Rule Category:
Pharmaceutical

Ref: No:

2022-PH-17

Version Control:
Version No.1.0

Effective Date:
30-01-23

Revision Date:
30-01-24

Guselkumab

Adjudication Guideline

Table of content

Approved by:
Daman

Responsible:
Medical Standards & Research

Related Adjudication Guidelines: NA

Abstract

For Members & Medical Professionals:

Guselkumab(Tremfya) is an interluken-23(IL-23) blocker that is indicated for adults with the following conditions:

- Plaque Psoriasis
- Psoriatic Arthritis

Scope

This adjudication rule aims to highlight the medical necessity and coverage details of Guselkumab for all health insurance plans administered by Daman.

Adjudication Policy

Eligibility / Coverage Criteria

Guselkumab(Tremfya) is an interluken-23(IL-23) blocker that is indicated for adults with the following conditions:

1. **Plaque Psoriasis (Psoriasis Vulgaris**) is a chronic autoimmune disease that causes thick scaly patches called plaques on the skin. Plaques can appear anywhere on the body but most commonly appears on the elbows, knees, back, and scalp. Severe forms of Psoriasis vulgaris appears on the face, feet, genitals, and extremities

   Guselkumab is indicated for cases of Plaque Psoriasis if a patient (above the age of 18) meets one of the following criteria when prescribed by an eligible clinician:

Indication for plaque psoriasis
Moderate to severe form of Psoriasis
Inadequate response to topical therapy
Inadequate response to Systemic Therapy
Contraindications to topical therapy, systemic therapy, and phototherapy

2. **Psoriatic Arthritis**

   Psoriatic arthritis is a chronic inflammatory disease which is characterized by skin changes, Nail changes, peripheral arthritis, and axial disease involvement. Guselkumab is indicated for cases of Psoriatic Arthritis if a patient (above the age of 18) meets one of the following criteria when prescribed by an eligible clinician:

Indication Criteria for Guselkumab for Psoriatic Arthritis
Inadequate response to Systemic Therapy
Contraindications to topical therapy, systemic therapy, and phototherapy

Dosage:

1. **Plaque Psoriasis:**

Week	Dosage
Week 0	100mg Subcutaneous
Week 4	100mg Subcutaneous
Every 8 weeks	100mg Subcutaneous

2. **Psoriatic Arthritis:**

Week	Dosage
Week 0	100mg Subcutaneous
Week 4	100mg Subcutaneous
Every 8 weeks	100mg Subcutaneous

Eligible Clinician Criteria:

Eligible Clinician Speciality
Dermatology
Rheumatology
Internal Medicine/Rheumatology

Requirements for Coverage

1. The Questionnaire must be filled out and submit the required documents for preauthorization request.
2. Failure to submit, upon request or when requesting a clinical history, an indication and the need for testing will result in the rejection of the claim.

Non-Coverage

1. Guselkumab is not covered when the above criteria (Coverage and Billing and CLN) are not met.
2. Coverage as per plan:

Plan	Coverage
Visitors Plan	Not covered
Basic	Covered
Enhanced	Covered
Thiqa	Covered

Payment and Coding Rules

Please apply DOH payment rules and regulations and relevant coding manuals for ICD, CPT, etc.

Denial codes: DOH denial codes with description are elaborated for reference.
These are specialized codes directed by DOH, that explains the reason of rejection of the service by DAMAN to the providers.

Denial Code	Code description
MNEC 004	Service is not clinically indicated based on good clinical practice
MNEC 003	Diagnoses are not covered
CODE-010	Activity/diagnosis inconsistent with clinician's specialty

Questionnaire:
https://www.damanhealth.ae/main/pdf/support/coverage-medical/Questionnaire/GuselkumabPre-authform.pdf

Appendices

Additional Information

JAWADA clinical quality KPI: not applicable

Questionnaire to be filled

Guselkumab Preauthorization Form
Section 1: Member Information: • Patient Name: _____ • Patient Card Number: _____
Section 2: Kindly fill in the diagnosis field: ☐ Plaque Psoriasis ☐ Psoriatic Arthritis Others: _____ Is this a re-authorization request? ☐ Yes ☐ No If yes, kindly provide prior requests completed and documentation regarding previous therapy. If no, kindly complete the below clinical assessment:(If "Yes" has been selected, refer to section 3) 1. Has the patient had an inadequate response to systemic therapy? ☐ Yes ☐ No 2. Has the patient had an inadequate response to topical therapy? ☐ Yes ☐ No 3. Does the patient have any contraindications to topical or systemic therapy? ☐ Yes ☐ No 4. Has the patient undergone Tuberculosis screening? (If yes, kindly provide the laboratory test result) ☐ Yes ☐ No
Section 3: • Previous drug therapy:(Specify name and dosage) _____ • Duration of previous therapy: _____ • Kindly specify the contraindicated drug (if applicable) _____ _____
Section 4: 1. Ordering clinician: _____ 2. Ordering Speciality: _____
Section 5: Additional Comments: _____ _____ _____ _____

Appendices

A. References

B. https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/761061s000lbl.pdf
C. https://www.medicines.org.uk/emc/product/9587/smpc#gref

D. Revision History

Date	Change(s)
27/12/22	Release of V1.0