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 and Therapeutics Committee of the criteria for prior authorization, as described in RX.003-Prior Authorization Process.

The drug Efalizumab (Raptiva®) 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 Efalizumab (Raptiva).

IV. SCOPE

This policy applies to the Pharmacy Department.
V. **PROCEDURE**

Raptiva is indicated for the treatment of chronic moderate-to-severe plaque psoriasis in members age 18 or older who are candidates for systemic therapy or phototherapy.

1. **Initial Authorization Criteria**
   a. The following criteria must be met:
      i. Must be prescribed by a dermatologist
      ii. Member must be ≥ 18 years old
      iii. Member must have a diagnosis of chronic (greater than one (1) year) moderate to severe plaque psoriasis, who is a candidate for systemic therapy
      iv. Member must have a minimum body surface area involvement of ≥ 10% (members with plaque psoriasis of palms, soles, head and neck, or genitalia are not required to have a minimum body surface area involvement)
      v. Member must have tried methotrexate for at least three (3) months with an inadequate response as reported by the prescribing provider; or
      vi. Member has experienced significant side effects/toxicity of methotrexate
      vii. Approvals will be granted only upon documented medical contraindications, by the prescribing provider, to methotrexate therapy
      viii. Currently not using a Tumor necrosis factor (TNF)-blocking agent or other biologic agent, such as Kineret, Enbrel, or Humira

Raptiva will be approved based on the above criteria for an initial period of 12 weeks. Raptiva will have quantity limits of 4 Vials (1 kit) per month.

2. **Reauthorization Criteria**
   a. Reauthorization for six (6) months will be given for patients demonstrating an improvement in Psoriasis Area and Severity Index (PASI) score of at least 50% from baseline and/or Physician Global Assessment (sPGA) score of at least 20%.
   b. Reauthorization for up to three (3) months of therapy will be given for patients demonstrating an improvement in PASI score of less than 50% from baseline and/or sPGA score of less than 20%.
   c. Chart documentation from the provider must indicate that that the member’s disease has improved based upon the provider’s assessment while on therapy.

**Limitations**
If the above criteria are not met, the request will be referred to a UPMC Health Plan Medical Director for review.
VI. BIBLIOGRAPHY