

Effective Date: 2/2020
Reviewed: 12/2019, 7/2020, 12/2020, 5/2021, 4/2022, 7/2022, 12/2022, 8/2023
Scope: Medicaid

## SPECIALTY GUIDELINE MANAGEMENT

### TREMIFYA (guselkumab)

#### POLICY

#### I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

##### FDA-Approved Indications

- Treatment of adult patients with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy
- Treatment of adult patients with active psoriatic arthritis

All other indications are considered experimental/investigational and are not a covered benefit.

#### II. CRITERIA FOR INTIAL AND RENEWAL CRITERIA

For all indications:

- Prior Authorization Request is submitted by the Provider's office; AND
- Prior Authorization Request is not submitted by a pharmacy or another third party; AND
- Submission of the member's chart or medical record is required, documenting medical necessity based on the criteria corresponding to the applicable indication

#### III. DOCUMENTATION

Submission of the following information is necessary to initiate the prior authorization review:

##### A. Plaque psoriasis

1. Initial requests:
  - i. Chart notes or medical record documentation of affected area(s) and body surface area (BSA) affected.
  - ii. Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.
2. Continuation requests: Chart notes or medical record documentation of decreased body surface area (BSA) affected and/or improvement in signs and symptoms.

##### B. Psoriatic arthritis:

1. Initial requests: Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.
2. For continuation requests: Chart notes or medical record documentation supporting positive clinical response.

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#### IV. CRITERIA FOR INITIAL APPROVAL

##### For all Indications:

- Tremfya will not be used concomitantly with any other biologic DMARD (e.g., adalimumab, infliximab) or targeted synthetic DMARD (e.g., apremilast, tofacitinib).
- Member has a pretreatment tuberculosis (TB) screening with a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB). *[Note: Members who have received Tremfya or any other biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) are exempt from requirements related to TB screening in this Policy.]*

##### Moderate to severe plaque psoriasis

Authorization of 12 months may be granted for treatment of moderate to severe plaque psoriasis for members who are 18 years of age or older when all of the following criteria are met:

1. Tremfya will be prescribed by, or in consultation with, a specialist in dermatology or rheumatology.
2. At least 10% of body surface area (BSA) is affected OR crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected.
3. Member meets either of the following criteria:
  - a. Member has had an inadequate response to at least a 3-month trial of methotrexate, cyclosporine or acitretin, or experienced clinically significant adverse effects from methotrexate, cyclosporine or acitretin
  - b. Member has had an inadequate response to at least a 3-month trial of phototherapy (e.g., UVB, PUVA), unless intolerance experienced
4. Member has had an inadequate response, intolerance or contraindication to at least a 3-month trial of adalimumab at maximum tolerated doses.

##### Active psoriatic arthritis (PsA)

Authorization of 12 months may be granted for treatment of moderate to severe psoriatic arthritis for members who are 18 years of age or older when all of the following criteria are met:

1. Tremfya is prescribed by, or in consultation with, a specialist in dermatology or rheumatology.
2. Documented moderate to severe active disease and member meets either of the following criteria:
  - a. If member has predominantly axial disease or active enthesitis and/or dactylitis, member has experienced an inadequate response or intolerance to at least two non-steroidal anti-inflammatory drugs (NSAIDs), unless use is contraindicated
  - b. If member has peripheral arthritis, member has experienced an inadequate response to a  $\geq 3$  consecutive month trial of one oral disease-modifying anti-rheumatic agent (DMARD) such as methotrexate, azathioprine, sulfasalazine, or hydroxychloroquine, unless intolerance experienced
3. Member has had an inadequate response, intolerance or contraindication to at least a 3-month trial of adalimumab at maximum tolerated doses.

#### V. CONTINUATION OF THERAPY

##### A. Moderate to severe plaque psoriasis (PsO)

Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for moderate to severe plaque psoriasis and who achieve or maintain positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when any of the following is met:

1. Reduction in body surface area (BSA) affected from baseline
2. Improvement in signs and symptoms from baseline (e.g., itching, redness, flaking, scaling, burning, cracking, pain)

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### **B. Active psoriatic arthritis (PsA)**

Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for active psoriatic arthritis and who achieve or maintain positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:

1. Number of swollen joints
2. Number of tender joints
3. Dactylitis
4. Enthesitis
5. Skin and/or nail involvement

## **VI. QUANTITY LIMIT**

Tremfya has a quantity limit of 100mg (1ml) per 8 weeks, with post-limit for loading dose of 200mg (2 ml) per month.

## **VII. REFERENCES**

1. Tremfya [package insert]. Horsham, PA: Janssen Biotech, Inc.; July 2023.
2. Menter A, Korman NJ, Elmets CA, et al. 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.* 2009;61:451-485.
3. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Section 6: Guidelines of care for the treatment of psoriasis and psoriatic arthritis: case-based presentations and evidence-based conclusions. *J Am Acad Dermatol.* 2011;65(1):137-174.
4. Reich K, Armstrong, 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. *Am J Clin Dermatol.* 2017;76(3):418-431.
5. Blauvelt A, Papp KA, Griffiths, CEM, 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. *Am J Clin Dermatol.* 2017;76(3):405-417.