

Clinical Policy: Certolizumab (Cimzia)

Reference Number: CP.PHAR.247

Effective Date: 08.16

Last Review Date: 2.19

Line of Business: HIM, Medicaid

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Certolizumab (Cimzia[®]) is a tumor necrosis factor (TNF) blocker.

FDA Approved Indication(s)

Cimzia is indicated for:

- Reducing signs and symptoms of Crohn's disease (CD) and maintaining clinical response in adult patients with moderately to severely active disease who have had an inadequate response to conventional therapy
- Treatment of adults with moderately to severely active rheumatoid arthritis (RA)
- Treatment of adult patients with active psoriatic arthritis (PsA)
- Treatment of adults with active ankylosing spondylitis (AS)
- Treatment of adults with moderate-to-severe plaque psoriasis (PsO) who are candidates for systemic therapy or phototherapy

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation[®] that Cimzia is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Crohn's Disease (must meet all):

1. Diagnosis of CD;
2. Prescribed by or in consultation with a gastroenterologist;
3. Age \geq 18 years;
4. Member meets one of the following (a or b):
 - a. Failure of a \geq 3 consecutive month trial of at least ONE immunomodulator (e.g., azathioprine, 6-mercaptopurine [6-MP], methotrexate [MTX]) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
 - b. Medical justification supports inability to use immunomodulators (*see Appendix D*);
5. Failure of a \geq 3 consecutive month trial of adalimumab (*Humira[®] is preferred*) unless contraindicated or clinically significant adverse effects are experienced;

**Prior authorization is required for adalimumab*

6. Dose does not exceed 400 mg at weeks 0, 2, and 4, followed by maintenance dose of 400 mg every 4 weeks.

Approval duration: 6 months

B. Rheumatoid Arthritis (must meet all):

1. Diagnosis of RA;
2. Prescribed by or in consultation with a rheumatologist;
3. Age \geq 18 years;
4. Member meets one of the following (a or b):
 - a. Failure of a \geq 3 consecutive month trial of MTX at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
 - b. If intolerance or contraindication to MTX (*see Appendix D*), failure of a \geq 3 consecutive month trial of at least ONE conventional disease-modifying anti-rheumatic drug [DMARD] (e.g., sulfasalazine, leflunomide, hydroxychloroquine) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
5. Failure of etanercept (*Enbrel[®] is preferred*) and adalimumab (*Humira is preferred*), each used for \geq 3 consecutive months, unless contraindicated or clinically significant adverse effects are experienced;
**Prior authorization is required for etanercept and adalimumab*
6. Dose does not exceed 400 mg at weeks 0, 2, and 4, followed by maintenance dose of 400 mg every 4 weeks.

Approval duration: 6 months

C. Psoriatic Arthritis (must meet all):

1. Diagnosis of PsA;
2. Prescribed by or in consultation with a dermatologist or rheumatologist;
3. Age \geq 18 years;
4. Member meets one of the following (a, b, or c), unless contraindicated or clinically significant adverse effects are experienced:
 - a. Failure of a \geq 3 consecutive month trial of MTX at up to maximally indicated doses;
 - b. If intolerance or contraindication to MTX (*see Appendix C*), failure of a \geq 3 consecutive month trial of cyclosporine, sulfasalazine, or leflunomide at up to maximally indicated doses;
 - c. For axial disease, failure of a \geq 4 week-trial of non-steroidal anti-inflammatory drugs (NSAIDs) at up to maximally indicated doses;
5. Failure of etanercept (*Enbrel is preferred*) and adalimumab (*Humira is preferred*), each used for \geq 3 consecutive months, unless contraindicated or clinically significant adverse effects are experienced;
**Prior authorization is required for etanercept and adalimumab*
6. Dose does not exceed 400 mg at weeks 0, 2, and 4, followed by maintenance dose of 400 mg every 4 weeks.

Approval duration: 6 months

D. Ankylosing Spondylitis (must meet all):

1. Diagnosis of AS;
2. Prescribed by or in consultation with a rheumatologist;
3. Age \geq 18 years;
4. Failure of at least TWO non-steroidal anti-inflammatory drugs (NSAIDs) at up to maximally indicated doses, each used for \geq 4 weeks unless contraindicated or clinically significant adverse effects are experienced;
5. Failure of etanercept (*Enbrel is preferred*) and adalimumab (*Humira is preferred*), each used for \geq 3 consecutive months, unless contraindicated or clinically significant adverse effects are experienced;
**Prior authorization is required for etanercept and adalimumab*
6. Dose does not exceed 400 mg at weeks 0, 2, and 4, followed by maintenance dose of 400 mg every 4 weeks.

Approval duration: 6 months

E. Plaque Psoriasis (must meet all):

1. Diagnosis of PsO;
2. Prescribed by or in consultation with a dermatologist or rheumatologist;
3. Age \geq 18 years;
4. Member meets one of the following (a or b):
 - a. Failure of a \geq 3 consecutive month trial of MTX at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
 - b. If intolerance or contraindication to MTX (*see Appendix D*), failure of a \geq 3 consecutive month trial of cyclosporine or acitretin at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
5. Failure of a \geq 3 consecutive month trial of adalimumab (*Humira is preferred*), unless contraindicated or clinically significant adverse effects are experienced;
**Prior authorization is required for adalimumab*
6. Dose does not exceed 400 mg every 2 weeks.

Approval duration: 6 months

F. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed:
 - a. For CD, RA, PsA, AS: 400 mg every 4 weeks;
 - b. For PsO: 400 mg every 2 weeks.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2):

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

6-MP: 6-mercaptopurine	MTX: methotrexate
AS: ankylosing spondylitis	NSAID: non-steroidal anti-inflammatory drug
CD: Crohn’s disease	PsA: psoriatic arthritis
DMARD: disease-modifying antirheumatic drug	PsO: plaque psoriasis
FDA: Food and Drug Administration	RA: rheumatoid arthritis
GI: gastrointestinal	TNF: tumor necrosis factor

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
acitretin (Soriatane [®])	PsO 25 or 50 mg PO QD	50 mg/day
azathioprine (Azasan [®] , Imuran [®])	RA 1 mg/kg/day PO QD or divided BID CD* 1.5 – 2 mg/kg/day PO	2.5 mg/kg/day
corticosteroids	CD* prednisone 40 mg PO QD for 2 weeks or IV 50 – 100 mg Q6H for 1 week budesonide (Entocort EC [®]) 6 – 9 mg PO QD	Various

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Cuprimine [®] (d-penicillamine)	RA* <u>Initial dose:</u> 125 or 250 mg PO QD <u>Maintenance dose:</u> 500 – 750 mg/day PO QD	1,500 mg/day
cyclosporine (Sandimmune [®] , Neoral [®])	PsA* 2.5 – 3 mg/kg/day PO QD RA, PsO 2.5 – 4 mg/kg/day PO divided BID	PsA: 3 mg/kg/day RA: 4 mg/kg/day
hydroxychloroquine (Plaquenil [®])	RA* <u>Initial dose:</u> 400 – 600 mg/day PO QD <u>Maintenance dose:</u> 200 – 400 mg/day PO QD	600 mg/day
leflunomide (Arava [®])	PsA* 100 mg/day PO loading dose for 3 days followed by 20 mg/day PO QD RA 100 mg PO QD for 3 days, then 20 mg PO QD	20 mg/day
6-mercaptopurine (Purixan [®])	CD* 50 mg PO QD or 1 – 2 mg/kg/day PO	2 mg/kg/day
methotrexate (Rheumatrex [®])	CD* 15 – 25 mg/week IM or SC PsA* 7.5 – 15 mg/week PO RA 7.5 mg/week PO, SC, or IM or 2.5 mg PO Q12 hr for 3 doses/week PsO 10 to 25 mg/week, IM, IV or PO or 2.5 mg PO Q12 hr for 3 doses/week	30 mg/week
NSAIDs (e.g., indomethacin, ibuprofen, naproxen, celecoxib)	AS, PsA Varies	Varies
Pentasa [®] (mesalamine)	CD 1,000 mg PO QID	4 g/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Ridaura [®] (auranofin)	RA 6 mg PO QD or 3 mg PO BID	9 mg/day (3 mg TID)
sulfasalazine (Azulfidine [®])	PsA* 2 g/day PO QD RA 2 g/day PO in divided doses	PsA: 5 g/day RA: 3 g/day
tacrolimus (Prograf [®])	CD* 0.27 mg/kg/day PO in divided doses or 0.15 – 0.29 mg/kg/day PO	N/A
Enbrel [®] (etanercept)	AS 50 mg SC once weekly PsA, RA 25 mg SC twice weekly or 50 mg SC once weekly	50 mg/week
Humira [®] (adalimumab)	AS, PsA, PsO 40 mg SC every other week CD <u>Initial dose:</u> 160 mg SC on Day 1, then 80 mg SC on Day 15 <u>Maintenance dose:</u> 40 mg SC every other week starting on Day 29 RA 40 mg SC every other week (may increase to once weekly)	AS, PsA, CD, PsO: 40 mg every other week RA: 40 mg/week

Therapeutic alternatives are listed as Brand name[®] (generic) when the drug is available by brand name only and generic (Brand name[®]) when the drug is available by both brand and generic.

**Off-label*

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): none reported
- Boxed warning(s):
 - There is an increased risk of serious infections leading to hospitalization or death including tuberculosis (TB), bacterial sepsis, invasive fungal infections (such as histoplasmosis), and infections due to other opportunistic pathogens.
 - Lymphoma and other malignancies have been observed.
 - Epstein Barr Virus-associated post-transplant lymphoproliferative disorder has been observed.

Appendix D: General Information

- Definition of failure of MTX or DMARDs
 - Child-bearing age is not considered a contraindication for use of MTX. Each drug has risks in pregnancy. An educated patient and family planning would allow use of MTX in patients who have no intention of immediate pregnancy.
 - Social use of alcohol is not considered a contraindication for use of MTX. MTX may only be contraindicated if patients choose to drink over 14 units of alcohol per week. However, excessive alcohol drinking can lead to worsening of the condition, so patients who are serious about clinical response to therapy should refrain from excessive alcohol consumption.
- Examples of positive response to therapy may include, but are not limited to:
 - Reduction in joint pain/swelling/tenderness
 - Improvement in ESR/CRP levels
 - Improvements in activities of daily living
- Several AS treatment guidelines call for a trial of 2 or 3 NSAIDs prior to use of an anti-TNF agent. A two year trial showed that continuous NSAID use reduced radiographic progression of AS versus on demand use of NSAID.
- The following may be considered for medical justification supporting inability to use an immunomodulator for Crohn’s disease:
 - Inability to induce short-term symptomatic remission with a 3-month trial of systemic glucocorticoids
 - High-risk factors for intestinal complications may include:
 - Initial extensive ileal, ileocolonic, or proximal GI involvement
 - Initial extensive perianal/severe rectal disease
 - Fistulizing disease (e.g., perianal, enterocutaneous, and rectovaginal fistulas)
 - Deep ulcerations
 - Penetrating, stricturing or stenosis disease and/or phenotype
 - Intestinal obstruction or abscess
 - High risk factors for postoperative recurrence may include:
 - Less than 10 years duration between time of diagnosis and surgery
 - Disease location in the ileum and colon
 - Perianal fistula
 - Prior history of surgical resection
 - Use of corticosteroids prior to surgery
- According to the CRADLE, a prospective, postmarketing, multicenter, pharmacokinetic study (n = 17), there were no or minimal certolizumab pegol transfer from the maternal plasma to breast milk, with a relative infant dose of 0.15% of the maternal dose.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
CD	<u>Initial dose:</u> 400 mg SC at 0, 2, and 4 weeks <u>Maintenance dose:</u> 400 mg SC every 4 weeks	400 mg every 4 weeks
RA	<u>Initial dose:</u> 400 mg SC at 0, 2, and 4 weeks	400 mg every 4 weeks
PsA	<u>Maintenance dose:</u> 200 mg SC every other	
AS	week (or 400 mg SC every 4 weeks)	

Indication	Dosing Regimen	Maximum Dose
PsO	400 mg SC every other week. For some patients (with body weight ≤ 90 kg), a dose of 400 mg SC at 0, 2 and 4 weeks, followed by 200 mg SC every other week may be considered.	400 mg every other week

VI. Product Availability

- Single-use vial: 200 mg
- Single-use prefilled syringe: 200 mg/mL

VII. References

1. Cimzia Prescribing Information. Smyrna, GA: UCB, Inc.; June 2018. Available at http://www.cimzia.com/assets/pdf/Prescribing_Information.pdf. Accessed September 4, 2018.
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3. Smolen JS, Landewé R, Breedveld FC, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2013 update. *Ann Rheum Dis.* 2014; 73: 492-509.
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6. Menter A, Gottlieb A, Feldman SR, et al. Guidelines for the management of psoriasis and psoriatic arthritis. Section 1: Overview of psoriasis and guidelines of care for the treatment of psoriasis with biologics. *J Am Acad Dermatol.* 2008; 58(5):826-850.
7. Ward MM, et al. American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network 2015 recommendations for the treatment of ankylosing spondylitis and nonradiographic axial spondyloarthritis. *Arthritis & Rheumatology*, 2015. DOI 10.1002/ART.39298.
8. Braun J, van den berg R, et al. 2010 Update of the ASAS/EULAR recommendations for the management of ankylosing spondylitis. *Am Rheu Dis.* 2011; 70; 896- 904.
9. Sandborn WJ. Crohn’s Disease Evaluation and Treatment: Clinical Decision Tool. *Gastroenterology* 2014; 147: 702-705.
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11. Clowse MEB, Forger F, Hwang C, et al. Minimal to no transfer of certolizumab pegol into breast milk: results from CRADLE, a prospective, postmarketing, multicenter, pharmacokinetic study. *Ann Rheum Dis* 2017;76:1980-1896. doi:10.1136/annrheumdis-2017-211384.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J0717	Injection, certolizumab pegol, 1 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy split from CP.PHAR.86.ArthritisTreatments, CP.PHAR.85 Psoriasis Treatment, CP.PHAR.87 IBD Treatment. CD, RA, PsA, AS: Removed criteria related to HBV, malignant disease, concomitant use with other biologics, and concurrent administration of live vaccines; added dosing requirement; added requirement for trial and failure of PDL Enbrel and Humira, unless contraindicated (just Humira for CD). PsA: required trial of MTX and added requirement for the following agents as an alternative if MTX cannot be used: leflunomide, cyclosporine, sulfasalazine, azathioprine. CD: removed aminosalicylate as an option for initial therapy. RA: changed age requirement to 18 years; modified criteria to require trial of MTX, unless contraindicated; added sulfasalazine and hydroxychloroquine as an alternative to MTX if MTX is contraindicated. Re-auth: combined into All Indications; added criteria for dosing and reasons to discontinue. Modified approval duration to 6 months for initial and 12 months for renewal. Shortened background section.	6.16	08.16
Converted to new template. RA: Revised criteria for confirmation of RA diagnosis per 2010 ACR Criteria. CD: revised list of poor prognostic indicators per AGA guidelines; examples of extensive disease added. Safety criteria was applied according to the safety guidance discussed at CPAC and endorsed by Centene Medical Affairs.	08.17	08.17
2Q 2018 annual review: added HIM; removed specific diagnosis requirements for CD; modified specialist requirement to any GI specialist for CD; removed TB testing for all indications; modified trial and failure for RA to at least one conventional DMARD; references reviewed and updated.	02.27.18	05.18
1Q 2019 annual review: criteria added for new FDA indication: plaque psoriasis; modified prescriber specialist from GI specialist to gastroenterologist for CD; added trial and failure of	09.04.18	2.19

Reviews, Revisions, and Approvals	Date	P&T Approval Date
immunosuppressants, or medical necessity for use of biologics in CD; allowed bypassing conventional DMARDs for axial PsA and required trial of NSAIDs; references reviewed and updated.		

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note:

For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy.

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