Reference number(s)
2018-A

Specialty Guideline Management
Rasuvo

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

Brand Name	Generic Name
Rasuvo	methotrexate

Indications

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-approved Indications[1]

Rheumatoid Arthritis (RA) including Polyarticular Juvenile Idiopathic Arthritis (pJIA)

Rasuvo is indicated in the management of selected adults with severe, active rheumatoid arthritis (RA) or children with active polyarticular juvenile idiopathic arthritis (pJIA), who have had an insufficient therapeutic response to, or are intolerant of, an adequate trial of first-line therapy including full dose non-steroidal anti-inflammatory agents (NSAIDs).

Psoriasis

Rasuvo is indicated in adults for the symptomatic control of severe, recalcitrant, disabling psoriasis that is not adequately responsive to other forms of therapy, but only when the diagnosis has been established, as by biopsy and/or after dermatologic consultation. It is important to ensure that a psoriasis “flare” is not due to an undiagnosed concomitant disease affecting immune responses.

Limitations of use

Rasuvo is not indicated for the treatment of neoplastic diseases.

Compendial Use

Microscopic polyangiitis[6]

All other indications are considered experimental/investigational and not medically necessary.

Documentation

Submission of the following information is necessary to initiate the prior authorization review:

- Chart notes, medical record documentation, or claims history supporting previous use of generic oral methotrexate and inadequate response or intolerance to therapy.
- Chart notes or medical record documentation of member's inability to prepare and administer generic injectable methotrexate.

Coverage Criteria[2-6]

Authorization of 12 months may be granted for treatment of rheumatoid arthritis (RA), polyarticular juvenile idiopathic arthritis (pJIA), psoriasis, or microscopic polyangiitis when BOTH of the following criteria are met:

- Member has had an inadequate response or intolerance to generic oral methotrexate.
- Member has an inability to prepare and administer generic injectable methotrexate.

Continuation of Therapy

Authorization of 12 months may be granted for all members (including new members) who meet ALL requirements in the coverage criteria section and achieve or maintain a positive clinical response after at least 3 months of therapy with Rasuvo as evidenced by low disease activity or improvement in signs and symptoms of the condition.

References

1. Rasuvo [package insert]. Chicago, IL: Medexus Pharma Inc.; March 2020.
2. Fraenkel L, Bathon JM, England BR, et al. 2021 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. Arthritis Care Res (Hoboken). 2021;73(7):924-939.

3. Smolen JS, Landewé R, Billsma J, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2019 update. Ann Rheum Dis. 2020;79:685-699.
4. Ringold S, Angeles-Han S, Beukelman T, et al. 2019 American College of Rheumatology recommendations for the treatment of juvenile idiopathic arthritis: Therapeutic approaches for non-systemic polyarthritis, sacroilitis, and enthesitis. Arthritis Care Res. 2019;71(6):717-734.
5. Menter A, Gelfand JM, Connor C, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management of psoriasis with systemic nonbiologic therapies. J Am Acad Dermatol. 2020;82(6):1445-1486.
6. IBM Micromedex® DRUGDEX® (electronic version). IBM Watson Health, Greenwood Village, Colorado, USA. Available at: https://www.micromedexsolutions.com/ (cited: 11/12/2024).