

Clinical Policy: Ustekinumab (Stelara)

Reference Number: CP.PHAR.264

Effective Date: 08.16

Last Review Date: 05.18

Line of Business: HIM, Medicaid

[Coding Implications](#)[Revision Log](#)

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

Description

Ustekinumab (Stelara[®]) is a human interleukin-12 (IL-12) and -23 (IL-23) antagonist.

FDA Approved Indication(s)

Stelara is indicated for the treatment of:

- Adult and adolescent (12 years or older) patients with moderate-to-severe plaque psoriasis (PsO) who are candidates for phototherapy or systemic therapy
- Adult patients with active psoriatic arthritis (PsA), alone or in combination with methotrexate
- Adult patients with moderately to severely active Crohn's disease (CD) who have:
 - Failed or were intolerant to treatment with immunomodulators or corticosteroids, but never failed a tumor necrosis factor (TNF) blocker; or
 - Failed or were intolerant to treatment with one or more TNF blockers

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 Stelara is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria**A. Plaque Psoriasis** (must meet all):

1. Diagnosis of PsO;
2. Request is for SC formulation;
3. Prescribed by or in consultation with a dermatologist or rheumatologist;
4. Age \geq 12 years;
5. 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 C*), 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;
6. 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*

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7. Dose does not exceed one of the following (a or b):
 - a. Adult: weight-based dosing initially and 4 weeks later, followed by maintenance dose every 12 weeks (i or ii);
 - i. Weight \leq 100 kg: 45 mg per dose;
 - ii. Weight $>$ 100 kg: 90 mg per dose;
 - b. Pediatrics: weight-based dosing initially and 4 weeks later, followed by maintenance dose every 12 weeks (i, ii, or iii);
 - i. Weight $<$ 60 kg: 0.75 mg/kg per dose;
 - ii. Weight 60 kg to 100 kg: 45 mg per dose;
 - iii. Weight $>$ 100 kg: 90 mg per dose.

Approval duration: 6 months

B. Psoriatic Arthritis (must meet all):

1. Diagnosis of PsA;
2. Request is for SC formulation;
3. Prescribed by or in consultation with a dermatologist or rheumatologist;
4. Age \geq 18 years;
5. Member meets one of the following (a or b):
 - a. Failure of a \geq 3 consecutive month trial of MTX at up to maximally indicated doses, for unless contraindicated or clinically significant adverse effects are experienced;
 - b. If intolerance or contraindication to MTX (*see Appendix C*), failure of a \geq 3 consecutive month trial of cyclosporine, sulfasalazine, or leflunomide at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
6. Failure of etanercept (*Enbrel is preferred*) and adalimumab (*Humira is preferred*), each used for \geq 3 consecutive months, unless contraindicated or clinically significant adverse effects are experienced;
**Prior authorization is required for etanercept and adalimumab*
7. Dose does not exceed one of the following (a or b):
 - a. 45 mg initially and 4 weeks later, followed by maintenance dose of 45 mg every 12 weeks;
 - b. Co-existent PsO and weight $>$ 100 kg: 90 mg initially and 4 weeks later, followed by maintenance dose of 90 mg every 12 weeks.

Approval duration: 6 months

C. Crohn's Disease (must meet all):

1. Diagnosis of CD;
2. Prescribed by or in consultation with a gastrointestinal (GI) specialist;
3. Age \geq 18 years;
4. Failure of a \geq 3 consecutive month trial of at least ONE immunomodulator (e.g., azathioprine, 6-mercaptopurine [6-MP], MTX) 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;

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**Prior authorization is required for adalimumab*

6. Dose does not exceed:
 - a. Initial dose (IV):
 - i. Weight \leq 55 kg: 260 mg once;
 - ii. Weight > 55 kg to 85 kg: 390 mg once;
 - iii. Weight > 85 kg: 520 mg once;
 - b. Maintenance dose (SC): 90 mg 8 weeks after the initial IV dose, followed by maintenance dose of 90 mg every 8 weeks.

Approval duration: 6 months

D. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid

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;
3. Request is for SC formulation;
4. If request is for a dose increase, new dose does not exceed one of the following (a, b, or c):
 - a. PsO alone (i or ii):
 - i. Adults (a or b):
 - a) Weight \leq 100 kg: 45 mg every 12 weeks;
 - b) Weight > 100 kg: 90 mg every 12 weeks;
 - ii. Pediatrics (a, b, or c):
 - a) Weight < 60 kg: 0.75 mg/kg every 12 weeks;
 - b) Weight 60 kg to 100 kg: 45 mg every 12 weeks;
 - c) Weight > 100 kg: 90 mg every 12 weeks;
 - b. PsA (i or ii):
 - i. 45 mg every 12 weeks;
 - ii. Co-existent PsO and weight > 100 kg: 90 mg every 12 weeks;
 - c. CD: 90 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 the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is

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NOT authorized): HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid.

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 policies – HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

6-MP: 6-mercaptopurine

CD: Crohn's disease

FDA: Food and Drug Administration

GI: gastrointestinal

IL-12: interleukin-12

IL-23: interleukin-23

MTX: methotrexate

PsO: plaque psoriasis

PsA: psoriatic arthritis

TNF: tumor necrosis factor

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
azathioprine (Azasan [®] , Imuran)	CD 1.5 – 2 mg/kg/day PO	2.5 mg/kg/day
corticosteroids	CD* prednisone 40 mg PO QD for 2 weeks or IV 50 – 100 mg Q6H for 1 week budesonide (Entocort EC [®]) 6 – 9 mg PO QD	Various
cyclosporine (Sandimmune [®] , Neoral [®])	PsO 2.5 – 4 mg/kg/day PO divided BID PsA* 2.5 – 3 mg/kg/day PO QD	PsO: 4 mg/kg/day PsA: 3 mg/kg/day
leflunomide (Arava [®])	PsA* 100 mg/day loading dose for 3 days, followed by 20 mg/day PO	20 mg/day
6-mercaptopurine (Purixan [®])	CD 50 mg PO QD or 1 – 2 mg/kg/day PO	2 mg/kg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
methotrexate (Rheumatrex [®])	<p>CD* 15 – 25 mg/week IM or SC</p> <p>PsO 10 – 25 mg/week PO or 2.5 mg PO Q12 hr for 3 doses/week</p> <p>PsA* 7.5 – 15 mg/week PO</p>	30 mg/week
Pentasa [®] (mesalamine)	<p>CD 1,000 mg PO QID</p>	4 g/day
sulfasalazine (Azulfidine [®])	<p>PsA* 2 g/day PO</p>	5 g/day
Enbrel [®] (etanercept)	<p>PsA 25 mg SC twice weekly or 50 mg SC once weekly</p>	50 mg/week
Humira [®] (adalimumab)	<p>CD <u>Initial dose:</u> 160 mg SC on Day 1, then 80 mg SC on Day 15</p> <p><u>Maintenance dose:</u> 40 mg SC every other week starting on Day 29</p> <p>PsA 40 mg SC every other week</p> <p>PsO <u>Initial dose:</u> 80 mg SC <u>Maintenance dose:</u> 40 mg SC every other week starting one week after initial dose</p>	40 mg every other week

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.

*Off-label

Appendix C: General Information

- Definition of failure of MTX or DMARDs

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- 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.
- Examples of positive response to therapy may include, but are not limited to:
 - Reduction in joint pain/swelling/tenderness
 - Improvement in erythrocyte sedimentation rate/C-reactive protein (ESR/CRP) levels
 - Improvements in activities of daily living

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
PsO	Weight based dosing SC at weeks 0 and 4, followed by maintenance dose every 12 weeks <i>Adult:</i> Weight ≤ 100 kg: 45 mg Weight > 100 kg: 90 mg <i>Pediatrics (Age 12 years and older):</i> Weight < 60 kg: 0.75 mg/kg Weight 60 to 100 kg: 45 mg Weight > 100kg: 90 mg	90 mg every 12 weeks
PsA	45 mg SC at weeks 0 and 4, followed by 45 mg every 12 weeks	45 mg every 12 weeks
PsA with co-existent PsO	Weight > 100 kg: 90 mg SC at weeks 0 and 4, followed by 90 mg every 12 weeks	90 mg every 12 weeks
CD	Weight based dosing IV at initial dose, followed by 90 mg SC every 8 weeks Weight ≤ 55 kg: 260 mg Weight 55 kg to 85 kg: 390 mg Weight > 85 kg: 520 mg	90 mg every 8 weeks

VI. Product Availability

- Single-dose prefilled syringe: 45 mg/0.5 mL, 90 mg/mL
- Single-dose vial for SC injection: 45 mg/0.5 mL
- Single-dose vial for IV infusion: 130 mg/26 mL

VII. References

1. Stelara Prescribing Information. Horsham, PA: Janssen Biotech; February 2018. Available at: www.stelarainfo.com. Accessed February 27, 2018.

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3. Menter A, Gottlieb A, Feldman SR, Van Voorhees AS, Leonardi CL, Gordon KB, et al. American Academy of Dermatology. Guidelines of care 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 May; 58(5):826-50.
4. Menter A, Gottlieb A, Feldman, SR, et al. American Academy of Dermatology. Guidelines of care for the management of psoriasis and psoriatic arthritis: Section 2. Psoriatic arthritis: overview and guidelines of care for treatment with an emphasis on the biologics. J Am Acad Dermatol May 2008; 58(5): 826-50.
5. Menter A, Korman, NJ, Elmets CA, et al. American Academy of Dermatology. Guidelines of care for the management of psoriasis and psoriatic arthritis. Section 3. Guidelines of care for the management and treatment of psoriasis with topical therapies. J Am Acad Dermatol. 2009;60:643-659.
6. Menter A, Korman NF, Elmets CA, et al. American Academy of Dermatology. Guidelines of care for the management of psoriasis and psoriatic arthritis. Section 4. Guidelines of care for the management and treatment of psoriasis with traditional systemic agents. J Am Acad Dermatol. 10.1016/j.jaad.2009.03.027
7. Bernell O, Lapidus A, Hellers G. Risk Factors for Surgery and Postoperative Recurrence in Crohn`s Disease. Annals of Surgery. 2000; 231(1): 38-45.
8. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2018. Available at <http://www.clinicalpharmacology-ip.com/>.

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
J3357	Ustekinumab, for subcutaneous injection, 1 mg
J3358	Ustekinumab, for intravenous injection, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy split from CP.PHAR.85.Psoriasis Treatments. Plaque psoriasis: removed criteria related to HBV, malignant disease and concurrent use with another biologic; modified requirement for the use of topical agent and phototherapy to not require 3 consecutive months of treatment; removed Otezla as a DMARD option for trial and failure; added requirement for failure of PDL Enbrel and Humira, unless contraindicated; added max dose requirement; updated contraindications per FDA labeling. Re-auth: modified specific efficacy criteria related to Psoriasis Area and Severity Index (PASI)-75	06.16	08.16

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Reviews, Revisions, and Approvals	Date	P&T Approval Date
to general efficacy statement; added max dose requirement. Psoriatic arthritis: modified criteria to require failure of PDL Enbrel and Humira, unless contraindicated; added max dose; updated contraindications per FDA labeling; required trial of MTX and added requirement for the following agents as an alternative if MTX cannot be used: leflunomide, cyclosporine, sulfasalazine, azathioprine. Re-auth: Combined into “All Indications”; added max dose and reasons to discontinue per PI; Shortened background section.		
Crohn’s disease: added criteria related to new FDA-approved indication of Crohn’s disease. Edited initial criteria to require trials of another biologic or immunomodulator therapy, as well as Humira. Removed “active TB” under continuation criteria - reasons to discontinue for consistency across similar policies; active TB is covered under “serious infections” under this same section.	11.16	12.16
Converted to the new template. PsO: Preferencing requirement for Enbrel removed; trial requirement modified to require the concomitant use of oral and topical or phototherapy. CD: updated list of poor prognostic indicators per AGA guidelines; examples of extensive disease added. Safety criteria was applied according to the safety guidance discussed at CPAC and endorsed by Centene Medical Affairs.	08.17	08.17
Converted to new template. Updated with new indication for use in adolescent patients with PsO. Modified age limit for PsO.	01.11.18	
2Q 2018 annual review: policies combined for HIM and Medicaid lines of business; For HIM and Medicaid: removed specific diagnosis requirements for PsO and CD, added rheumatologist as prescriber specialty requirement for PsO, removed trial and failure of phototherapy and topical therapy for PsO, modified trial and failure to require use of methotrexate or alternative DMARD in addition to Humira for PsO, modified max dosing requirements per package insert, removed TB testing for all indications; references reviewed and updated.	02.27.18	05.18

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

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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.

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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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For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy.

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