

Clinical Policy: Guselkumab (Tremfya)

Reference Number: CP.PHAR.364

Effective Date: 08.29.17

Last Review Date: 11.18

Line of Business: Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Guselkumab (Tremfya[®]) is an interleukin-23 (IL-23) blocker.

FDA Approved Indication(s)

Tremfya is indicated for the treatment of adult patients with moderate-to-severe plaque psoriasis (PsO) who are candidates for systemic therapy or phototherapy.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

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

I. Initial Approval Criteria

A. Plaque Psoriasis (must meet all):

1. Diagnosis of PsO;
2. Prescribed by or in consultation with a dermatologist or rheumatologist;
3. Age \geq 18 years;
4. Member meets one of the following (a or b):
 - a. Failure of a \geq 3 consecutive month trial of methotrexate (MTX) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
 - b. If intolerance or contraindication to MTX (*see Appendix D*), failure of a \geq 3 consecutive month trial of cyclosporine or acitretin at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
5. Failure of a \geq 3 consecutive month trial of adalimumab (*Humira[®] is preferred*), unless contraindicated or clinically significant adverse effects are experienced;
**Prior authorization is required for adalimumab*
6. Dose does not exceed 100 mg at weeks 0 and 4, followed by maintenance dose of 100 mg every 8 weeks.

Approval duration: 6 months

B. Other diagnoses/indications

1. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. Plaque Psoriasis (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;
3. If request is for a dose increase, new dose does not exceed 100 mg every 8 weeks.

Approval duration: 12 months

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

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

Approval duration: Duration of request or 6 months (whichever is less); or

2. Refer to CP.PMN.53 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.PMN.53 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration

IL-23: interleukin-23

MTX: methotrexate

PsO: plaque psoriasis

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
acitretin (Soriatane [®])	PsO 25 or 50 mg PO daily	50 mg/day
cyclosporine (Sandimmune [®] , Neoral [®])	PsO 2.5 – 4 mg/kg/day PO divided BID	4 mg/kg/day
methotrexate (Rheumatrex [®])	PsO 10 – 25 mg/week PO or 2.5 mg PO Q12 hr for 3 doses/week	30 mg/week
Humira [®] (adalimumab)	PsO <u>Initial dose:</u> 80 mg SC <u>Maintenance dose:</u>	40 mg every other week

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	40 mg SC every other week starting one week after initial dose	

Therapeutic alternatives are listed as Brand name[®] (generic) when the drug is available by brand name only and generic (Brand name[®]) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

None reported

Appendix D: General Information

- Definition of failure of MTX or DMARDs
 - Child-bearing age is not considered a contraindication for use of MTX. Each drug has risks in pregnancy. An educated patient and family planning would allow use of MTX in patients who have no intention of immediate pregnancy.
 - Social use of alcohol is not considered a contraindication for use of MTX. MTX may only be contraindicated if patients choose to drink over 14 units of alcohol per week. However, excessive alcohol drinking can lead to worsening of the condition, so patients who are serious about clinical response to therapy should refrain from excessive alcohol consumption.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
PsO	<u>Initial dose:</u> 100 mg SC at weeks 0 and 4 <u>Maintenance dose:</u> 100 mg SC every 8 weeks	100 mg every 8 weeks

VI. Product Availability

Single-dose prefilled syringe: 100 mg/mL

VII. References

1. Tremfya Prescribing Information. Horsham, PA: Janssen Biotech, Inc.; October 2017. Available at <https://www.tremfyahcp.com/>. Accessed September 4, 2018.
2. Blauvelt A, PappKA, Griffiths CE et al. Efficacy and safety of guselkumab, an anti-interleukin-23 monoclonal antibody, compared with adalimumab for the continuous treatment of patients with moderate to severe psoriasis: Results from the phase III, double-blinded, placebo- and active comparator-controlled VOYAGE 1 trial. *J Am Acad Dermatol.* 2017 Mar;76(3):405-417. Doi: 10.1016/j.jaad.2016.11.041. Epub 2017 Jan 2.
3. Reich K, Armstron AW, Foley P et al. Efficacy and safety of guselkumab, an anti-interleukin-23 monoclonal antibody, compared with adalimumab for the treatment of patients with moderate to severe psoriasis with randomized withdrawal and retreatment: Results from the phase III, double-blind, placebo- and active comparator-controlled VOYAGE 2 trial. *J Am Acad Dermatol.* 2017 Mar;76(3):418-431. Doi: 10.1016/j.jaad.2016.11.042. Epub 2017 Jan 2.

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4. Nakamura M, Lee K, Jeon C et al. Guselkumab for the Treatment of Psoriasis: A Review of Phase III Trials. *Dermatol Ther (Heidelb)*. 2017 Jun 21. Doi: 10.1007/s13555-017-0187-0.
5. Langley RG, Tsai TF, Flavin S et al. Efficacy and safety of guselkumab in patients with psoriasis who have an inadequate response to ustekinumab: Results of the randomized, double-blind, Phase 3 NAVIGATE trial. *Br J Dermatol*. 2017 Jun 21. Doi: 10.1111/bjd.15750.

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
C9029	Injection, guselkumab, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created.	08.29.17	11.17
2Q 2018 annual review: removed trial and failure of phototherapy and topical therapy; modified trial and failure to require use of cyclosporine or acitretin if methotrexate is not tolerated or contraindicated; removed TB testing requirement; references reviewed and updated.	02.27.18	05.18
4Q 2018 annual review: no significant changes; references reviewed and updated.	09.04.18	11.18

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,

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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.

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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.

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