Abatacept IV

Included Products: Orencia IV (Abatacept IV)

Nonformulary for outpatient benefit. PA required on medical benefit.

Created: 12/24/2009 *Revised:* 03/10/2022 *Reviewed:* 01/12/2023 *Updated:* 02/01/2023

All Diagnoses

Initial Criteria: All Diagnoses		If yes	If no
1.	Is the requested agent indicated for or supported for use in the submitted diagnosis for the member's age?	Continue to #2.	Do not approve.
2.	Is the request for maintenance of remission in a patient who already achieved remission with of the requested product or has already initiated therapy?	Continue to renewal criteria.	Continue to #3.
3.	Does the member have a history of COPD?	Do not approve.	Continue to #4.
4.	Has the treatment been initiated by or is an appropriate specialist currently supervising it? a. Juvenile Idiopathic Arthritis: Rheumatologist b. Psoriatic Arthritis: Dermatologist or Rheumatologist c. Rheumatoid Arthritis: Rheumatologist d. Acute Graft Versus Host Disease: Hematologist or Oncologist	Continue to indication.	Do not approve.

Prophylaxis of Acute Graft Versus Host Disease

Initial Criteria		If yes	If no
1.	Does the member have a diagnosis of high-risk hematologic malignancy (such as AML or ALL) or myelodysplastic syndrome (MDS) or another indication supported by the NCCN?	Continue to #3.	Do not approve.

Continued >>

2.	Is the member receiving a bone marrow transplant from a matched donor or unmatched donor with only 1-allele mismatch?	Continue to #4.	Do not approve.
3.	Will the member be treated with a calcineurin inhibitor (such as tacrolimus) and methotrexate?	Continue to #4.	Do not approve.
4.	Approve for 2 months for 4 total doses.		

Juvenile Idiopathic Arthritis

Initial Criteria		If yes	If no
1.	Does the member have juvenile idiopathic arthritis with active systemic features of JIA, with a physician global assessment of 5 or higher (or any systemic activity in the absence of active joint involvement)?	Continue to #3.	Continue to #2.
2.	Does the member have juvenile idiopathic arthritis without active systemic features of JIA?	Continue to #4.	Do not approve.
3.	Has the member tried and failed systemic corticosteroids?	Continue to #4.	Do not approve.
4.	Has the member tried and failed ALL of the following: a. Methotrexate or leflunomide for at least 3 months or contraindication to both. b. Actemra	Continue to #5.	Do not approve.
5.	Approve for 6 months.		
Renewal Criteria		**If yes**	**If no**
1.	Has the member experienced 20% or greater improvement in tender joint count and swollen joint count, or a reduction in systemic effects of JIA?	Continue to #2.	Do not approve.
2.	Approve for 12 months.		

Continued >>

Psoriatic Arthritis

Initial Criteria		If yes	If no
1.	Does the member have psoriatic arthritis based on at least 3 out of 5 of the following? a. Psoriasis (1 point for personal or family history, 2 points for current) b. Psoriatic nail dystrophy c. Negative test result for RF d. Dactylitis (current or history) e. Radiological evidence of juxta-articular new bone formation	Continue to #2.	Do not approve.
2.	Is the member transitioning to the requested treatment from a different biologic product?	Continue to #4.	Continue to #3.
3.	Has the member failed or have contraindications to conventional management with all of the following? a. NSAIDs, and b. Methotrexate or other DMARD such as leflunomide, sulfasalazine, or cyclosporine.	Continue to #4.	Do not approve.
4.	Has the member tried and failed or have a contraindication to infliximab?	Continue to #5.	Do not approve.
5.	Approve for 6 months.		
Renewal Criteria		**If yes**	**If no**
1.	Has the member experienced 20% or greater improvement in tender joint count and swollen joint count?	Continue to #2.	Do not approve.
2.	Approve for 12 months.		

Rheumatoid Arthritis

Initial Criteria		If yes	If no
1.	Does the member have a baseline of moderate to high disease activity of rheumatoid arthritis measured as such by an accepted assessment instrument (PAS, PASII, RAPID3, CDAI, DAS28, SDAI)?	Continue to #2.	Do not approve.

Continued >>

2.	Is the member transitioning to the requested treatment from a different biologic product?	Continue to #5.	Continue to #3.
3.	Has the member tried and failed or have contraindications to methotrexate dosed at least 20mg per week for at least 8 weeks?	Continue to #4.	Do not approve.
4.	Has the member tried and failed or have contraindications to the following: leflunomide, hydroxychloroquine, or sulfasalazine?	Continue to #5.	Do not approve.
5.	Has the member tried and failed or have a contraindication to infliximab?	Continue to #6	Do not approve.
6.	Is the requested product being prescribed along with at least one of the following DMARDs: methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine, unless contraindicated?	Continue to #7.	Do not approve.
7.	Approve for 6 months.		
Renewal Criteria		**If yes**	**If no**
1.	Has the member experienced 20% or greater improvement in tender joint count and swollen joint count?	Continue to #2.	Do not approve.
2.	Approve for 12 months.		

REFERENCES

- 2013 update of the 2011 ACR Recommendations for the treatment of juvenile idiopathic arthritis
- 2019 American College of Rheumatology/Arthritis Foundation Guideline for the Treatment of Juvenile Idiopathic Arthritis: Therapeutic Approaches for Non-Systemic Polyarthritis, Sacroiliitis, and Enthesitis
- 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis