UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Soriatane

Program	Prior Authorization
Medication	Soriatane (acitretin)
Markets in Scope	Arizona, California, Hawaii, Maryland, Nevada, New Jersey, New York, New York EPP, Pennsylvania CHIP, Rhode Island, South Carolina
Issue Date	12/2010
Pharmacy and Therapeutics Approval Date	4/2020
Effective Date	6/2020

1. Background:

Soriatane is indicated for the treatment of severe psoriasis in adults. Because of significant adverse effects associated with its use, Soriatane should be prescribed only by those knowledgeable in the systemic use of retinoids. In females of reproductive potential, Soriatane should be reserved for non-pregnant patients who are unresponsive to other therapies or whose clinical condition contraindicates the use of other treatments. Most patients experience relapse of psoriasis after discontinuing therapy. Subsequent courses, when clinically indicated, have produced efficacy results similar to the initial course.

Soriatane has a black boxed warning for the following: ethanol ingestion has been shown to be associated with the transesterification; pregnancy risk category X; blood donation should be avoided during and for 3 years following completion of therapy; therapy requires an experienced clinician who has special competence in the diagnosis and treatment of severe psoriasis. Please see full prescribing information for additional details.

2. Coverage Criteria:

A. <u>Psoriasis</u>

1. <u>Initial Therapy</u>

a. **Soriatane** will be approved based on **<u>all</u>** of the following criteria:

(1) Diagnosis of severe psoriasis

-AND-

(2) Prescribed or recommended by a dermatologist

-AND-

(3) **One** of the following:

(a) Patient is unresponsive to other therapies (e.g., topical corticosteroids, topical vitamin D analogs, tazarotene, methotrexate)

-OR-

(b) Other therapies are contraindicated based on the patient's clinical condition

-AND-

(4) **One** of the following:

- Greater than or equal to 10% body surface area involvement
- Palmoplantar, facial, or genital involvement
- Severe scalp psoriasis

Authorization will be issued for 12 months.

2. Reauthorization

a. **Soriatane** will be approved based on **all** of the following criteria:

(1) Documentation of positive clinical response to Soriatane therapy

-AND-

(2) Prescribed or recommended by a dermatologist

Authorization will be issued for 12 months.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Soriatane [package insert]. Research Triangle Park, NC: Stiefel Laboratories; September 2017.
2. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Section 4. Guidelines of care for the management and treatment of psoriasis with traditional systemic agents. J Am Acad Dermatol. 2009; 61: 451-85.
3. Menter A, Gottlieb A, Feldman SR, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Section 1. Overview of psoriasis and guidelines of care for the treatment of psoriasis with biologics. J Am Acad Dermatol. 2008; 58: 826-50.

Program	Prior Authorization –Soriatane (acitretin)
Change Control	
Date	Change
12/2010	New policy
12/2011	Annual review, no change
12/2012	Annual review, no change
12/2015	Annual review, no change
11/2016	Annual review, updated policy template
9/2017	Removed age requirement. Updated references.
9/2018	Updated criteria to align closer with other psoriasis programs. Updated references.
9/2019	Annual review. Updated references.
4/2020	Revised diagnosis requirement since medication can be used for different types of psoriasis. Revised prerequisite therapies to align with package insert.