

**Regence BlueCross BlueShield of Oregon • Regence BlueShield  
Regence BlueCross BlueShield of Utah • Regence BlueShield of Idaho  
Independent licensees of the Blue Cross and Blue Shield Association**

**Medication Policy Manual**

**Policy No:** dru129

**Topic:** Orenzia<sup>®</sup>, abatacept

**Date of Origin:** March 2006

**Revised/Effective Date:** November 14, 2008

**Next Review Date:** November 2009

**IMPORTANT REMINDER**

This Medical Policy has been developed through consideration of medical necessity, generally accepted standards of medical practice, and review of medical literature and government approval status.

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

The purpose of medical policy is to provide a guide to coverage. Medical Policy is not intended to dictate to providers how to practice medicine. Providers are expected to exercise their medical judgment in providing the most appropriate care.

**Description**

Abatacept (Orenzia<sup>®</sup>) inhibits the activity of T cells, which reduces inflammation caused by the immune system. It is used for the treatment of rheumatoid arthritis and juvenile idiopathic arthritis.

## Policy/Criteria

- I. Most contracts require prior authorization approval of abatacept (Orencia<sup>®</sup>) prior to coverage. Abatacept may be considered medically necessary in patients with rheumatoid arthritis (RA) or juvenile idiopathic arthritis (JIA) when criteria A and B below are met.
  - A. A diagnosis has been established by a rheumatologist (or, for RA, by the criteria in Appendix 1).

### AND

- B. Methotrexate is ineffective after at least a 6 to 12 week treatment course based on documentation which includes one or more of the assessment components listed in Appendix 2 except if methotrexate is contraindicated or not tolerated based on clinical documentation.

## II. Administration, Quantity Limitations, and Authorization Period

- A. Regence does not consider abatacept to be a self-administered medication.
- B. When prior authorization is approved, abatacept may be authorized in the following quantities:
  - 1. **Initial Authorization:** A maximum of 8 infusions in a 6 month period may be authorized when criteria are met.
  - 2. **Continued Authorization:** For continued authorization after the initial 6 month period, documentation (including chart notes) indicating that there is disease stability or improvement must be provided. The maximum number of infusions that may be authorized per year after the initial authorization period is 13.
- C. Authorization may be reviewed at least annually to confirm that current medical necessity criteria are met and that the medication is effective.

## III. Abatacept is considered investigational when used for all other conditions, including but not limited to:

- A. Diffuse Systemic Sclerosis (Scleroderma)

- B. Ulcerative Colitis
- C. Crohn's Disease
- D. Systemic Lupus Erythematosus

## **Position Statement**

*Treatment of rheumatic disorders (rheumatoid arthritis, psoriatic arthritis, juvenile idiopathic arthritis, ankylosing spondylitis)* <sup>[1, 11-16]</sup>

- There are many treatments for rheumatic disorders that are effective, have known long-term safety profiles, and are recommended by national treatment guidelines.
- Non-medical therapies, such as prescribed exercise therapy, physical therapy and weight loss, are important components in any treatment plan for patients suffering from a rheumatic disorder.
- When a systemic medication therapy is needed to manage one of the rheumatic disorders, oral therapies are usually the best value.
  - \* Medications to control inflammation, such as nonsteroidal anti-inflammatory medications (e.g., meloxicam, nabumetone, and naproxen) and glucocorticoids (oral and injected into the joint) are effective for the management of symptoms, particularly during the early stages of disease.
  - \* Orally administered disease-modifying antirheumatic drugs (DMARDs), including methotrexate (MTX), hydroxychloroquine, leflunomide, and sulfasalazine, are effective for decreasing symptoms and slowing disease progression, have a proven track record, and have been the standard of care for many years.
  - \* Oral therapies have known potential risks. The management of these risks is well established.
- When non-medical therapies and oral medications are inadequate, the biologic medications (e.g., adalimumab, etanercept, infliximab, or abatacept) may be appropriate. Certolizumab and rituximab have been studied in RA, but their role in therapy remains uncertain at this time.

- No studies have shown that any of biologic medications are more effective than another in the treatment of rheumatic disorders.
  - \* The biologic agents can decrease symptoms, help preserve joint functioning, and slow the progression of rheumatic disease.
  - \* There have been no reliable, direct-comparative trials that have demonstrated a difference in clinical effect or safety of one agent over another.
  - \* Individual responses and tolerability are unpredictable and may vary between patients.
  - \* Because responses vary, if one of the biologic agents provides an inadequate response, another biologic medication may yet be effective.
  - \* In RA, the best response is seen when methotrexate is used concomitantly with any of the biologics. Infliximab has been shown to be effective only when used with methotrexate.

*Efficacy of biologic agents in rheumatic conditions* <sup>[1, 11-16]</sup>

The benefit of medications can be indirectly compared by calculating their number needed to treat (NNT). The number needed to treat is a measure of the chances of a patient achieving a benefit (how many patients need to be treated before a benefit is achieved over a certain period of time). The lower the number needed to treat, the more likely the medication will have benefit.

Table 1 summarizes the chances that certain biologic rheumatologic medications will improve joint pain and stiffness in rheumatoid arthritis, psoriatic arthritis and ankylosing spondylitis:

**Table 1: Chances of improving joint pain and stiffness by at least 20% after six months of treatment with biologic medications (compared to no treatment).** <sup>[1, 11-16]</sup>

<b>Biologic Medications (when used with methotrexate)</b>	<b>Rheumatoid Arthritis</b>	<b>Psoriatic Arthritis</b>	<b>Ankylosing Spondylitis</b>
adalimumab (Humira) etanercept (Enbrel) infliximab (Remicade)	About 1 in 3 likely to benefit <sup>a</sup>  NNT = 3 (Range 2-4)	About 1 in 3 likely to benefit <sup>a</sup>  NNT = 3	About 1 in 4 likely to benefit <sup>a</sup>  NNT = 4 (Range 3-4)
abatacept (Orencia)	About 1 in 4 likely to benefit <sup>a</sup>  NNT = 4 (Range 3-4)	N/A	N/A
anakinra (Kineret)	About 1 in 7 likely to benefit <sup>a</sup>  NNT = 7	N/A	N/A
certolizumab (Cimzia)	Uncertain <sup>b</sup>	N/A	N/A
rituximab (Rituxan)	Uncertain <sup>b</sup>	N/A	N/A

<sup>a</sup> Benefit = at least 20% improvement in joint pain and stiffness after six months of treatment.

<sup>b</sup> The trials for these medications had flaws that make estimating their efficacy uncertain. These flaws included large numbers of patients not completing the clinical trials, not all patients counted in the final results, and uncertainty about whether patients and caregivers were truly unaware of the assigned treatments.

- There is reliable evidence that etanercept, adalimumab, and abatacept (when given with methotrexate) are effective in the management of patients with juvenile idiopathic arthritis (JIA). The design of the clinical studies prevents calculation of “number-needed-to-treat” (NNT) for this use. <sup>[1, 11, 12]</sup>

### *Efficacy of abatacept in rheumatic conditions*

- There is evidence that abatacept, in combination with methotrexate, reduces pain and inflammation (as measured by ACR20, ACR50, and ACR70) for up to 1 year in patients who did not respond to methotrexate alone.<sup>[2-3, 7]</sup>
- Abatacept in combination with oral DMARDs has been shown to reduce pain and inflammation (as measured by ACR20, ACR50, and ACR70) for up to 1 year in patients who did not respond to TNF inhibitors.<sup>[4]</sup>
- Abatacept in combination with methotrexate or other DMARDs improved quality of life as measured by the Short Form Health Survey (SF-36) and the Health Assessment Questionnaire (HAQ).<sup>[8,9]</sup>

### *Safety of abatacept*

- In abatacept clinical trials, the most serious adverse reactions were serious infections and malignancies.<sup>[1]</sup> The most commonly reported adverse events (occurring in  $\geq 10\%$  of patients treated with abatacept) were headache, upper respiratory tract infection, nasopharyngitis, and nausea.
- Administration of abatacept to patients with rheumatoid arthritis receiving background biologic agents was associated with a greater frequency of serious adverse events (22.3%) than in other subgroups (11.7 to 12.5%, p-values not reported).<sup>[10]</sup>

**Appendix 1: American College of Rheumatology (ACR) Classification Criteria for Establishing the Diagnosis of Rheumatoid Arthritis (RA) <sup>[5]</sup>**

Diagnosis of RA requires the presence of at least 4 of 7 criteria below:

1.	Morning stiffness in and around joints lasting more than 1 hour.
2.	Arthritis in at least 1 area in a wrist or proximal interphalangeal (PIP) joint (hands or fingers) for > 6 weeks.
3.	Simultaneous swelling or fluid accumulation in 3 or more joints for > 6 weeks.
4.	Symmetric (bilateral joint) involvement for > 6 weeks.
5.	Presence of rheumatoid nodules.
6.	Positive serum rheumatoid factor.
7.	Radiographic changes typical of RA (erosion or unequivocal bony decalcification in or adjacent to the involved joint) on hand and wrist are present.

**Appendix 2: American College of Rheumatology (ACR) Assessment Components for Improvement in Rheumatoid Arthritis (RA) <sup>[6]</sup>**

-	Tender joint count.
-	Swollen joint count.
-	Patient's assessment of pain.
-	Patient's global assessment of disease activity.
-	Physician's global assessment of disease activity.
-	Patient's assessment of physical function.
-	Acute phase reactant measures (erythrocyte sedimentation rate or C-reactive protein levels).

## References

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12. Enbrel<sup>®</sup> [package insert]. Thousand Oaks, CA.: Immunex Corporation; June 2008
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14. Cimzia<sup>®</sup> [package insert]. Smyrna, GA: UCB, Inc.; April 2008

15. Saag KG, Teng GG, Patkar NM, et al. ; American College of Rheumatology. American College of Rheumatology 2008 recommendations for the use of nonbiologic and biologic disease-modifying antirheumatic drugs in rheumatoid arthritis. *Arthritis Rheum.* 2008 Jun 15;59(6):762-84.
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Cross References
Enbrel <sup>®</sup> , etanercept dru035
Humira <sup>®</sup> , adalimumab dru081
Kineret <sup>®</sup> , anakinra dru049
Remicade <sup>®</sup> , infliximab dru036
Cimzia <sup>®</sup> , certolizumab dru160

Codes	Number	Description
CPT	90765	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour
CPT	90767	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion, up to 1 hour (List separately in addition to code for primary procedure) (Use 90767 in conjunction with 90765)
HCPCS	J0129	Injection, abatacept, 10 mg