

STELARA® (USTEKINUMAB)

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Related Policies
<ul style="list-style-type: none"> • Acquired Rare Disease Drug Therapy Exception Process • Drug Coverage Guidelines • Maximum Dosage • Specialty Pharmacy for Certain Specialty Medications Administered in an Outpatient Hospital Setting

INSTRUCTIONS FOR USE

This Clinical Policy provides assistance in interpreting Oxford benefit plans. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify its policies as necessary. This Clinical Policy is provided for informational purposes. It does not constitute medical advice. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

When deciding coverage, the member specific benefit plan document must be referenced. The terms of the member specific benefit plan document [e.g., Certificate of Coverage (COC), Schedule of Benefits (SOB), and/or Summary Plan Description (SPD)] may differ greatly from the standard benefit plan upon which this Clinical Policy is based. In the event of a conflict, the member specific benefit plan document supersedes this Clinical Policy. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the member specific benefit plan coverage prior to use of this Clinical Policy. Other Policies may apply.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

CONDITIONS OF COVERAGE

Applicable Lines of Business/ Products	This policy applies to Oxford Commercial plan membership.
Benefit Type	General Benefits Package ^{1,2}
Referral Required (Does not apply to non-gatekeeper products)	No
Authorization Required (Precertification always required for inpatient admission)	Yes ^{1,2,3}
Precertification with Medical Director Review Required	No
Applicable Site(s) of Service (If site of service is not listed, Medical Director review is required)	Other ^{3,4}
Special Considerations	<p>¹Precertification is not required when provided in an office or outpatient setting.</p> <p>²New Jersey small group plan members should refer to their Certificate of Coverage for precertification and quantity limit guidelines.</p> <p>³Providers must call Oxford's Pharmacy Benefit Manager (PBM) to obtain precertification for Stelara when</p>

Special Considerations
(continued)

obtained at a pharmacy for self-administration; refer to the policy titled [Drug Coverage Guidelines](#).

⁴Participating hospitals are required to purchase Stelara[®] (ustekinumab) from the BriovaRx Specialty Pharmacy when the medication is administered in an outpatient hospital setting; refer to the policy titled [Specialty Pharmacy for Certain Specialty Medications Administered in an Outpatient Hospital Setting](#) for additional information.

BENEFIT CONSIDERATIONS

Before using this policy, please check the member specific benefit plan document and any federal or state mandates, if applicable.

Some Certificates of Coverage allow coverage of experimental/investigational/unproven treatments for life-threatening illnesses when certain conditions are met. The member specific benefit plan document must be consulted to make coverage decisions for this service. Some states mandate benefit coverage for off-label use of medications for some diagnoses or under some circumstances when certain conditions are met. Where such mandates apply, they supersede language in the member specific benefit plan document or in the Medical or Drug Policy. Benefit coverage for an otherwise unproven service for the treatment of serious rare diseases may occur when certain conditions are met; refer to the policy titled [Acquired Rare Disease Drug Therapy Exception Process](#).

Essential Health Benefits for Individual and Small Group

For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs"). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs, the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this policy, it is important to refer to the member specific benefit plan document to determine benefit coverage.

COVERAGE RATIONALE

This policy refers to Stelara (ustekinumab) injection.

Stelara is proven and medically necessary for the treatment of:

- **Crohn's disease** when **all** of the following criteria are met:¹
 - Diagnosis of moderately to severely active Crohn's disease; **and**
 - **One** of the following:
 - History of failure, contraindication, or intolerance to at least **one** tumor necrosis factor (TNF) blocker [e.g., Remicade/Inflectra (infliximab), Humira (adalimumab), Cimzia (certolizumab)]; **or**
 - **Both** of the following:
 - History of failure, contraindication, or intolerance to at least **one** immunomodulator or corticosteroid (e.g., corticosteroids, 6-mercaptopurine, azathioprine, methotrexate, etc.)
 - Patient has never failed a TNF blocker [e.g., Remicade/Inflectra (infliximab), Humira (adalimumab), Cimzia (certolizumab)]
- and**
- **One** of the following:
 - **Initial Therapy**
 - Stelara is to be administered as an intravenous induction dose; **and**
 - Stelara induction dosing is accordance with the United States Food and Drug Administration approved labeled dosing for Crohn's disease:
 - 260mg for patients weighing ≤55kg
 - 390mg for patients weighing >55kg to ≤85kg
 - 520mg for patients weighing >85kg
 - and**
 - Patient is not receiving Stelara in combination with **any** of the following:
 - Biologic DMARD [e.g., Remicade/Inflectra (infliximab), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]
 - Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]¹⁶

- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]
and
- Authorization will be for one induction dose
or
- **Continuation Therapy**
 - Patient is unable to self-administer subcutaneous doses; **and**
 - Stelara is to be subcutaneously administered 8 weeks after the initial intravenous dose; **and**
 - Stelara continuation dosing is in accordance with the United States Food and Drug Administration approved labeled dosing for Crohn's disease:
 - 90mg every 8 weeks subcutaneously
 - and**
 - Patient is not receiving Stelara in combination with **any** of the following:
 - Biologic DMARD [e.g., Remicade/Inflectra (infliximab), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]
 - Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]¹⁶
 - Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]
- **Plaque psoriasis** when **all** of the following criteria are met:¹
 - Diagnosis of moderate to severe plaque psoriasis; and
 - **One** of the following:
 - Patient is a candidate for phototherapy
 - Patient is a candidate for systemic therapy
 - and**
 - Patient is unable to self-administer subcutaneous doses; **and**
 - Stelara is initiated and titrated according to US Food and Drug Administration labeled dosing for plaque psoriasis up to a maximum of (or equivalent dose and interval schedule):
 - 45mg every 12 weeks for patients weighing ≤100kg subcutaneously
 - 90mg every 12 weeks for patients weighing >100kg subcutaneously
 - and**
 - Patient is not receiving Stelara in combination with **any** of the following:
 - Biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]
 - Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]¹⁶
 - Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]
- **Psoriatic arthritis** when **all** of the following criteria are met:¹
 - Diagnosis of psoriatic arthritis; **and**
 - Stelara is initiated and titrated according to US Food and Drug Administration labeled dosing for psoriatic arthritis up to a maximum of 90mg every 12 weeks subcutaneously (or equivalent dose and interval schedule); **and**
 - Patient is unable to self-administer subcutaneous doses; **and**
 - Patient is not receiving Stelara in combination with **any** of the following:
 - Biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]
 - Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]¹⁶
 - Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

Stelara is unproven and not medically necessary for the treatment of:

- Multiple sclerosis

In available studies, ustekinumab does not demonstrate efficacy in the treatment of multiple sclerosis.

U.S. FOOD AND DRUG ADMINISTRATION (FDA)

Stelara is a human interleukin-12 and -23 antagonist indicated for the treatment of:¹

- Adult patients (18 years or older) with:
 - Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy.
 - Active psoriatic arthritis, alone or in combination with methotrexate.
 - Moderately to severely active Crohn's disease who have:
 - Failed or were intolerant to treatment with immunomodulators or corticosteroids, but never failed a tumor necrosis factor (TNF) blocker; or
 - Failed or were intolerant to treatment with one or more TNF blockers.

- Adolescent patients (12 years or older) with:
 - Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy.

BACKGROUND

Stelara is a human IgG1k monoclonal antibody that binds with high affinity and specificity to the p40 protein subunit used by both the interleukin (IL)-12 and IL-23 naturally occurring cytokines. IL-12 and IL-23 are involved in inflammatory and immune responses, such as natural killer cell activation and CD4+ T-cell differentiation and activation.¹

APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies may apply.

HCPCS Code	Description
J3357	Ustekinumab, for subcutaneous injection, 1 mg
J3358	Ustekinumab, for intravenous injection, 1 mg

ICD-10 Diagnosis Code	Description
K50.00	Crohn's disease of small intestine without complications
K50.011	Crohn's disease of small intestine with rectal bleeding
K50.012	Crohn's disease of small intestine with intestinal obstruction
K50.013	Crohn's disease of small intestine with fistula
K50.014	Crohn's disease of small intestine with abscess
K50.018	Crohn's disease of small intestine with other complication
K50.019	Crohn's disease of small intestine with unspecified complications
K50.10	Crohn's disease of large intestine without complications
K50.111	Crohn's disease of large intestine with rectal bleeding
K50.112	Crohn's disease of large intestine with intestinal obstruction
K50.113	Crohn's disease of large intestine with fistula
K50.114	Crohn's disease of large intestine with abscess
K50.118	Crohn's disease of large intestine with other complication
K50.119	Crohn's disease of large intestine with unspecified complications
K50.80	Crohn's disease of both small and large intestine without complications
K50.811	Crohn's disease of both small and large intestine with rectal bleeding
K50.812	Crohn's disease of both small and large intestine with intestinal obstruction
K50.813	Crohn's disease of both small and large intestine with fistula
K50.814	Crohn's disease of both small and large intestine with abscess
K50.818	Crohn's disease of both small and large intestine with other complication
K50.819	Crohn's disease of both small and large intestine with unspecified complications
K50.90	Crohn's disease, unspecified, without complications
K50.911	Crohn's disease, unspecified, with rectal bleeding
K50.912	Crohn's disease, unspecified, with intestinal obstruction
K50.913	Crohn's disease, unspecified, with fistula
K50.914	Crohn's disease, unspecified, with abscess
K50.918	Crohn's disease, unspecified, with other complication
K50.919	Crohn's disease, unspecified, with unspecified complications
L40.0	Psoriasis vulgaris
L40.1	Generalized pustular psoriasis

ICD-10 Diagnosis Code	Description
L40.2	Acrodermatitis continua
L40.3	Pustulosis palmaris et plantaris
L40.4	Guttate psoriasis
L40.50	Arthropathic psoriasis, unspecified
L40.51	Distal interphalangeal psoriatic arthropathy
L40.52	Psoriatic arthritis mutilans
L40.53	Psoriatic spondylitis
L40.54	Psoriatic juvenile arthropathy
L40.59	Other psoriatic arthropathy
L40.8	Other psoriasis
L40.9	Psoriasis, unspecified

Maximum Dosage Requirements

HCPCS Code Based Maximum Dosage Information

This section provides information about the maximum dosage per administration for ustekinumab administered by a medical professional.

Medication Name		Maximum Dosage per Administration	HCPCS Code	Maximum Allowed
Brand	Generic			
Stelara	ustekinumab	90 mg	J3357	90 HCPCS units (1 mg per unit)

Maximum Allowed Quantities by National Drug Code (NDC) Units

The allowed quantities in this section are calculated based upon both the maximum dosage information supplied within this policy as well as the process by which NDC claims are billed. This list may not be inclusive of all available NDC's for each drug product and is subject to change.

Medication Name		How Supplied	National Drug Code	Maximum Allowed
Brand	Generic			
Stelara	ustekinumab	45 mg/0.5 mL prefilled syringe	57894-0060-03	0.5 mL
Stelara	ustekinumab	45 mg/0.5 mL solution in vials	57894-0060-02	0.5 mL
Stelara	ustekinumab	90 mg/1 mL prefilled syringe	57894-0061-03	1 mL

CLINICAL EVIDENCE

Proven/Medically Necessary

Crohn's Disease

Ustekinumab was evaluated in three randomized, double-blind, placebo-controlled clinical studies in adult patients with moderately to severely active Crohn's disease. There were two 8-week intravenous induction studies followed by a 44-week subcutaneous randomized withdrawal maintenance study representing 52 weeks of therapy.^{1,17}

In the two induction studies, 1409 patients were randomized, and 1368 (CD-1, n=741; CD-2, n=627) were included in the final efficacy analysis. Induction of clinical response at Week 6 and clinical remission at Week 8 were primary endpoints. In both studies, patients were randomized to receive a single intravenous administration of ustekinumab at either approximately 6 mg/kg, placebo, or 130 mg. In the first study, patients had failed or were intolerant to prior treatment with a TNF blocker: 29% patients had an inadequate initial response (primary non-responders), 69% responded but subsequently lost response (secondary non-responders) and 36% were intolerant to a TNF blocker. Of these patients, 48% failed or were intolerant to one TNF blocker and 52% had failed 2 or 3 prior TNF blockers. At baseline and throughout this study, approximately 46% of the patients were receiving corticosteroids and 31% of the patients were receiving immunomodulators (azathioprine, 6-mercaptopurine, methotrexate). The median baseline CDAI score was 319 in the ustekinumab approximately 6 mg/kg group and 313 in the placebo group.^{1,17,18}

In the second induction study, patients had failed or were intolerant to prior treatment with corticosteroids (81% of patients), at least one immunomodulator; (68% of patients), or both (49% of patients). Additionally, 69% never received a TNF blocker and 31% previously received but had not failed a TNF blocker. At baseline, and throughout the study, approximately 39% of the patients were receiving corticosteroids and 35% of the patients were receiving immunomodulators. The median baseline CDAI score was 286 in the ustekinumab and 290 in the placebo group.^{1,17,18}

In both of the induction studies, a greater proportion of patients treated with ustekinumab achieved clinical response at Week 6 and clinical remission at Week 8 compared to placebo. Clinical response and remission were significant as early as Week 3 in ustekinumab treated patients and continued to improve through Week 8.^{1,17,18}

The maintenance study, evaluated 388 patients who achieved clinical response (≥ 100 point reduction in CDAI score) at Week 8 of induction with ustekinumab in either of the induction studies. Patients were randomized to receive a subcutaneous maintenance regimen of either 90 mg ustekinumab every 8 weeks or placebo for 44 weeks (see Table 10).^{1,17,18}

At Week 44, 47% of patients who received ustekinumab were corticosteroid-free and in clinical remission, compared to 30% of patients in the placebo group. At Week 0 of this study, 34/56 (61%) ustekinumab treated patients who previously failed or were intolerant to TNF blocker therapies were in clinical remission and 23/56 (41%) of these patients were in clinical remission at Week 44. In the placebo arm, 27/61 (44%) patients were in clinical remission at Week 0 while 16/61 (26%) of these patients were in remission at Week 44. At Week 0 of this study, 46/72 (64%) ustekinumab treated patients who had previously failed immunomodulator therapy or corticosteroids (but not TNF blockers) were in clinical remission and 45/72 (63%) of these patients were in clinical remission at Week 44. In the placebo arm, 50/70 (71%) of these patients were in clinical remission at Week 0 while 31/70 (44%) were in remission at Week 44. In the subset of these patients who were also naïve to TNF blockers, 34/52 (65%) of ustekinumab treated patients were in clinical remission at Week 44 as compared to 25/51 (49%) in the placebo arm. Patients who were not in clinical response 8 weeks after ustekinumab induction were not included in the primary efficacy analyses; however, these patients were eligible to receive a 90 mg subcutaneous injection of ustekinumab upon entry into the maintenance study. Of these patients, 102/219 (47%) achieved clinical response eight weeks later and were followed for the duration of the study.^{1,17,18}

Plaque Psoriasis

A phase 3, multi-center, double-blind, placebo-controlled, randomized study evaluated the safety and efficacy of ustekinumab in patients age 12 to 17 years who had moderate-to-severe psoriasis.¹⁷ Patients (n = 110) were randomly assigned (2:2:1:1) ratio to ustekinumab (SD; 0.75 mg/kg [≤ 60 kg], 45 mg [$>60 - \leq 100$ kg], and 90 mg [>100 kg]) or half-standard dosing (HSD; 0.375 mg/kg [≤ 60 kg], 22.5 mg [$>60 - \leq 100$ kg], and 45 mg [>100 kg]) at weeks 0 and 4 and every 12 weeks or placebo at weeks 0 and 4 with crossover to ustekinumab SD or HSD at weeks 12 and 16 and thereafter every 12 weeks through week 40. At week 8, patients with a PASI increase $\geq 50\%$ from baseline were eligible to commence treatment with moderate-to-high potency topical steroid preparations through week 12. The primary endpoint was the proportion of patients with a Physician's Global Assessment (PGA) 0/1 at week 12. Major secondary endpoints were the proportions of patients achieving at least 75% improvement in PASI (PASI 75) and at least 90% improvement in PASI (PASI 90) at week 12 and the change from baseline in Children's Dermatology Life Quality Index (CDLQI) at week 12. Assessments were performed through week 52. At week 12, the proportions of patients achieving PGA 0/1 were significantly greater in the HSD (67.6%) and SD (69.4%) groups versus placebo (5.4%; $P < 0.001$ for both dose groups). Approximately one-third of patients in each ustekinumab group achieved PGA 0/1 at week 4. Significantly greater proportions of patients in the HSD (32.4%) and SD (47.2%) groups achieved a PGA of 0 at week 12 compared to placebo (2.7%, $P < 0.001$). Significantly greater proportions of patients receiving ustekinumab achieved PASI 75 (HSD, 78.4%; SD, 80.6%; placebo, 10.8%; $P < 0.001$) or PASI 90 (HSD, 54.1%; SD, 61.1%; placebo, 5.4%; $P < 0.001$). Additionally, 21.6% of patients in the HSD group and 38.9% in the SD group achieved a PASI score of 0 (cleared) at week 12 compared with 2.7% in the placebo group ($P = .014$ and $P < 0.001$, respectively). The treatment effect of both the HSD and SD of ustekinumab through week 12 for patients < 60 kg was consistent with that observed in patients > 60 kg to ≤ 100 kg. Placebo patients who crossed over to ustekinumab at week 12, PASI 75 response rates increased by week 16 and were maintained through week 52. The proportions of patients achieving PGA 0/1, PASI 75, or PASI 90 after crossover were generally similar to those observed in patients who started ustekinumab at baseline. Through week 40, all 110 patients received at least 1 injection of ustekinumab; among these, 81.8% reported an adverse event (AE) through week 60. By week 12, only one serious AE (SAE) was reported in the HSD group. After week 12, 5 additional singular SAEs were reported (total, 6; HSD, 5; SD, 1) through week 60. The investigators concluded that ustekinumab, in patients 12 to 17 years, the standard dose provided response comparable to that in adults with no unexpected adverse events through 1 year.

Griffiths et al. conducted a blinded, multi-center, head-to-head comparison of ustekinumab versus etanercept in the treatment of moderate-to-severe plaque psoriasis.¹¹ Patients (n=903) were randomly assigned in a 3:5:5 ratio to receive subcutaneous injections of ustekinumab 45 mg (n=209) at weeks 0 and 4, ustekinumab 90 mg (n=347) at weeks 0 and 4, or etanercept 50 mg (n=347) twice weekly for 12 weeks. The primary end point was the proportion of patients with at least 75% improvement in the PASI index at week 12. A secondary end point was the proportion with cleared or minimal disease on the basis of the physician's global assessment. At week 12, a total of 67.5% of patients who received 45 mg of ustekinumab and 73.8% of patients who received 90 mg of ustekinumab had at least 75% improvement in the PASI score, as compared with 56.8% of those who received high-dose etanercept ($p=0.01$ and $p<0.001$, respectively). Similarly, 65.1% of patients who received 45 mg of ustekinumab and 70.6% of patients who

received 90 mg of ustekinumab had cleared or minimal disease according to the physician's global assessment, as compared with 49.0% of those who received etanercept ($p < 0.001$ for both comparisons). Among patients who did not have a response to etanercept, 48.9% had at least 75% improvement in the PASI within 12 weeks after crossover to ustekinumab. One or more adverse events occurred through week 12 in 66.0% of patients who received 45 mg of ustekinumab and 69.2% of patients who received 90 mg of ustekinumab and in 70.0% who received etanercept; 1.9%, 1.2%, and 1.2%, respectively, had serious adverse events. Safety patterns were similar before and after crossover from etanercept to ustekinumab. The investigators concluded that ustekinumab at a dose of 45 or 90 mg had superior efficacy to high-dose etanercept over a 12-week period in patients with psoriasis.

Unproven/Not Medically Necessary

Multiple Sclerosis

Kasper et al. conducted a phase I, double-blind, placebo-controlled, sequential dose escalation study in 20 subjects with multiple sclerosis (MS).⁸ Subjects were randomized (4:1) to receive a single subcutaneous injection of either ustekinumab (0.3, 0.75, 1.5, and 3 mg/kg) or placebo. Clinical and laboratory evaluations were performed through 16 weeks following administration. Single subcutaneous administrations of ustekinumab in this first study of relapsing MS were generally well tolerated. Adverse events were generally mild or moderate, with no apparent dose-related trends. There was a large degree of variability in T2 lesion volume and total number of gadolinium-positive lesions, both unaffected by dose escalation. Three relapses of MS occurred in two placebo-treated subjects. Over the range of single doses studied, the median T_{max} ranged from 9.0 to 16.5 days, and the median T_{1/2} ranged from 20.2 to 30.9 days. The authors concluded that safety of ustekinumab in MS needs to be tested in a study of longer duration and involving a larger cohort of subjects.

In a phase II, multicenter, randomized, double-blind, placebo-controlled trial, Segal et al. studied repeated injections of ustekinumab in patients (n=249) with relapsing-remitting multiple sclerosis (RRMS).⁹ Subjects aged 18-65 years were assigned to one of five groups: placebo (n=49) or four different ustekinumab dosages (n=50 for all) at weeks 0, 1, 2, 3, 7, 11, 15, and 19. Ustekinumab doses were 27 mg, 90 mg q8w, 90 mg, or 180 mg; the 90 mg q8w dosage group received placebo substitute at weeks 7 and 15. The primary endpoint was the cumulative number of new gadolinium-enhancing T1-weighted lesions on serial cranial MRI through week 23. Patients were followed up through week 37. In the intent to treat analysis, ustekinumab treatment did not show a significant reduction in the primary endpoint for any dosage groups versus placebo. At week 37, adverse events occurred in 38 (78%) placebo-treated patients and 170 (85%) ustekinumab-treated patients, with infections most commonly reported. Serious adverse events occurred in one (2%) placebo-treated patient and six (3%) ustekinumab-treated patients. Malignant diseases were reported in two patients shortly after the initiation of ustekinumab treatment; both patients were withdrawn from the trial and given appropriate treatment, which resulted in complete remission. No serious infections, cardiovascular events, or exacerbation of demyelinating events occurred. A dose-dependent increase in serum concentrations of ustekinumab was recorded. The investigators concluded that ustekinumab is generally well tolerated but does not show efficacy in reducing the cumulative number of gadolinium-enhancing T1-weighted lesions in multiple sclerosis.

Professional Societies

American Academy of Dermatology

The American Academy of Dermatology guidelines of care for the management of psoriasis and psoriatic arthritis (PsA) state that patients with limited skin disease should not automatically be treated with systemic treatment if they do not improve, because treatment with systemic therapy may carry more risk than the disease itself.¹⁰

The strength of AAD recommendations for the treatment of moderate to severe plaque psoriasis using ustekinumab is A (highest recommendation; level I evidence). Compared with the TNF- α inhibitors, the most comprehensive ustekinumab safety data to date come from a pooled analysis of phase II and phase III clinical trials involving slightly more than 3,000 patients with just over 3 years of continuous therapy. Therefore, the use of registries to monitor the long-term safety of ustekinumab and other new agents currently under development, and to monitor the long-term safety of all of the systemic agents available, is an essential step in defining the long-term adverse effects of ustekinumab and other new agents.¹¹

When considering the use of ustekinumab for PsA, the AAD states that until the results of ongoing phase III trials of ustekinumab for PsA become available, the TNF- α inhibitors should be considered the biologic class of choice for these patients.¹¹

Technology Assessments

A 2016 Cochrane review was published to assess the efficacy and safety of anti-IL-12/23p40 antibodies for induction of remission in Crohn's disease. The review evaluated six studies with 2324 participants. The authors concluded that the high quality evidence suggests that ustekinumab is effective for induction of clinical remission and clinical improvement in patients with moderate to severe Crohn's disease. Moderate to high quality evidence suggests that

the optimal dosage of ustekinumab is 6 mg/kg. Briakinumab and ustekinumab appear to be safe. Moderate quality evidence suggests no increased risk of serious adverse events. Future studies are required to determine the long-term efficacy and safety of ustekinumab in patients with moderate to severe Crohn's disease.¹⁹

REFERENCES

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare Pharmacy Clinical Pharmacy Program that was researched, developed and approved by the UnitedHealth Group National Pharmacy & Therapeutics Committee [2018D0045L]

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POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
10/01/2018	<ul style="list-style-type: none"> • Updated list of related policies; added reference link to the policy titled <i>Specialty Pharmacy for Certain Specialty Medications Administered in an Outpatient Hospital Setting</i> • Revised conditions of coverage/special considerations; added language to indicate: <ul style="list-style-type: none"> ○ Participating hospitals are required to purchase Stelara® (ustekinumab) from the BrioVaRx Specialty Pharmacy when the medication is administered in an outpatient hospital setting; refer to the policy titled Specialty Pharmacy for Certain Specialty Medications Administered in an Outpatient Hospital Setting for additional information • Archived previous policy version PHARMACY 218.17 T2