Zoryve™ (roflumilast cream)

Policy # 00827
Original Effective Date: 02/13/2023
Current Effective Date: 02/12/2024

Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc.(collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Company may consider Zoryve™‡ (roflumilast cream) to be **eligible for coverage**** when the patient selection criteria are met.

Patient Selection Criteria

Coverage eligibility for Zoryve (roflumilast cream) will be considered when the following patient selection criteria are met:

- Patient has a diagnosis of plaque psoriasis; AND
- Patient is 12 years of age or older; AND
- Patient's psoriasis affects less than or equal to 20% of the body surface area; AND
  *(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met.)*
- Zoryve will not be used in combination with Otezla®‡ (apremilast); AND
- Patient has tried at least TWO medium-, medium-high-, high-, or super-high potency prescription topical corticosteroids for at least 4 consecutive weeks EACH unless there is clinical evidence or patient history that suggests the use of topical corticosteroids will be ineffective or cause an adverse reaction to the patient OR patient's psoriasis affects the face, eyes/eyelids, skin folds, and/or genitalia making topical corticosteroid use impractical. Note that examples of medium-, medium-high-, high-, or super-high potency prescription topical corticosteroids include betamethasone valerate, desoximetasone, fluocinolone acetonide, fluticasone propionate, mometasone furoate, triamcinolone acetonide 0.1%, trianex, triderm, amcinonide, augmented betamethasone dipropionate cream, apexicon E, betamethasone dipropionate, betamethasone valerate, desoximetasone, diflorasone diacetate, fluocinonide,

fluocinonide E, triamcinolone acetonide 0.5%, augmented betamethasone dipropionate ointment, clobetasol emollient, clobetasol propionate, clodan, cormax, diflorasone diacetate, and halobetasol propionate; AND
*(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met.)*

- Patient has tried and failed at least TWO topical vitamin D analogs for at least 4 consecutive weeks EACH unless there is clinical evidence or patient history that suggests the use of at least 2 vitamin D analogs will be ineffective or cause an adverse reaction to the patient. Note that examples of topical vitamin D analogs include calcipotriene 0.005% foam, cream, or ointment; calcitriol 3 mcg/g ointment; Enstilar; calcipotriene 0.005%; and betamethasone dipropionate 0.064% ointment or suspension.
  *(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met.)*

When Services Are Considered Not Medically Necessary

Based on review of available data, the Company considers the use of Zoryve (roflumilast) when the patient's psoriasis affects greater than 20% of the body surface area or the patient has not tried at least TWO topical corticosteroids and TWO topical vitamin D analogs to be **not medically necessary.****

When Services Are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Based on review of available data, the Company considers the use of Zoryve (roflumilast) when the patient selection criteria have not been met (except those noted above as **not medically necessary****) to be **investigational.***

Background/Overview

Zoryve is a topical phosphodiesterase 4 (PDE4) inhibitor indicated for the treatment of plaque psoriasis, including intertriginous areas. It is thought to work by decreasing the production of immune modulators contributing to the condition. It should be applied to the affected areas once

daily. Zoryve is the only topical therapy specifically FDA-approved for the treatment of intertriginous psoriasis. However, other topical products can be used to treat psoriasis in these areas and the efficacy of Zoryve in the treatment of intertriginous psoriasis has not been extensively studied.

There are various other treatment options for plaque psoriasis including first line agents such as topical corticosteroids and topical vitamin D analogs. Many of these agents are available in generic form which are often a more economical option for the treatment of plaque psoriasis compared to the available branded products. Additionally, there are no head to head studies comparing Zoryve to any of the other products in this treatment category to suggest superiority.

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)

Zoryve was approved in July 2022 for the topical treatment of plaque psoriasis, including intertriginous areas, in patients 12 years of age and older.

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to federal regulations, other plan medical policies, and accredited national guidelines.

The efficacy of Zoryve was established in two multicenter, randomized, double-blind, vehicle-controlled trials (DERMIS-1 and DERMIS-2). Both trials enrolled a total of 881 subjects with mild to severe plaque psoriasis and an affected BSA of 2% to 20%. The study population ranged in age from 6 to 88 years with 4 subjects younger than 12 years of age at baseline. At baseline, 16% of subjects had an Investigator's Global Assessment (IGA) score of 2 (mild), 76% had an IGA score of 3 (moderate), and 8% had an IGA score of 4 (severe). One hundred seventy nine (20%) patients had an intertriginous IGA (I-IGA) score of 2 or higher, and 678 (77%) had a baseline Worst Itch-Numeric Rating Score (WI-NRS) score of 4 or higher on a scale of 0 to 10. Subjects were randomized 2:1 To receive Zoryve or vehicle applied once daily for 8 weeks. The primary endpoint was the proportion of subjects who achieved IGA treatment success at Week 8. Success was defined as a

score of "Clear" (0) or "Almost clear" (1), plus a 2-grade improvement from baseline. In DERMIS-1, 41.5% of patients achieved IGA success in the Zoryve group compared to 5.8% in the vehicle group. In DERMIS-2, 36.7% of patients achieved IGA success compared to 7.1% in the vehicle group.

References

1. Zoryve [package insert]. Arcutis Biotherapeutics, Inc. Westlake Village, CA. Updated August 2022.
2. Zoryve Drug Evaluation. Express Scripts. Updated August 2022.

Policy History

Original Effective Date: 02/13/2023
Current Effective Date: 02/12/2024
01/05/2023 Medical Policy Committee review
01/11/2023 Medical Policy Implementation Committee approval. New policy.
01/04/2024 Medical Policy Committee review
01/10/2024 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
Next Scheduled Review Date: 01/2025

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:

Zoryve™ (roflumilast cream)

Policy # 00827
Original Effective Date: 02/13/2023
Current Effective Date: 02/12/2024

1. Consultation with technology evaluation center(s);
2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
3. Reference to federal regulations.

**Medically Necessary (or "Medical Necessity") - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

A. In accordance with nationally accepted standards of medical practice;
B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "nationally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

‡ Indicated trademarks are the registered trademarks of their respective owners.

NOTICE: If the Patient's health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

Zoryve™ (roflumilast cream)

Policy # 00827
Original Effective Date: 02/13/2023
Current Effective Date: 02/12/2024

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.