# Cytokine and CAM Antagonists: Oral PDE-4 inhibitors

## WA.PHAR.49.AF Effective Date: 3/1/2025

### Related medical policies:

| Policy Number | Policy Name |
|---|---|
| WA.PHAR.49.AA | Cytokine and CAM Antagonists: Tumor Necrosis Factor (TNF) Inhibitors |
| WA.PHAR.49.AB | Cytokine and CAM Antagonists: IL-4/IL-13 Inhibitors |
| WA.PHAR.49.AC | Cytokine and CAM Antagonists: IL-6 Inhibitors |
| WA.PHAR.49.AD | Cytokine and CAM Antagonists: IL-12/IL-23 Inhibitors |
| WA.PHAR.49.AE | Cytokine and CAM Antagonists: IL-17 Inhibitors |
| WA.PHAR.49.AG | Cytokine and CAM Antagonists: T-Lymphocyte Inhibitors |
| WA.PHAR.49.AH | Cytokine and CAM Antagonists: Janus Associated Kinase (JAK) Inhibitors |
| WA.PHAR.49.AI | Cytokine and CAM Antagonists: IL-1 Inhibitors |
| WA.PHAR.49.AJ | Cytokine and CAM Antagonists: Integrin Receptor Antagonists |
| WA.PHAR.49.AK | Cytokine and CAM Antagonists: S1-P Receptor Modulator |

***Note:*** *New-to-market drugs included in this class based on the Apple Health Preferred Drug List are non-preferred and subject to this prior authorization (PA) criteria. Non-preferred agents in this class require an inadequate response or documented intolerance due to severe adverse reaction or contraindication to at least TWO preferred agents. If there is only one preferred agent in the class documentation of inadequate response to ONE preferred agent is needed. If a drug within this policy receives a new indication approved by the Food and Drug Administration (FDA), medical necessity for the new indication will be determined on a case-by-case basis following FDA labeling.*

*To see the list of the current publication of the Coordinated Care of Washington, Inc. Preferred Drug List (PDL), please visit:*
*https://www.coordinatedcarehealth.com/content/dam/centene/centene-pharmacy/pdl/FORMULARY-CoordinatedCare_Washington.pdf*

### Medical necessity:

| Drug | Medical Necessity |
|---|---|
| apremilast (Otezla)<br>Click or tap here to enter text. | **Oral PDE-4 Inhibitor - apremilast** may be considered medically necessary in patients who meet the criteria described in the clinical policy below.<br><br>If all criteria are not met, the clinical reviewer may determine there is a medically necessary need and approve on a case-by-case basis. The clinical reviewer may choose to use the reauthorization criteria when a patient has been previously established on therapy and is new to Apple Health. |

### Clinical policy:

| Clinical Criteria |
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*Policy: Oral PDE-4 inhibitors*

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| **Behcet's Syndrome**<br>apremilast (Otezla) | Apremilast (Otezla) may be approved when all the following documented criteria are met:<br>1. Patient is 18 years of age or older, **AND**<br>2. Prescribed by, or in consultation with a rheumatologist, dermatologist, ophthalmologist, etc.; **AND**<br>3. Not used in combination with another Cytokine and CAM medication; **AND**<br>4. Diagnosis of recurrent Behcet Syndrome manifesting as oral ulcers of the mouth; **AND**<br>a. History of failure to ALL the following, unless ALL are contraindicated or not tolerated:<br>i. Topical corticosteroids (e.g., triamcinolone) [minimum trial of 7 days]; **AND**<br>ii. Sucralfate mouthwash [minimum trial of 7 days]; **AND**<br>iii. Colchicine [minimum trial of 3 months]; **AND**<br>iv. Oral corticosteroids (e.g., prednisone) [minimum trial of 1 month]; **AND**<br>5. Treatment with one preferred adalimumab biosimilar has been ineffective, unless all are contraindicated, or not tolerated [minimum trial of 24 weeks].<br><br>If ALL criteria are met, the request will be authorized for **6 months.**<br><br>**Criteria (Reauthorization)**<br>Apremilast (Otezla) may be approved when all the following documented criteria are met:<br><br>1. Not used in combination with another Cytokine and CAM medication; **AND**<br>2. Documentation is submitted demonstrating disease stability or a positive clinical response (e.g., improvement in oral lesions, vitreous haze, visual acuity, corticosteroid usage, etc.).<br><br>If ALL criteria are met, the request will be authorized for **12 months.** |
| **Plaque Psoriasis (PsO)**<br>apremilast (Otezla) | Apremilast (Otezla) may be approved when all the following documented criteria are met:<br><br>1. Patient is 6 years of age or older, **AND**<br>a. For pediatric patients, current weight is provided; **AND**<br>2. Prescribed by, or in consultation with a dermatologist; **AND**<br>3. Not used in combination with another Cytokine and CAM medication; **AND**<br>4. Diagnosis of moderate to severe plaque psoriasis; **AND**<br>5. Presence of ongoing disease for greater than 6 months; **AND**<br>6. The patient meets one of the following:<br>a. Disease affects at least 10% body surface area; **OR**<br>b. Disease affects the face, ears, hands, feet, or genitalia; **AND** |

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| | 7. Baseline assessments are included (e.g., body surface area (BSA), Psoriasis Area and Severity Index (PASI), Psoriasis Physician's Global Assessment (PGA), itch numeric rating scale, etc.); **AND**<br>8. History of failure to one of the following, unless all are contraindicated or not tolerated:<br>a. Phototherapy (UVB or PUVA) [minimum trial of 12 weeks]; **OR**<br>b. Treatment with at least one non-Cytokine and CAM DMARD (e.g., methotrexate, cyclosporine, acitretin, azathioprine, etc.) [minimum trial of 12 weeks]; **AND**<br>9. Patient meets one of the following:<br>a. For pediatric requests: Treatment with etanercept (Enbrel) been ineffective, unless contraindicated or not tolerated [minimum trial of 12 weeks]; **OR**<br>b. For adult requests, treatment with one preferred adalimumab biosimilar and etanercept has each been ineffective, unless all are contraindicated, or not tolerated [minimum trial of 12 weeks].<br><br>If ALL criteria are met, the request will be authorized for **6 months.**<br><br>**Criteria (Reauthorization)**<br>Apremilast (Otezla) may be approved when all the following documented criteria are met:<br><br>1. Not used in combination with another Cytokine and CAM medication; **AND**<br>2. Documentation is submitted demonstrating disease stability or a positive clinical response (e.g., improvement in BSA, PASI, Psoriasis PGA, itch numeric rating scale).<br><br>If ALL criteria are met, the request will be authorized for **12 months.** |
| **Psoriatic Arthritis (PsA)**<br>apremilast (Otezla) | Apremilast (Otezla) may be approved when all the following documented criteria are met:<br><br>1. Patient is 18 years of age or older, **AND**<br>2. Prescribed by, or in consultation with a rheumatologist or dermatologist; **AND**<br>3. Not used in combination with another Cytokine and CAM medication; **AND**<br>4. Diagnosis of Psoriatic Arthritis (PsA); **AND**<br>5. Patient meets one of the following:<br>a. Treatment with at least one non-Cytokine and CAM DMARD (e.g., methotrexate, sulfasalazine, leflunomide, cyclosporine) has been ineffective, unless all are contraindicated or not tolerated [minimum trial of 3 months]; **OR** |

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| | b. Presence of active, severe disease as indicated by provider assessment and the presence of at least ONE of the following:<br>i. Erosive disease<br>ii. Elevated C-reactive protein (CRP) or erythrocyte sedimentation rate (ESR)<br>iii. Long-term damage interfering with function (e.g., joint deformities, vision loss)<br>iv. Major impairment of quality of life due to high disease activity at many sites (including dactylitis, enthesitis) or functionally limiting arthritis at a few sites; **AND**<br>6. Treatment with one preferred adalimumab biosimilar and etanercept has each been ineffective, unless all are contraindicated, or not tolerated [minimum trial of 12 weeks].<br><br>If ALL criteria are met, the request will be authorized for **6 months.** |
| | **Criteria (Reauthorization)**<br>Apremilast (Otezla) may be approved when all the following documented criteria are met:<br><br>1. Not used in combination with another Cytokine and CAM medication; **AND**<br>2. Documentation is submitted demonstrating disease stability or a positive clinical response (e.g., improvement in joint pain, swelling, activities of daily living, reduction in diseases flares, etc.).<br><br>If ALL criteria are met, the request will be authorized for **12 months.** |

## Dosage and quantity limits:

| Drug | Indication | FDA Approved Dosing | Dosage Form and Quantity Limit |
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| **Otezla** | Behcet's Syndrome<br>Plaque Psoriasis<br>Psoriatic Arthritis | 10-30 mg twice daily | 20 mg and 30 mg tablets: 60 tablets (quantity limit includes all tablet strengths) per 30 days |

## Coding:

| HCPCS Code | Description |
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| *N/A* | N/A |

## Background:

Behcets syndrome, also known as Behcet disease, is an inflammatory disease with numerous potential manifestations involving the skin, mucosa, joints, eyes, arteries, veins, nervous system, and gastrointestinal system. Most clinical manifestations are believed to be due to vasculitis. The therapeutic approach is highly variable and guided by disease manifestation. For oral manifestations, the first line treatment is triamcinolone acetonide cream 0.1% in orabase or sucralfate mouthwash per the 2018 EULAR Recommendations. Colchicine is used as the first-line treatment for prevention of mucocutaneous lesions. Benzathine penicillin is often added to colchicine to increase the effectiveness. Additional treatment options include thalidomide, oral corticosteroids, oral DMARDs, and TNF-alpha inhibitors. Apremilast (Otezla) has been shown to be effective for prevention of oral ulcers and is currently FDA approved for this indication. Although apremilast is an FDA-approved medication for Behcet's syndrome, anti-TNF alpha therapies have equal or greater safety and efficacy data to support their use in this condition. Guidelines and key opinion leaders have consensus in regard to use of anti-TNF alpha therapies prior to use of apremilast. For ophthalmic manifestations, corticosteroids and oral DMARDS (typically azathioprine) have been mainstays of Behcet's syndrome.

Plaque psoriasis is a common chronic skin disorder typically characterized by erythematous papules and plaques with a silver scale. Joint American Academy of Dermatology–National Psoriasis Foundation guidelines for the management of psoriasis with systemic nonbiologic therapies and for the management and treatment of psoriasis with biologics indicate that the majority of patients are capable of adequately controlling disease solely with topical medications or phototherapy. Phototherapy is recognized as a beneficial therapy for controlled plaque psoriasis and is a cost-effective treatment strategy. Additionally, oral immunomodulatory medications (e.g., methotrexate, cyclosporine, acitretin) are cost-effective therapies with a well-known safety profile for the treatment of plaque psoriasis. For moderate-to-severe disease, where a JAK inhibitor or biologics are warranted, adalimumab (Humira) and etanercept (Enbrel) are one of many options. However, it would not be indicated for mild psoriasis given that patients are better managed from a safety perspective on well-established therapies (e.g., topical agents, phototherapy, conventional DMARDS, apremilast [Otezla]).

Psoriatic arthritis is an inflammatory musculoskeletal disease associated with psoriasis that was initially considered a variant of rheumatoid arthritis but has emerged as a distinct clinical entity. The 2018 American College of Rheumatology/National Psoriasis Foundation Guideline (ACR) for psoriatic arthritis make a conditional recommendation for starting a TNF inhibitor over an oral small molecule (OSM) as a first-line option for patients who are treatment-naïve with active psoriatic arthritis. This recommendation is based on low- to very-low quality of evidence. Many of the studies in which greater benefit was seen in terms of disease severity or radiographic progression compared methotrexate to TNF inhibitors, however, most patients included in these groups were not truly treatment naïve to OSM medications. Guidelines note that OSM can be used first-line in naïve patients who do not have severe PsA, severe PsO, prefers oral therapy, or has contraindications to TNF inhibitors.

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## History:

| Approved Date | Effective Date | Version | Action and Summary of Changes |
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| **08.14.2024** | 04.01.2025 | 66.27.00.AF-5 | - Added language for preferred adalimumab biosimilars<br>- Formatting updates |
| **08.14.2024** | 03.01.2025 | 66.27.00.AF-4 | Approved by the DUR Board<br>- Split 66.27.00 policy into different policies<br>-Added new drug indications when applicable<br>-Update language in medical necessity section |

| Previous policy changes (relevant from Cytokine & CAM Antagonists Policy) | |
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| **Date** | **Action and Summary of Changes** |
| 10.21.2021 | Removed Hyrimoz from the policy and updated the initial dosing for infliximab. |
| 11.30.2020 | Removed Preferred/Non-Preferred listing and added link to AHPDL publication |
| 11.12.2020 | Added language in clinical policy section for cases which do not meet policy criteria |

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| 09.01.2020 | Updated wording in clinical criteria for products with only one preferred option. |
| 08.19.2020 | Approved by DUR Board |
| 8.20.2020 | Update to dosing and limits section for all products and indications |
| 08.12.2020 | Updated policy clinical criteria and dosing & quantity limits to include nonradiographic axial spondyloarthritis |
| 06.01.2020 | Added new agents to class; updated age limit for Uveitis indication; updated dosing and quantity limits; updated HCPCS coding |
| 07.31.2019 | Updated criteria that trial of preferred biologics only applies to non-preferred biologics |
| 06.07.2019 | Updates to TB skin test requirements for apremalist; updates to initial authorization clinical criteria |
| 11.02.2018 | Addition of Hyrimoz (adalimumab-adaz) |
| 09.07.2018 | Addition of new medication |
| 08.16.2017 | New Policy |