



CIGNA HEALTHCARE COVERAGE POSITION

Revised Date	5/30/2008
Original Effective Date	5/15/2005
Next Review Date.....	5/15/2009
Coverage Position Number	4014

Subject **Alefacept (Amevive®)**

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Hyperlink to Related Coverage Positions

Enbrel®
Humira®
Kineret®
Remicade®

INSTRUCTIONS FOR USE

Coverage Positions are intended to supplement certain **standard** CIGNA HealthCare benefit plans. Please note, the terms of a participant's particular benefit plan document [Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Positions are based. For example, a participant's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Position. In the event of a conflict, a participant's benefit plan document **always supercedes** the information in the Coverage Positions. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable group benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Positions and; 4) the specific facts of the particular situation. Coverage Positions relate exclusively to the administration of health benefit plans. Coverage Positions are not recommendations for treatment and should never be used as treatment guidelines. Proprietary information of CIGNA. Copyright © 2008 CIGNA

Coverage Position

CIGNA HealthCare covers alefacept (Amevive®) as medically necessary for treatment of moderate-to-severe chronic plaque psoriasis when ALL of the following indications are met:

- patient is age 18 or older
- patient is a candidate for, or has previously received ONE of the following:
 - Systemic therapy (e.g., methotrexate, cyclosporin, soriatane)
 - Phototherapy [narrow or broad band ultraviolet B (UVB), or psoralen plus ultraviolet A (PUVA)]

Note: Coverage may be approved for up to 12 weeks. Coverage may be approved for re-treatment **ONCE** as long as the total lymphocyte and CD4+ T cell counts are within normal range and a minimum of 12 weeks has passed since the last course of therapy. Data on re-treatment beyond two cycles are limited.

General Background

Alefacept is a biological agent labeled for the treatment of moderate-to-severe chronic plaque psoriasis for adult patients who are candidates for systemic therapy or phototherapy. Alefacept is fusion protein that prevents the activation of T lymphocytes involved in the pathogenesis of psoriasis.

Clinical efficacy of alefacept has been established in only two placebo-controlled trials. Alefacept demonstrated improvement in psoriasis-specific indices when compared to baseline values and patients taking placebo. Alefacept is effective when given either intravenously or intramuscularly. The first course of therapy with alefacept is attributed to the greatest clinical improvement and a second course is well-tolerated and increases efficacy. Clinical response is related to reductions in lymphocyte counts. Repeat courses of alefacept show equal to greater benefit and may increase duration of response; however, data concerning usage beyond two treatment cycles are limited. Rebounds in psoriasis after completion of therapy have not been reported with alefacept, indicating it acts as remittive therapy rather than an immunosuppressive.

Two controlled clinical studies included 1060 patients who had chronic (i.e., duration of one year or longer) plaque psoriasis with involvement of at least 10% of the body surface area and who were candidates for or had previously received systemic therapy or phototherapy. In these studies, 14 or 21% of patients receiving alefacept 7.5 mg intravenous (IV) or 15 mg intramuscular (IM) once weekly, respectively, achieved a response (i.e., reduction in Psoriasis Area and Severity Index [PASI] score of at least 75% compared with baseline) at two weeks following a 12-week course of therapy, compared with 4–5% of patients receiving placebo. An additional 7–11% of patients receiving alefacept achieved a response (i.e., reduction in PASI score of at least 75% compared with baseline) beyond two weeks post-treatment. Response rate at two weeks following a second 12-week course of IV or IM alefacept therapy was 26%, or 30%, respectively.

In both clinical studies, onset of response (reduction in PASI score of at least 50% compared with baseline) reportedly was observed 60 days after initiation of alefacept therapy. The median duration of response (maintenance of 75% or greater reduction in PASI score) after a 12-week course of therapy with alefacept 7.5 mg IV or 15 mg IM once weekly was 3.5 or two months, respectively. However, patients who achieved at least a 75% reduction in baseline PASI score during or after a single 12-week course of IV alefacept therapy maintained a 50% or greater reduction in PASI score for a median of seven months. The duration of response appeared to be longer after a second course of IV alefacept therapy; however, median duration of response was not determined, since the study was terminated after one year.

In clinical practice, the severity of a patient's psoriasis is evaluated by combining the objective assessment (e.g. body surface area (BSA) of involvement, disease location, thickness) and subjective assessment of the physical, financial, and emotional impact of the disease on the patient's life. This subjective assessment is combined with the physician's global assessment of psoriasis to determine psoriasis severity and appropriate therapy. The National Psoriasis Foundation Medical Board (Pariser, et al., 2007) recommends two-tiered system that categorizes patients based on treatment plans as candidates for localized therapy or for systemic therapy and/or phototherapy. Localized therapy, which includes topical treatments and excimer laser treatments, is recommended for patients with psoriasis that affects less than 5% BSA. Appropriate therapies include, but are not restricted to, topical corticosteroids, topical cholecalciferol analogs, combinations of these 2, topical retinoids, tar preparations, anthralin, keratolytics, and excimer (UV-B) laser treatments. In general, the effects of topical therapy should become evident within the first two to three weeks of use. Clearing of scale is usually observed first, followed by flattening of the treated plaques. Resolution of erythema may take six to eight weeks. Systemic therapy and/or phototherapy, which includes broad and narrowband phototherapy, photochemotherapy (PUVA), systemic agents, and biologics, is recommended for patients with psoriasis affecting greater than 5% BSA, for those with less than 5% BSA affected in vulnerable areas, such as the face, genitals, hands or feet, and for other forms of psoriasis, including but not limited to erythrodermic, pustular, and guttate. In addition, patients with limited affected areas and inadequate response to localized therapy or impairment in physical or mental functioning should also be considered candidates for systemic and/or phototherapy treatment.

The American Academy of Dermatology (AAD) published a consensus statement (Callen, et al., 2003) on psoriasis therapies. The document is intended to be used as a guide to the evaluation and treatments of psoriasis until evidence based guidelines are developed. Within this document, the authors state that BSA should not generally be used to determine which therapy to select; moderate and severe disease overlap and individuals with limited disease can be considered moderate for the purposes of selecting a therapy. Topical therapies are recommended for limited plaque disease. For moderate to severe disease,

the AAD recommends phototherapy, targeted phototherapy, narrowband UVB, photochemotherapy with psoralen and UVA light (PUVA), topicals and systemic treatments.

Alefacept should not be used concurrently with other immunosuppressive agents or in patients currently receiving phototherapy. The concomitant use of low-potency topical corticosteroids was permitted during clinical studies. According to the U.S. Food and Drug Administration (FDA), data on the safety and efficacy of alefacept treatment beyond two courses are limited.

Alefacept is well-tolerated with a side-effect profile comparable to placebo and preferable compared to conventional therapies used to treat moderate-to-severe psoriasis. The most common adverse reactions are chills, increased cough, nausea, dizziness, pruritus, injection site inflammation, injection site pain, myalgia, accidental injury, cough and pharyngitis. Serious adverse reactions, although infrequent, were lymphopenia, serious infections and malignancy.

The recommended dose of alefacept is 7.5 mg given once weekly as an IV bolus or 15 mg given once weekly as an IM injection. The recommended regimen is a course of 12 weekly injections. Re-treatment may be initiated if CD4+ T lymphocyte counts are within the normal range, and a 12-week treatment-free interval has passed. T lymphocyte counts should be monitored at baseline and weekly during the 12-week dosing regimen, and therapy should be adjusted for patients with low CD4+ T lymphocyte counts. According to the FDA, data on the safety and efficacy of alefacept treatment beyond two courses are limited.

Coding/Billing Information

Note: This list of codes may not be all-inclusive.

Covered when medically necessary:

CPT [®] * Codes	Description

HCPCS Codes	Description

ICD-9-CM Diagnosis Codes	Description

Experimental/Investigational/Unproven/Not Covered:

CPT* Codes	Description

HCPCS Codes	Description

ICD-9-CM Diagnosis Codes	Description

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