UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Soriatane

Program	Prior Authorization
Medication	Soriatane (acitretin)
Issue Date	12/2010
Pharmacy and Therapeutics Approval Date	9/2017
Effective Date	11/2017

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.

2. Coverage Criteria:

A. Plaque Psoriasis

1. Initial Therapy

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

(1) Confirmed diagnosis of plaque psoriasis.

-AND-

(2) The medication is being prescribed by a dermatologist.

-AND-

(3) Documented treatment failure, intolerance, or contraindication to **one** of the following:

(a) A high potency steroid (ex. Betamethasone, Fluocinonide,

Desoximetasone)
(b) Dovonex (Calcipotriene)
(c) Methotrexate
(d) Cyclosporine

-AND-

(4) A Body Surface Area (BSA) involvement of ≥ 10%

-OR-

(5) A Body Surface Area (BSA) involvement of ≤ 10% and **both** of the following:

(i) Plaque psoriasis involves a critical area(s) (ex. palms, soles, face, genitalia)

-AND-

(ii) The disease in the critical area(s) interferes with daily activities.

Authorization will be issued for 12 months.

2. **Reauthorization**

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

(1) Confirmed diagnosis of plaque psoriasis.

-AND-

(2) The medication is being prescribed by a dermatologist.

-AND-

(3) Clinical benefit of Soriatane therapy is documented.

Authorization will be issued for 12 months.

3. References:

1. Soriatane® Prescribing Information. Stiefel Laboratories, May 2015.

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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.
4. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Section 3. Guidelines of care for the management and treatment of psoriasis with topical therapies. J Am Acad Dermatol. 2009; 60: 643-59.
5. Luba KM, Stulberg DL. Chronic plaque psoriasis. *American Family Physician* 2006; 73(4):636-44.
6. Fisher V. Clinical Monograph for Drug Formulary Review: Systemic Agents for Psoriasis/Psoriatic Arthritis. JMCP. 2005; 11(1): 33-55.
7. Clinical Pharmacology Gold Standard 2017.
8. Facts and Comparisons, 4.0;2017..
9. Das A, Panda S. Use of Topical Corticosteroids in Dermatology: An Evidence-based Approach. Indian J Dermatol. 2017; 62(3): 237–250.

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.

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