Apremilast

Included Products: Otezla (apremilast)

Created: 07/22/2014 *Revised:* 01/12/2023 *Reviewed:* 11/14/2019 *Updated:* 02/01/2023

All Diagnoses

Initial Criteria		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.	Has the treatment been initiated by or is an appropriate specialist currently supervising it? a. Plaque Psoriasis: Dermatologist b. Psoriatic Arthritis: Dermatologist or Rheumatologist c. Behçet Disease: Dermatologist, Gastroenterologist, Neurologist, or Rheumatologist	Continue to #3.	Do not approve.
3.	Continue to diagnosis.		

Psoriatic Arthritis

Initial Criteria		If yes	If no
1.	Does the member have a diagnosis of 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 rest result for RF d. Dactylitis (current or history) e. Radiological evidence of juxta-articular new bone formation	Continue to #2.	Do not approve.

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2.	Has the member failed all of the following: a. NSAIDs, and b. At least two DMARDs such as methotrexate, sulfasalazine, leflunomide, or cyclosporine.	Continue to #3.	Do not approve.
3.	Is the request for combination therapy with a biologic, to control skin symptoms associated with psoriatic arthritis or psoriasis?	Continue to #3 under plaque psoriasis criteria.	Continue to #4.
4.	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.		

Plaque Psoriasis

Initial Criteria		If yes	If no
1.	Does the member have chronic, moderate to severe plaque psoriasis with functional impairment and one or more of the following: a. At least 10% body surface area involved b. Hand, foot, face, or mucous membrane involvement	Continue to #4.	Continue to #2.
2.	Is the member under the age of 21?	Continue to #3.	Do not approve. Plaque psoriasis without functional impairment and hand, foot, face, or mucous membrane involvement or affecting less than 10% of body surface area is not covered for treatment by the Oregon Health Plan.
3.	Is it medically necessary or medically appropriate to treat the psoriasis due to contributing factors to a comorbid condition or impact on growth, learning, or development?	Continue to #4.	Do not approve based on medical necessity or appropriateness.

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4.	Has the member tried and failed or have contraindications to ALL of the following: a. High-potency topical corticosteroids (betamethasone dipropionate, clobetasol, fluocinonide) b. At least one other topical agent: calcipotriene, tazarotene, anthralin c. PUVA or UVB Phototherapy d. Methotrexate e. At least one other systemic agent: cyclosporine or acitretin.	Continue to #5.	Do not approve.
5.	Is the requested drug intended for use in combination with a biologic?	Continue to #6.	Continue to #8.
6.	Does the member have persistent moderate to severe psoriasis on biologic therapy for at least 3 months, with at least 10% body surface area involved, or hand, foot or mucous membrane involvement AND documentation of functional impairment?	Continue to #7.	Do not approve.
7.	Has the member failed combination therapy with the biologic and one of the following: methotrexate, cyclosporine, or acitretin?	Continue to #8.	Do not approve.
8.	Approve for 6 months.		

Renewal Criteria		If yes	If no
1.	Has the member experienced a clinically significant response, such as PASI-75 (75% improvement) and/or is there evidence of functional improvement?	Continue to #2.	Do not approve.
2.	Approve for 12 months.		

Behçet's Disease

Initial Criteria		If yes	If no
1.	Does the member have active recurrent oral ulcers associated with Behçet's disease?	Continue to #2.	Do not approve.

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2.	Is the diagnosis of Behçet's disease supported by at least THREE of the following manifestations: a. Recurrent genital ulcerations b. Eye lesions (uveitis or retinal vasculitis) c. Skin lesions (erythema nodosum, pseudofolliculitis, papulopustular lesions, acneiform nodules) found in adult patients not being treated with corticosteroids d. Positive pathergy test read by a physician within 24-48 hours of testing	Continue to #3.	Do not approve.
3.	Is the member currently receiving another biologic or systemic treatment for Behçet's disease?	Do not approve.	Continue to #4.
4.	Has the member tried and failed ALL of the following: a. Oral systemic or oral topical antibiotics (in mouthwash) – tetracycline (nonformulary), doxycycline, minocycline b. Triamcinolone acetonide 0.1% in Orabase paste (nonformulary) c. Corticosteroid (prednisone, dexamethasone) oral tablets or mouthwash d. Colchicine	Continue to #5.	Do not approve.
5.	Approve for 6 months.		
Renewal Criteria		**If yes**	**If no**
1.	Is there chart note documentation showing that symptoms have improved or stabilized with treatment?	Continue to #2.	Do not approve.
2.	Approve for 12 months.		

REFERENCES

- 2018 American College of Rheumatology/National Psoriasis Foundation Guideline for the Treatment of Psoriatic Arthritis
- Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with awareness and attention to comorbidities (2019)
- Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics (2019)