Custom Criteria for
BlueCross Blue Shield of Rhode Island Commercial

STELARA (ustekinumab)

GPI CODING:

902505850020**

DESCRIPTION:

Stelara is an interleukin-12 and -23 blocker indicated for the treatment of adult patients (18 years or older) with moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy.

APPROVAL DURATION:

Approval duration is lifetime

Quantity limit on 45mg/dose: 1 syringe per 28 days for the first 56 days, then 1 syringe every 84 days
Quantity limit on 90mg/dose: 1 syringe every 84 days (only after clinical criteria have been met)

CRITERIA FOR STELARA

None of the following are present:

I. Tuberculosis (active or untreated) or any other active serious infection
II. Patients who have not had a tuberculin skin test (TST), or a CDC-recommended equivalent, to rule out latent tuberculosis
III. Use of Stelara in combination with any other biologic medication

AND

Chronic moderate to severe plaque psoriasis

I. Patient is 18 years of age or older **AND**
II. Patient has a diagnosis of moderate to severe plaque psoriasis with either of the following:
    A. Patient has greater than ≥5% of body surface area with psoriasis
    B. Less than 5% of body surface area with plaque psoriasis involving sensitive areas (such as palms, soles of feet, head/neck, or genitalia) OR involving areas that would significantly impact daily function

AND

III. Patient has had an inadequate response to phototherapy AND systemic therapies **AND**
IV. The patient was adherent to therapy AND therapy was optimized with respect to dose and route of administration
    A. Methotrexate OR
    B. Acitretin (Soriatane) OR
    C. Cyclosporine (Neoral, Sandimmune)

OR

II. The patient has a documented intolerance, contraindication, or other clinical reason to avoid systemic therapy

Authorization for 90 mg dose shall be reviewed for the following criteria: patient weight is >100 kg (220 lbs) and patient has had an inadequate response to a dose of 45 mg.