

## **Clinical Policy: Brodalumab (Siliq)**

Reference Number: CP.PHAR.375

Effective Date: 06.01.18

Last Review Date: 11.18

Line of Business: Medicaid

[Revision Log](#)

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

### **Description**

Brodalumab (Siliq<sup>™</sup>) is an interleukin 17A (IL-17A) receptor antagonist.

### **FDA Approved Indication(s)**

Siliq is indicated for the treatment of moderate-to-severe plaque psoriasis (PsO) in adult patients who are candidates for systemic therapy or phototherapy and have failed to respond or have lost response to other systemic therapies.

### **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<sup>®</sup> that Siliq is **medically necessary** when the following criteria are met:

#### **I. Initial Approval Criteria**

##### **A. 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 methotrexate (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<sup>®</sup> is preferred*), unless contraindicated or clinically significant adverse effects are experienced;  
*\*Prior authorization is required for adalimumab*
6. Dose does not exceed 210 mg at weeks 0, 1, and 2, followed by maintenance dose of 210 mg every 2 weeks.

**Approval duration: 6 months**

##### **B. Other diagnoses/indications**

## CLINICAL POLICY

### Brodalumab

1. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

## II. Continued Therapy

### A. Plaque Psoriasis (must meet all):

1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions 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 210 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 CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

## 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 policy – CP.PMN.53 or evidence of coverage documents;
- B. Treatment of patients with Crohn’s disease.

## IV. Appendices/General Information

### Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration

IL-17A: interleukin 17A

MTX: methotrexate

PsO: plaque psoriasis

### 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 and may require prior authorization.*

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
acitretin (Soriatane <sup>®</sup> )	<b>PsO</b> 25 or 50 mg PO daily	50 mg/day
cyclosporine (Sandimmune <sup>®</sup> , Neoral <sup>®</sup> )	<b>PsO</b> 2.5 – 4 mg/kg/day PO divided BID	4 mg/kg/day
methotrexate (Rheumatrex <sup>®</sup> )	<b>PsO</b> 10 – 25 mg/week PO or 2.5 mg PO Q12 hr for 3 doses/week	30 mg/week

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Humira® (adalimumab)	<b>PsO</b> <u>Initial dose:</u> 80 mg SC <u>Maintenance dose:</u> 40 mg SC every other week starting one week after initial dose	40 mg every other 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.*

*Appendix C: Contraindications/Boxed Warnings*

- Contraindication(s): patients with Crohn’s disease
- Boxed warning(s): suicidal ideation and behavior

*Appendix D: General Information*

- Contraindications:
  - Siliq is contraindicated in patients with Crohn’s disease because Siliq may cause worsening of the disease.
- 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.

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
PsO	<u>Initial dose:</u> 210 mg SC at weeks 0, 1, and 2 <u>Maintenance dose:</u> 210 mg SC every 2 weeks	210 mg every 2 weeks

**VI. Product Availability**

Single-dose prefilled syringe: 210 mg/1.5 mL

**VII. References**

1. Siliq Prescribing Information. Bridgewater, NJ: Valeant Pharmaceuticals North America LLC; February 2017. Available at <http://www.valeant.com/Portals/25/Pdf/PI/Siliq-pi.pdf>. Accessed September 4, 2018.

## CLINICAL POLICY

### Brodalumab

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8. Pariser DM, Bagel J, Gelfand JM et al. National psoriasis foundation clinical consensus on disease severity. *Arch Dermatol*. 2007 Feb; 143: 239-242.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	02.27.18	05.18
4Q2018 annual review: no significant changes; references reviewed and updated.	09.04.18	11.18

#### **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

## CLINICAL POLICY

### Brodalumab

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.

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