mg per week

VI. Product Availability

Injection: 25 mg/0.5 mL and 50 mg/mL solution in a single-dose prefilled syringe
Injection: 50 mg/mL solution in single-dose prefilled SureClick®
For Injection: 25 mg lyophilized powder in a multiple-dose vial for reconstitution

VII. References

1. Enbrel Prescribing Information. Thousand Oaks, CA: Immunex Corporation; July 2017. Available at http://pi.amgen.com/~/media/amgen/repositorysites/pi-amgen-com/enbrel/enbrel_pi.ashx Accessed August 3, 2017.

2. Smolen JS, Landewé R, Breedveld FC, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2013 update. *Ann Rheum Dis*. 2014; 73: 492-509.
3. Singh JA, Furst DE, Bharat A, et al. 2012 update of the 2008 American College of Rheumatology recommendations for the use of disease-modifying antirheumatic drugs and biologic agents in the treatment of rheumatoid arthritis. *Arthritis Care Res.* 2012; 64(5): 625-639.
4. Ringold, S, Weiss PF, et al. 2013 Update of the 2011 American College of Rheumatology recommendations for the treatment of juvenile idiopathic arthritis. Arthritis Care Res. 2013; 65 (10): 2499-2512.
5. Beukelman T, et al. 2011 American College of Rheumatology recommendations for the treatment of juvenile idiopathic arthritis: initiation and safety monitoring of therapeutic agents for the treatment of arthritis and systemic features. Arthritis Care & Research, 2011;63(4):465-482.
6. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Section 6: Guidelines of care for the treatment of psoriasis and psoriatic arthritis: case-based presentations and evidence-based conclusions. *J Am Acad Dermatol*. 2011;65(1):137-174.
7. Menter A, Gottlieb A, Feldman SR, et al. Guidelines for the management of psoriasis and psoriatic arthritis. Section 1: Overview of psoriasis and guidelines of care for the treatment of psoriasis with biologics. *J Am Acad Dermatol*. 2008;58(5):826-850.
8. Ward MM, et al. American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network 2015 recommendations for the treatment of ankylosing spondylitis and nonradiographic axial spondyloarthritis. Arthritis & Rheumatology, 2015. DOI 10.1002/ART.39298.
9. Braun J, van den berg R, et al. 2010 Update of the ASAS/EULAR recommendations for the management of ankylosing spondylitis. Am Rheu Dis. 2011: 70; 896-904.
10. Aletaha D, Neogi T, Silman AJ, et al. 2010 Rheumatoid arthritis classification criteria: an American College of Rheumatology/European League Against Rheumatism collaborative initiative, Arthritis Rheum , 2010, vol. 62 (pg. 2569 - 81).

Coding Implications
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J1438	Injection, etanercept, 25 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)

Reviews, Revisions, and Approvals	Date	Approval Date
Policy split from CP.PHAR.85.Psoriasis Treatments and CP.PHAR.86.Arthritis Treatments. RA, PJIA, PsA, AS, PsO: Removed criteria related to HBV, malignant disease, concomitant use with other biologics, and concurrent administration of live vaccines; added dosing requirement. PJIA: removed question related to number of affected joints; modified criteria to require trial of MTX, unless contraindicated; added sulfasalazine as an alternative to MTX if MTX is contraindicated. RA: changed age requirement to 18; modified criteria to require trial of MTX, unless contraindicated; added sulfasalazine and hydroxychloroquine as an alternative to MTX if MTX is contraindicated. PsO: removed duration of trial for topical and phototherapy. PsA: required trial of MTX and added requirement for the following if MTX cannot be used: leflunomide, cyclosporine, sulfasalazine & azathioprine. Re-auth: combined into All Indications; added dosing and reasons to discontinue; for PsO, changed efficacy criteria related to Psoriasis Area and Severity Index (PASI)-75 to general efficacy statement. Removed Otezla from list of therapies to trial per PDL. Modified approval duration to 6 months for initial and 12 months for renewal.	06/16	08/16
Changed age for plaque psoriasis to ≥ 4 to reflect changes in PI indication.	12/16	
Converted to new template. RA: Revised criteria for confirmation of diagnosis per 2010 ACR Criteria. PsO: Trial requirement modified to require the concomitant use of oral and topical or phototherapy. Safety criteria was applied according to the safety guidance discussed at CPAC and endorsed by Centene Medical Affairs.	08/17	08/17

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.