# PHARMACY POLICY STATEMENT

**Ohio Medicaid**

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>Amevive (alefacept)</th>
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</thead>
<tbody>
<tr>
<td>BILLING CODE</td>
<td>J0215 (1 unit = 0.5 mg)</td>
</tr>
<tr>
<td>BENEFIT TYPE</td>
<td>Medical</td>
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<tr>
<td>SITE OF SERVICE ALLOWED</td>
<td>Outpatient Hospital/Office</td>
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**COVERAGE REQUIREMENTS**
- Prior Authorization Required (Non-Preferred Product)
- Alternative preferred products include Humira, Enbrel
- QUANTITY LIMIT — 60 mg per 30 days

**LIST OF DIAGNOSES CONSIDERED NOT MEDICALLY NECESSARY**
- Click Here

### Amevive (alefacept)

Amevive (alefacept) is a non-preferred product and will only be considered for coverage under the medical benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

## PLAQUE PSORIASIS (PP)

For **initial** authorization:
1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by a rheumatologist or dermatologist; AND
3. Member’s CD4 count is documented in chart notes, and it is greater than 250 cells/microliter; AND
4. Member has moderate to severe chronic PP for one year or over, and it involves 10% or more of the body surface area (BSA); AND
5. Member’s baseline of Psoriasis Area and Severity Index (PASI) score documented in chart notes; AND
6. Member has tried and failed to respond to treatment with at least one of the following:
   a) At least 12 weeks of photochemotherapy (i.e. psoralen plus ultraviolet A therapy);
   b) At least 12 weeks of phototherapy (i.e. UVB light therapy, Excimer laser treatments; tanning beds emit mostly UVA light and therefore would not meet this criteria);
   c) At least a 4 week trial with topical antipsoriatic agents (i.e. anthralin, calcipotriene, coal tar, corticosteroids, tazarotene); AND
7. Member has tried and failed to respond to treatment of an immunosuppressant (i.e. cyclosporine, methotrexate, acetretin) for at least 12 weeks; AND
8. Member has tried and failed treatment with both Enbrel and Humira.
9. **Dosage allowed:** IV: 7.5 mg once weekly for 12 weeks; IM: 15 mg once weekly for 12 weeks.

**If member meets all the requirements listed above, the medication will be approved for 3 months.**

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show the member has shown improving signs and symptoms of disease; AND
3. Member’s CD4 count is greater than 250 cells/microliter; AND
4. PASI score improvement of 50% from baseline documented in chart notes.

**If member meets all the reauthorization requirements above, the medication will be approved for additional 12 months.**
CareSource considers Amevive (alefacept) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Active infections
- Ankylosing spondylitis
- Asthma
- Cellulitis
- Crohn’s Disease
- Dissecting scalp cellulitis
- For use in combination with other TNF-inhibitors (i.e. Kineret, Enbrel, Remicade)
- Giant-cell arteritis
- Guttate psoriasis
- Infectious uveitis
- Lupus pernio
- Osteoarthritis
- Psoriatic arthritis
- Recurrent pregnancy loss
- Relapsing polychondritis
- Rheumatoid arthritis
- Sarcoidosis
- Sciatica
- Spondyloarthritis (other than ankylosing spondylitis)
- Takayasu’s arteritis
- Vogt-Koyanagi

<table>
<thead>
<tr>
<th>DATE</th>
<th>ACTION/DESCRIPTION</th>
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<tbody>
<tr>
<td>07/18/2017</td>
<td>New policy for Amevive created.</td>
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References:

Effective date: 08/09/2017
Revised date: 07/18/2017