I. POLICY

It is the policy of UPMC Health Plan to maintain a prior authorization process that promotes appropriate utilization of specific drugs with potential for misuse or limited indications. This process involves a review using Food and Drug Administration (FDA) criteria to make a determination of Medical Necessity, as defined in CRM.015-Medical Necessity, and approval by the Pharmacy & Therapeutics Committee of the criteria for prior authorization, as described in RX.003-Prior Authorization Process.

The drug, Alefacept (Amevive) is subject to the prior authorization process.

II. DEFINITIONS

N/A

III. PURPOSE

The purpose of this policy is to define the Prior Authorization Process for Alefacept (Amevive).

IV. SCOPE

This policy applies to the Pharmacy Services Department.

V. PROCEDURE
Alefacept is indicated for the treatment of members 18 and over with moderate to severe chronic plaque psoriasis who are candidates for systemic therapy or phototherapy.

1. Initial Authorization
   Based upon diagnosis, the member must have a confirming diagnosis by a dermatologist, and the following criteria must be met:
   a. A dermatologist must be prescribing
   b. Member is age 18 or older
   c. Member must have a diagnosis of chronic (greater than or equal to 1 year) moderate to severe plaque psoriasis, who is a candidate for systemic therapy
   d. Member must have a minimum body surface area involvement of ≥10%,
      (members with plaque psoriasis of the palms, soles, head and neck, or genitalia are not required to have a minimum body surface area involvement).
   e. Member must have tried methotrexate and TNF blocking agent for at least 3 months with an inadequate response as reported by the prescribing provider; or,
   f. Member has experienced significant side effects / toxicity of methotrexate and/or TNF blocking agents
   g. Approvals will be granted only upon documented medical contraindications, by the prescribing provider, to methotrexate therapy and/or TNF blocking agents
   h. Member must have a normal CD4 lymphocyte count (250 cells/µL or greater)
   i. Member cannot have Human Immunodeficiency Virus (HIV), as this is a contraindication for treatment with Alefacept
   j. Currently not using a TNF-blocking agent or other biologic agent, such as Kineret, Enbrel, or Humira
   k. The medication will be approved based on the above criteria for an initial period of 12 weeks.

2. Continued Authorization
   Reauthorization may be granted for an additional 12 weeks of therapy if the following criteria are met:
   a. Member must have had at least 12 weeks off of therapy after the initial 12 weeks on therapy
   b. Chart documentation from the provider must indicate that that the member’s disease has improved based upon the provider’s assessment while on therapy.
   c. If the above reauthorization criteria are met, the medication will be approved for an additional 12 weeks of therapy.
   d. The maximum length of therapy for this medication is 2 treatment courses (24 weeks) since limited information exists for safety and efficacy beyond treatment with 2 courses.

Limitations:
If a member does not meet the above approval criteria, the request will be referred to a UPMC Health Plan Medical Director for review.

Proprietary and Confidential Information of UPMC Health Plan
V. BIBLIOGRAPHY

10. Menter A, Cather J. Long-term use of intravenous alefacept: safety and off-treatment responses in patients who have received four or more courses of therapy [abstract]. J Am Acad Derm. 2004 (suppl);50:P151.