Pharmacy Management Drug Policy

SUBJECT: Stelera (ustekinumab)
POLICY NUMBER: PHARMACY-59
EFFECTIVE DATE: 09/25/2014
LAST REVIEW DATE: 01/01/2025

If the member's subscriber contract excludes coverage for a specific service or prescription drug, it is not covered under that contract. In such cases, medical or drug policy criteria are not applied. This drug policy applies to the following line/s of business:

Policy Application

Category:	☒ Commercial Group (e.g., EPO, HMO, POS, PPO)	☒ Medicare Advantage
	☒ On Exchange Qualified Health Plans (QHP)	☐ Medicare Part D
	☒ Off Exchange Direct Pay	☒ Essential Plan (EP)
	☒ Medicaid & Health and Recovery Plans (MMC/HARP)	☒ Child Health Plus (CHP)
	☐ Federal Employee Program (FEP)	☐ Ancillary Services
	☒ Dual Eligible Special Needs Plan (D-SNP)	

DESCRIPTION:

Stelara® (Ustekinumab) is a human monoclonal antibody that binds to and interferes with the proinflammatory cytokines, interleukin 12 (IL-12) and IL-23. Biological effects of IL-12 and IL-23 include natural killer cell activation and CD4+ T-cell differentiation and activation. Ustekinumab also interferes with the expression of monocyte chemotactic protein-1, tumor necrosis factor-alpha, interferon-inducible protein-10, and IL-8. Significant clinical improvement in psoriasis and psoriatic arthritis patients is seen in association with reduction of these proinflammatory signalers

Stelara® is indicated for:

- the treatment of patients 6 years or older with moderate to severe plaque psoriasis who are candidates for systemic therapy or phototherapy
- the treatment of patients 6 years or older with active psoriatic arthritis.
- the treatment of adult patients with moderately to severely active Crohn's disease
- the treatment of adult patients with moderately to severely active ulcerative colitis

Stelara® can be administered by a healthcare professional or can be self-administered if individual has been trained by a health care professional.

- If administered by a healthcare professional, it goes under the medical benefit.
- If self-administered, it goes under the pharmacy (Rx) benefit.

POLICY:

Based upon our assessment and review of the peer-reviewed literature Stelara® has been medically proven to be effective and therefore, **medically necessary** for the treatment of the following diagnoses if specific criteria are met:

A. Plaque Psoriasis

1. Must be prescribed by or in consultation with a Dermatologist or Rheumatologist **AND**
2. Member must be at least 6 years of age **AND**
3. Member must have moderate to severe chronic plaque psoriasis that involves at least 10% of their body surface area. Consideration will be given to those who have less than 10% body surface area involvement but have severe disease of sensitive areas or areas causing significant disruption in normal activities (such as the hands, feet, face, genitalia) **AND**
4. Member must be a candidate for systemic therapy, i.e., acitretin, methotrexate, or cyclosporine with a trial period of at least 3 months. If contraindications are present or had developed severe intolerance to the above-mentioned agents before 3 months, a trial of one of the other three criteria listed below must be present **OR**
5. If systemic therapy is contraindicated, then one of the following must be attempted for a reasonable period of time (at least 3 months):
    a. UVB in combination with a topical therapy such as coal tar, steroids or tazarotene **OR**
    b. PUVA in combination with topical corticosteroids **OR**
    c. Medium/High potency topical steroids in combination with anthralin, calcipotriene, or tazarotene
6. Approved dosing is in chart listed below on page 3.

B. Psoriatic Arthritis

1. Must be prescribed by or in consultation with a Rheumatologist or Dermatologist **AND**
2. Member must be at least 6 years of age **AND**
3. Must have a diagnosis of active Psoriatic Arthritis
4. Approved dosing is in chart listed on page 3.

C. Crohn's Disease

1. Must be prescribed by or in consultation with a Gastroenterologist **AND**
2. The patient must have a diagnosis of moderately to severely active Crohn's Disease **AND**
3. Patient must be at least 18 years of age **AND**
4. There must be documentation that azathioprine, 6-mercaptopurine, or methotrexate is ineffective, contraindicated, or not tolerated
    a. Treatment with a biologic medication as first-line therapy will be assessed on a case-by-case basis through a letter of medical necessity and clinical progress notes based on severity of the disease
5. Approved dosing:
    a. Induction dosing - At week 0, a one-time weight-based IV loading dose (260 mg [55 kg or less], 390 mg [more than 55 kg to 85 kg], or 520 mg [more than 85 kg]) is given by a healthcare professional. This will be paid for under the medical benefit.
    b. Maintenance dosing - starting at week 8, Stelara 90mg is given subcutaneously every 8 weeks. This can be self-injected under the Rx benefit or given subcutaneously by a healthcare professional under the medical benefit.

D. Ulcerative Colitis

1. Must be prescribed by or in consultation with a Gastroenterologist **AND**
2. The patient must have a diagnosis of moderately to severely active Ulcerative Colitis **AND**
3. The patient must be at least 18 years of age **AND**
4. Must meet for ONE of the following (a or b):
   a. Must have tried and failed or has documented intolerance to at least ONE of the following conventional therapies for at least 3 months:
      i. Thiopurines: azathioprine/6-mercaptopurine (6-MP)
      ii. 5-Aminosalicylates: sulfasalazine, mesalamine, olsalazine
      iii. IV or oral steroids - note, a 3-month trial of systemic steroid therapy will not be required
   b. The patient has been diagnosed with pouchitis and has tried an antibiotic, corticosteroid enema, or mesalamine enema
5. Approved dosing:
   a. Induction dosing - At week 0, a one-time weight-based IV loading dose (260 mg [55 kg or less], 390 mg [more than 55 kg to 85 kg], or 520 mg [more than 85 kg]) is given by a healthcare professional. This will be paid for under the medical benefit.
   b. Maintenance dosing - starting at week 8, Stelara 90mg is given subcutaneously every 8 weeks. This can be self-injected under the Rx benefit or given subcutaneously by a healthcare professional under the medical benefit.

Dosing guidelines for Plaque Psoriasis (PP):

If patient weighs:	Initial and maintenance dose
≤ 100kg	45mg at week 0 and 4, followed by 45mg every 12 weeks
> 100kg	90mg at week 0 and 4, followed by 90mg every 12 weeks

- **Pediatric dosing SC (≥ 6 years of age):**
  - **< 60kg:** 0.75mg/kg at weeks 0, 4, and every 12 weeks thereafter
  - **60kg to 100kg:** 45mg at weeks 0, 4, and every 12 weeks thereafter
  - **> 100kg:** 90mg at weeks 0, 4, and every 12 weeks thereafter

Dosing guidelines for Psoriatic Arthritis (PsA):

If patient weighs:	Initial and maintenance dose
Any weight	45mg at week 0and 4, followed by 45mg every 12 weeks
> 100kg and co-existent PP and PsA, regardless of TNF-history	90mg at week 0and 4, followed by 90mg every 12 weeks

***** If there is **no response** to initial dosing other than increasing from 45mg to 90mg at week 16 if patient weighs > 100kg, then the dose increase request will **NOT** be allowed.

- **Pediatric dosing SC (≥ 6 years of age):**
  - **< 60kg:** 0.75mg/kg at weeks 0, 4, and every 12 weeks thereafter
  - **60kg to 100kg:** 45mg at weeks 0, 4, and every 12 weeks thereafter

- **> 100kg:** 90mg at weeks 0, 4, and every 12 weeks thereafter

E. Quantity Limit: 45mg SC syringe 0.5mL per 84 days; 90mg SC syringe 1mL per 84 days

APPROVAL TIME PERIODS:

Line of Business	Rx Initial approval	Rx Recertification	Medical Initial approval	Medical Recertification
Commercial, Exchange, Safety Net (Medicaid, HARP, CHP, Essential Plan)	1 year *Does not apply to Medicaid and HARP	1 year *Does not apply to Medicaid and HARP	All sites of service: 1 year	All sites of service: 1 year
Medicare	Already defined in policy	Already defined in policy	All sites of service: 2 years	All sites of service: 2 years

POLICY GUIDELINES:

1. Utilization Management are contract dependent and coverage criteria may be dependent on the contract renewal date. Additionally, coverage of drugs listed in this policy are contract dependent. Refer to specific contract/benefit language for exclusions.
2. Not all contracts cover all Medical Infusible drugs. Refer to specific contract/benefit plan language for exclusions of Injectable Medications.
3. This policy does not apply to Medicare Part D and D-SNP pharmacy benefits. The drugs in this policy may apply to all other lines of business including Medicare Advantage.
4. For members with Medicare Advantage, medications with a National Coverage Determination (NCD) and/or Local Coverage Determination (LCD) will be covered pursuant to the criteria outlined by the NCD and/or LCD. NCDs/LCDs for applicable medications can be found on the CMS website at https://www.cms.gov/medicare-coverage-database/search.aspx. Indications that have not been addressed by the applicable medication's LCD/NCD will be covered in accordance with criteria determined by the Health Plan (which may include review per the Health Plan's Off-Label Use of FDA Approved Drugs policy). Step therapy requirements may be imposed in addition to LCD/NCD requirements.
5. Continued approval at time of recertification will require documentation that the drug is providing ongoing benefit to the patient in terms of improvement or stability in disease state or condition. Such documentation may include progress notes, imaging or laboratory findings, and other objective or subjective measures of benefit which support that continued use of the requested product is medically necessary. Also, ongoing use of the requested product must continue to reflect the current policy's preferred formulary. Recertification reviews may result in the requirement to try more cost-effective treatment alternatives as they become available (i.e., generics, biosimilars, or other guideline-supported treatment options). Requested dosing must continue to be consistent with FDA-approved or off-label/guideline-supported dosing recommendations.
6. This policy is applicable to drugs that are included on a specific drug formulary. If a drug referenced in this policy is non-formulary, please reference Non-Formulary Medication Exception Review Policy for all Lines of Business policy (Pharmacy-69)
7. If Stelara® is being self-administered, it will be paid for under the pharmacy benefit. If Stelara® is being given in the office or by a healthcare professional, it would then go under the medical benefit.
8. Requests for 45 mg every 8 weeks will be denied as off label as there is no efficacy data for any weight.
9. While the FDA-approved dosing for persons weighing > 100kg with psoriasis is to start with 90mg dose, the 45mg dose was effective in clinical trials (PASI 75 response at week 12: 54% vs 68% in

45mg and 90mg, respectively). We will allow the dose increase to 90mg by week 16 if little to no improvement.

10. **Concurrent use of Inflammatory Agents**
    a. Stelara as well as other immunomodulating therapies or Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs) (Enbrel, Cimzia, Remicade, biosimilars, etc.) should not be administered in combination with another biologic or targeted synthetic DMARD used for an inflammatory condition. Combination therapy is generally not recommended due to the added risk of immunosuppression, potential for a higher rate of adverse effects, and lack of evidence for additive therapy. NOTE: This does NOT exclude the use of conventional synthetic DMARDs (e.g., MTX, leflunomide, hydroxychloroquine, and sulfasalazine) in combination with biologics and targeted synthetic DMARDs.
    b. Requests for the concurrent use of inflammatory agents will be evaluated for safety and efficacy and subject to off-label review.
    c. Otezla in combination with biologic DMARD therapy (such as adalimumab, Enbrel, Cosentyx, etc.) is not FDA approved or supported with a high level of clinically valid medical evidence for the treatment of plaque psoriasis or psoriatic arthritis. Therefore, these requests are considered combination therapy and are considered not medically necessary.
11. All requests will be reviewed to ensure they are being used for an appropriate indication and may be subject to an off-label review in accordance with our Off-Label Use of FDA Approved Drugs Policy (Pharmacy-32).

UPDATES:

Date:	Revision:
01/01/2025	Revised
08/15/2024	Reviewed / P&T Committee Approval
06/24/2024	Revised
06/04/2024	Revised
12/06/2023	Revised
08/24/2023	P&T Committee Approval
04/01/2023	Revised
03/15/2023	Revised
01/01/2023	Revised
09/2022	P&T Committee Approval
08/2022	Revised
06/2022	Revised
02/2022	Revised
09/2021	Reviewed / P&T Committee Approval
01/2021	Revised
9/16/2020	P&T Approval
08/2020	Revised
05/2020	Revised
02/2020	Revised
01/2020	Revised
02/2019	Reviewed
03/2018	Revised
12/2017	Revised
07/2017	Revised

09/2016	Revised
03/2016	Revised
12/2014	Revised
12/2014	Committee approval
09/2014	Created

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