Pharmacy Medical Necessity Guidelines: Cimzia® (certolizumab pegol)

Effective: July 11, 2017

Prior Authorization Required | √ | Type of Review – Care Management
Not Covered | | Type of Review – Clinical Review | √
Pharmacy (RX) or Medical (MED) Benefit | RX | Department to Review | RXUM

This Pharmacy Medical Necessity Guideline applies to the following:

Tufts Health Plan Commercial Plans
☐ Tufts Health Plan Commercial Plans – large group plans
☐ Tufts Health Plan Commercial Plans – small group and individual plans

Tufts Health Public Plans
☐ Tufts Health Direct – Health Connector
☒ Tufts Health Together – A MassHealth Plan
☐ Tufts Health RITogether – A Rite Care + Rhody Health Partners Plan

Tufts Health Freedom Plan products
☐ Tufts Health Freedom Plan - large group plans
☐ Tufts Health Freedom Plan - small group plans

Fax Numbers:
RXUM: 617-673-0988

OVERVIEW

FDA-APPROVED INDICATIONS
Cimzia (certolizumab pegol) is a tumor necrosis factor (TNF) blocker indicated for:

Ankylosing Spondylitis
Treatment of adults with active ankylosing spondylitis (AS).

Crohn’s Disease
Reducing signs and symptoms of Crohn’s disease and maintaining clinical response in adult patients with moderately to severely active disease who have had an inadequate response to conventional therapy.

Psoriatic Arthritis
Treatment of adult patients with active psoriatic arthritis (PsA).

Rheumatoid Arthritis
Treatment of adults with moderately to severely active rheumatoid arthritis.

COVERAGE GUIDELINES
The plan may authorize coverage of Cimzia (certolizumab pegol) for members when all of the following criteria for a particular regimen are met and limitations do not apply:

For Ankylosing Spondylitis
1. The Member has a documented diagnosis of active ankylosing spondylitis
   AND
2. The prescription is written by a rheumatologist
   AND
3. The Member is 18 years of age or older
   AND
4. The Member has tried and failed treatment with, or the patient has a contraindication to at least one NSAID
   AND
   Failure or intolerance to adalimumab (Humira®) and etanercept (Enbrel®)
   OR
5. The Member is new to the plan and has been stable on Cimzia prior to enrollment.

For Crohn’s Disease
1. The Member has a documented diagnosis of Crohn’s disease by a gastroenterologist
   AND
2. The Member is 18 years of age or older

AND

3. The Member has demonstrated an inadequate response to an appropriate trial with two or more of the following agents:
   - Corticosteroids (e.g., prednisone, prednisolone, methylprednisolone)
   - 5-Aminosalicylates (e.g., sulfasalazine, Azulfidine®, Apriso™, Delzicol™, Pentasa®, Rowasa®, Dipentum®, Colazal®)
   - 6-mercaptopurine (6-MP, Purinethol®) and/or azathioprine (Imuran®)
   - Methotrexate (MTX)  
   
   Failure or intolerance to adalimumab (Humira®)
   
   OR

4. The Member is new to the plan and has been stable on Cimzia prior to enrollment.

For Psoriatic Arthritis
1. The Member has a documented diagnosis of psoriatic arthritis

AND

2. The prescription is written by a rheumatologist

AND

3. The Member is 18 years of age or older

AND

4. The Member has a documented inadequate response or inability to take methotrexate OR sulfasalazine at maximal doses for three months.

   AND

   Failure or intolerance to adalimumab (Humira®) and etanercept (Enbrel®)

OR

5. The Member is new to the plan and has been stable on Cimzia prior to enrollment.

Note: Maximal doses of methotrexate are defined as 15mg to 25mg per week depending on the patient’s tolerance.

For Rheumatoid Arthritis
1. The Member has a documented diagnosis of Rheumatoid Arthritis by a rheumatologist

AND

2. The Member is 18 years of age or older

AND

3. The Member tried and failed treatment with, or has a contraindication to at least one DMARD (Disease Modifying Anti-rheumatic Drugs), such as azathioprine, gold therapy, hydroxychloroquine, methotrexate, penicillamine, sulfasalazine, cyclosporine or leflunomide.

   AND

   Failure or intolerance to adalimumab (Humira®) and etanercept (Enbrel®)

OR

4. The Member is new to the plan and has been stable on Cimzia prior to enrollment.

Note: Maximal doses of methotrexate are defined as 15mg to 25mg per week depending on the patient’s tolerance.

LIMITATIONS
1. Samples, free goods or similar offerings of Cimzia (certolizumab) do not qualify for an established clinical response and will not be considered for prior authorization.
2. Initial approval of Cimzia (certolizumab pegol) will be limited to 12 months. Subsequent authorizations may be approved in 12 month intervals when the provider indicates improvement with therapy.

3. Coverage of Cimzia prefilled syringe is limited to 28-day supplies as follows:
   - Cimzia 200 mg syringe – 6 syringes per 28 days (initial 4 weeks) then 2 syringes per 28 days thereafter.

REFERENCES


**APPROVAL HISTORY**

June 2009: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:
- December 2, 2014: Reviewed by the Pharmacy and Therapeutics Committee.
- September 16, 2015: No changes
- January 1, 2016: Administrative change to rebranded template.
- September 13, 2016: Added exception language for Members new to the plan and stable on Cimzia prior to enrollment.
- November 18, 2016: Administrative update; clarified for the diagnosis of Crohn's disease that member must have tried and failed a nonbiologic DMARD and adalimumab (Humira).
- April 11, 2017: Administrative update, Adding Tufts Health RITogether to the template.
- July 11, 2017: Administrative update to add the following Limitation: Samples, free goods or similar offerings of Cimzia (certolizumab) do not qualify for an established clinical response and will not be considered for prior authorization.

**BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION**

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They are used in conjunction with a Member's benefit document and in coordination with the Member's physician(s). The plan makes coverage decisions on a case-by-case basis considering the individual Member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

This Pharmacy Medical Necessity Guideline does not apply to Uniformed Services Family Health Plan Members or to certain delegated service arrangements. Unless otherwise noted in the Member’s benefit document or applicable Pharmacy Medical Necessity Guideline, Pharmacy Medical Necessity Guidelines do not apply to CareLinkSM Members. For self-insured plans, drug coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a coverage guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates will take precedence.

For Tufts Health Plan Medicare Preferred Members, please refer to the Tufts Health Plan Medicare Preferred Prior Authorization Criteria.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to Member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.

Provider Services