blue of california

etanercept (ENBREL)

Diagnoses Considered for Coverage:

- Spondyloarthritis (including ankylosing and non-radiographic axial spondyloarthritis)
- Polyarticular Juvenile Idiopathic Arthritis (PJIA)
- Psoriatic Arthritis (PsA)
- Plaque Psoriasis
- Rheumatoid Arthritis (RA)
- Hidradenitis Suppurativa – *offlabel support listed in DrugDex (IIa)*
- Graft vs Host Disease (GVHD) – *offlabel support NCCN category 2A*

Coverage Criteria:

1. **For diagnosis of ankylosing spondylitis (AS):**
   - Being prescribed by or in consultation with a rheumatologist, **and**
   - Not being used in combination with other targeted immunotherapies, **and**
   - One of the following:
     - Patient unable to use NSAIDs due to history of GI bleed or ulcer, **or**
     - For patient with high-risk potential for development of GI bleed or ulcer: Inadequate response or intolerable side effect to ONE prescription-strength oral NSAID in combination with a proton pump inhibitor (PPI), **or**
     - For patient with no bleeding or ulcer risk factors: Either inadequate response or non-GI related intolerable side effect with TWO prescription-strength oral NSAIDs, OR intolerable GI side effect with ONE prescription-strength oral NSAID monotherapy not relieved with addition of concomitant proton pump inhibitor (PPI) therapy, **and**
   - Dose does not exceed 50 mg given SQ once per week.

   Coverage Duration: one year

2. **For diagnosis of Polyarticular Juvenile Idiopathic Arthritis (PJIA), (including Juvenile Rheumatoid Arthritis):**

- Being prescribed by or in consultation with a rheumatologist, **and**
- Inadequate response or intolerable side effect with one DMARD agent OR patient has a medical justification why methotrexate cannot be used, **and**
- Not being used in combination with other targeted immunotherapies, **and**
- Dose does not exceed 50 mg given SQ once per week.

Coverage Duration: one year

3. For diagnosis of moderate to severe plaque psoriasis:

INITIAL AUTHORIZATION (induction therapy)

• Patient is at least 4 years old, **and**
• Being prescribed by or in consultation with a dermatologist or rheumatologist, **and**
• Inadequate response, intolerable side effect, or contraindication to one of the following: methotrexate, cyclosporine (Neoral), acitretin (Soriatane), **or** PUVA/UVB, **and**
• Not being used in combination with another targeted biologic, or Sotyktu, **and**
• Dose does not exceed 50 mg given SQ twice per week for 12 weeks, then 50 mg given SQ once per week **and**
• One of the following:
  • Baseline PASI score is 10 or more prior to initiating targeted immunomodulator (e.g. Enbrel, Humira, Stelara, Cosentyx, Otezla, Taltz), or
  • Baseline BSA is 3% or more prior to initiating targeted immunomodulator (e.g. Enbrel, Humira, Stelara, Cosentyx, Otezla, Taltz), or
  • Sensitive area is involved (i.e. groin, face, etc.), or
  • Disease is otherwise debilitating.
 	
Coverage Duration: 24 weeks

REAUTHORIZATION
• Patient has shown improvement in the baseline PASI (or BSA if provided on initial request) score, **and** • Not being used in combination with another targeted biologic, or Sotyktu, **and** • Dose does not exceed 50 mg given SQ once per week (See Additional Information section.)

Coverage Duration: one year

2nd INDUCTION DOSE

- Drug will be administered at home by the patient or the patient's caregiver, **and**
- Not being used in combination with another targeted biologic or Sotyktu, **and**
- Dose does not exceed 50 mg given SQ twice per week, **and**
- One of the following:
  - Patient flared while on maintenance dose, **or**
  - Patient was slow to respond while on induction or maintenance dose, **or**
  - Patient had an interruption of induction or maintenance therapy.

Coverage Duration: 12 weeks

DOSE ESCALATION BEYOND FDA MAXIMUM FOR MAINTENANCE

- Drug will be administered at home by the patient or the patient's caregiver, **and**
- Not being used in combination with another targeted biologic or Sotyktu, **and**
- Dose does not exceed 50 mg given SQ twice per week.
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Coverage Duration: one year

4. For diagnosis of psoriatic arthritis:

- Being prescribed by or in consultation with a rheumatologist, **and**
- Inadequate response or intolerable side effect with one DMARD agent OR patient has a medical reason why methotrexate, leflunomide, and sulfasalazine cannot be used, **and**
- Not being used in combination with other targeted immunotherapies, **and**
- Dose does not exceed 50 mg given SQ once per week.

Coverage Duration: one year

5. For diagnosis of rheumatoid arthritis:

- Being prescribed by or in consultation with a rheumatologist, **and**
- Inadequate response, intolerable side effect, or contraindication to

methotrexate, **and**
- Not being used in combination with another targeted immunomodulator, **and**
- Dose does not exceed 50 mg given SQ once per week.

Coverage Duration: one year

6. For diagnosis of hidradenitis suppurativa:

INITIAL AUTHORIATION
• Being prescribed by or in consultation with a dermatologist, **and** • Patient has moderate to severe HS disease as evidenced by Hurley stage II or III disease, **and** • Inadequate response, intolerable side effect, or contraindication to Hadlima or Humira, **and** • Not being used in combination with other targeted immunotherapies, **and** *Coverage Duration:* 12 weeks
REAUTHORIZATION
• Provider attests patient is responding to Enbrel therapy, **and** • Not being used in combination with other targeted immunotherapies, **and** • Dose does not exceed 50 mg given SQ twice per week. *Coverage Duration:* 6 months

7. For diagnosis of Graft vs Host Disease (GVHD):

- Inadequate response to at least one prior drug for GVHD (i.e. systemic corticosteroids, immunosuppressants), **and**
- Dose does not exceed 25 mg twice weekly

Coverage Duration: one year

Coverage Duration: see individual diagnosis

Effective Date: 1/3/2024