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Abatacept

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Disclaimer

Medical policies are a set of written guidelines that support current standards of practice. They are based on current generally accepted standards of care developed by: nonprofit professional association(s) for the relevant clinical specialty, third-party entities that develop treatment criteria, or other federal or state governmental agencies. A requested therapy must be proven effective for the relevant diagnosis or procedure. For drug therapy, the proposed dose, frequency and duration of therapy must be consistent with recommendations in at least one authoritative source. This medical policy is supported by FDA-approved labeling and/or nationally recognized authoritative references to major drug compendia, peer reviewed scientific literature and generally accepted standards of medical care. These references include, but are not limited to: MCG care guidelines, DrugDex (IIa level of evidence or higher), NCCN Guidelines (IIb level of evidence or higher), NCCN Compendia (IIb level of evidence or higher), professional society guidelines, and CMS coverage policy.

Carefully check state regulations and/or the member contract.

Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there are any exclusions or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

Legislative Mandates

EXCEPTION: For members residing in the state of Ohio, § 3923.60 requires any group or individual policy (Small, Mid-Market, Large Groups, Municipalities/Counties/Schools, State Employees, Fully-Insured, PPO, HMO, POS, EPO) that covers prescription drugs to provide for the coverage of any drug approved by the U. S. Food and Drug Administration (FDA) when it is prescribed for a use recognized as safe and effective for the treatment of a given indication in one or more of the standard medical reference compendia adopted by the United States Department of Health and Human Services or in medical literature even if the FDA has not approved the drug for that indication. Medical literature support is only satisfied when safety and efficacy has been confirmed in two articles from major peer-reviewed professional medical journals that present data supporting the proposed off-label use or uses as generally safe and effective. Examples of accepted journals include, but are not limited to, Journal of

American Medical Association (JAMA), New England Journal of Medicine (NEJM), and Lancet. Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. Evidence limited to case studies or case series is not sufficient to meet the standard of this criterion. Coverage is never required where the FDA has recognized a use to be contraindicated, and coverage is not required for non-formulary drugs.

Coverage

NOTE 1: This medical policy does NOT address oncologic indications. This medical policy IS NOT TO BE USED for oncologic indications. Refer to RX502.061 Oncology Medications for oncologic indications.

NOTE 2: Abatacept (Orencia®) may be self-administered. Refer to the applicable pharmacy benefit plan when self-administered.

Abatacept (Orencia®) **may be considered medically necessary** when administered intravenously (IV) for the following indications:

- Moderately to severely active rheumatoid arthritis (RA) in adults if there is a previous inadequate response to:
 1. One or more nonbiologic disease-modifying antirheumatic drug(s) (DMARDs), OR
 2. A biologic DMARD;
- Active psoriatic arthritis (PsA) in adults if there is a previous inadequate response to:
 1. One or more nonbiologic disease-modifying antirheumatic drug(s) (DMARDs), OR
 2. A biologic DMARD;
- Moderately to severely active polyarticular juvenile idiopathic arthritis in individuals 6 years of age or older if there is a previous inadequate response to:
 1. One or more nonbiological disease-modifying antirheumatic drug(s) (DMARDs), OR
 2. A biologic DMARD;
- Prophylaxis of acute graft versus host disease (aGVHD), in combination with a calcineurin inhibitor and methotrexate, in adults and pediatric individuals 2 years of age and older undergoing hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated donor.

NOTE 3: Orencia may not be used concomitantly with Janus kinase (JAK) inhibitors or biologic DMARDs (e.g., tumor necrosis factor [TNF] antagonists).

Abatacept (Orencia®) **is considered experimental, investigational and/or unproven** for all other non-Food and Drug Administration approved indications.

Policy Guidelines

None.

Description

Abatacept (Orencia®), a selective costimulation modulator, inhibits T-cell activation by binding to CD80 and CD86, thereby blocking interaction with CD28. This interaction provides a co-stimulatory signal necessary for full activation of T lymphocytes. Activated T lymphocytes are implicated in the pathogenesis of rheumatoid arthritis (RA) and psoriatic arthritis (PsA) and are found in the synovium of patients with RA and PsA. (1)

Rheumatoid Arthritis

Rheumatoid arthritis (RA) is an autoimmune and inflammatory disease in which the immune system attacks healthy cells by mistake, causing inflammation or painful swelling in affected parts of the body. RA mainly attacks the joints in the hands, wrists and knees. The damage from RA can result in long-lasting (chronic) pain, swelling, balance issues and deformed joints. RA can also affect other tissues in the body and cause problems in organs such as the lungs, heart and eyes. (2)

Psoriatic Arthritis

Psoriatic arthritis (PsA) is a condition involving joint inflammation (arthritis) that usually occurs in conjunction with psoriasis, a skin disorder characterized by patches of red, irritated skin that are often covered by flaky white scales. Psoriasis may cause changes to fingernails and toenails, causing pitting, ridges, crumbling of the nail or separation of the nail from the nail bed. PsA causes stiff, painful joints with redness, heat and swelling in the surrounding tissues. Swelling and redness may result in a sausage-like appearance of the fingers or toes when the hands or feet are affected. Psoriasis appears before joint problems develop in most people. It typically begins during adolescence or as a young adult, with PsA occurring between the ages of 30 and 50. Both conditions may occur at any age; and in a small number of cases, PsA develops without any noticeable skin changes. (3)

Polyarticular Juvenile Idiopathic Arthritis

Polyarticular juvenile idiopathic arthritis (formerly called polyarticular-onset juvenile rheumatoid arthritis [JRA]) is a subset of juvenile idiopathic arthritis (JIA) that is defined by the presence of more than four affected joints during the first six months of illness. This disease, which comprises 20 to 30 percent of patients with JIA, is included in the group termed "childhood polyarthritis." Polyarticular JIA is more frequent in females than males. There is a bimodal distribution of the age at onset. The first peak is between the ages of two and five years, and the second is between 10 and 14 years. This age distribution suggests that two or more distinct diseases may be included in this classification. In children less than 10 years of age, polyarticular JIA often begins similarly to oligoarticular disease, with one or two joints affected. The development of the disease is often indolent until an intercurrent infection precipitates a dramatic increase in symptoms. The disease then becomes relentlessly progressive, spreading to involve five or more joints within the first six months after disease onset. Joint involvement is symmetric, with the knees, wrists, and ankles most frequently affected. There are typically periods of apparent response to therapy followed by relapses with

an increasing number of involved joints. Polyarticular JIA may go unrecognized at first because of its initial indolent course. This failure to recognize the initial symptoms may make it appear that the disease had a sudden onset and rapid progression. In older children and adolescents, these patients usually have a relatively rapid onset of inflammation in multiple joints, including involvement of the many small joints of the hands and feet, within two to three months of disease onset. Pain in the small joints is a common manifestation of polyarticular JIA and initially may be out of proportion to the degree of inflammation and stiffness. The joints of the fingers, wrists, elbows, hips, knees, and ankles are most commonly affected. (4)

Graft Versus Host Disease (GVHD)

Graft versus host disease is a common complication of allogeneic hematopoietic cell transplantation (HCT). (5) GVHD occurs when immune cells transplanted from a non-identical donor (the graft) recognize the transplant recipient (the host) as foreign, thereby initiating an immune reaction that causes disease in the transplant recipient. This usually occurs in the early post-transplantation period. The skin, gastrointestinal tract, and liver are the principal target organs in patients with acute GVHD. Clinical manifestations of acute GVHD include a classic maculopapular rash; persistent nausea and/or emesis; abdominal cramps with diarrhea; and a rising serum bilirubin concentration. In contrast, patients with chronic GVHD commonly demonstrate skin involvement resembling lichen planus or the cutaneous manifestations of scleroderma; dry oral mucosa with ulcerations and sclerosis of the gastrointestinal tract; and a rising serum bilirubin concentration.

The severity of acute GVHD is determined by an assessment of the degree of involvement of the skin, liver, and gastrointestinal tract. Models for grading severity of acute GVHD combine individual organ involvement to produce an overall disease grade, which can be summarized as follows:

Grade I (A)-Mild

Grade II (B)-Moderate

Grade III (C)-Severe

Grade IV (D)-Life-threatening

Increasing incidence of GVHD has been observed in recent years, primarily due to the increased use of unrelated and/or human leukocyte antigen (HLA)-mismatched donors and granulocyte-colony stimulating factor (G-CSF)–mobilized peripheral blood progenitor cells (PBPCs), among other factors. (6) Mild manifestations limited to a single organ are often managed with close observation, with topical treatment, or by slowing the tapering of immunosuppressive agents. More severe manifestations or multi-organ involvement typically require systemic corticosteroid treatment (with or without secondary systemic agents). Management of GVHD can be optimized by providing coordinated care from a multidisciplinary team, preferably in medical centers with access to specialized transplant services.

Regulatory Status

- Orencia® (abatacept) was approved by the U.S. Food and Drug Administration (FDA) in 2005 for intravenous use in the treatment of RA.

- In 2011, the FDA approved a subcutaneous formulation of Orencia for adults with moderate to severe rheumatoid arthritis; and in 2017, it was approved for treatment of active PsA in adults.
- In December 2021, the FDA approved Orencia for the prophylaxis of acute graft versus host disease (aGVHD), in combination with a calcineurin inhibitor and methotrexate, in adults and pediatric patients 2 years of age and older undergoing hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated donor. (7)
- In October 2023, the FDA approved an expansion of Orencia subcutaneous use to include treatment of patients aged 2 years and older with active psoriatic arthritis (PsA). (1)

Rationale

This policy is based on the U.S. Food and Drug Administration (FDA) labeled indications for abatacept (Orencia®).

ORENCIA®

Adult Rheumatoid Arthritis (RA) (1)

Description of Clinical Studies of Intravenous ORENCIA for the Treatment of Patients with RA

The efficacy and safety of Orencia® (abatacept) for intravenous administration were assessed in six randomized, double-blind, controlled studies (five placebo-controlled and one active controlled) in patients ≥18 years of age with active RA diagnosed according to American College of Rheumatology (ACR) criteria. Studies I, II, III, IV, and VI required patients to have at least 12 tender and 10 swollen joints at randomization. Study V did not require any specific number of tender or swollen joints. Orencia or placebo treatment was given intravenously at weeks 0, 2, and 4 and then every 4 weeks thereafter in intravenous Studies I, II, III, IV, and VI.

- Study I (NCT00279760) evaluated Orencia as monotherapy in 122 patients with active RA who had failed at least one non-biologic disease modifying antirheumatic drug (DMARD) or etanercept.
- In Study II (NCT00162266) and Study III (NCT00048568), the efficacy of Orencia were assessed in patients with an inadequate response to methotrexate (MTX) and who were continued on their stable dose of MTX.
- In Study IV (NCT00048581), the efficacy of Orencia was assessed in patients with an inadequate response to a tumor necrosis factor (TNF) antagonist, with the TNF antagonist discontinued prior to randomization; other DMARDs were permitted.
- Study V (NCT00048932) primarily assessed safety in patients with active RA requiring additional intervention in spite of current therapy with DMARDs; all DMARDs used at enrollment were continued. Patients in Study V were not excluded for comorbid medical conditions.
- In Study VI (NCT00122382), the efficacy and safety of Orencia were assessed in MTX-naïve patients with RA of less than 2 years disease duration. In Study VI, patients previously naïve to MTX were randomized to receive Orencia plus MTX or MTX plus placebo.

Study I patients were randomized to receive one of three doses of Orencia (0.5, 2, or 10 mg/kg) or placebo ending at week 8. Study II patients were randomized to receive Orencia 2 or 10 mg/kg or placebo for 12 months. Study III, IV, V, and VI patients were randomized to receive a dose of Orencia based on weight range or placebo for 12 months (Studies III, V, and VI) or 6 months (Study IV). The dose of Orencia was 500 mg for patients weighing less than 60 kg, 750 mg for patients weighing 60 to 100 kg, and 1,000 mg for patients weighing greater than 100 kg.

Description of Clinical Studies of Subcutaneous or Intravenous Orenci for the Treatment of Patients with Adult RA

The efficacy of Orenci for subcutaneous administration were assessed in Study SC-1 (NCT00559585), which was a randomized, double-blind, double-dummy, non-inferiority study that compared Orenci administered subcutaneously to Orenci administered intravenously in 1457 patients with moderate to severely active RA, receiving background methotrexate (MTX), and experiencing an inadequate response to methotrexate (MTX-IR). In Study SC-1, patients were randomized with stratification by body weight (<60 kg, 60 to 100 kg, >100 kg) to receive Orencia 125 mg subcutaneous injections weekly, after a single intravenous loading dose of Orencia based on body weight or Orencia intravenously on Days 1, 15, 29, and every four weeks thereafter. Subjects continued taking their current dose of MTX from the day of randomization.

Clinical Response in Adult RA Patients

The percent of Orencia-treated patients achieving ACR 20, 50, and 70 responses and major clinical response in Studies I, III, IV, and VI are shown in Table 1. Orencia-treated patients had higher ACR 20, 50, and 70 response rates at 6 months compared to placebo-treated patients. Month 6 ACR response rates in Study II for the 10 mg/kg group were similar to the Orencia group in Study III.

In Studies III and IV, improvement in the ACR 20 response rate versus placebo was observed within 15 days in some patients and within 29 days versus MTX in Study VI. In Studies II, III, and VI, ACR response rates were maintained to 12 months in Orencia-treated patients. ACR responses were maintained up to three years in the open-label extension of Study II. In Study III, Orencia-treated patients experienced greater improvement than placebo-treated patients in morning stiffness.

In Study VI, a greater proportion of patients treated with Orencia plus MTX achieved a low level of disease activity as measured by a disease activity score 28 with C-reactive protein (DAS28-CRP) less than 2.6 at 12 months compared to those treated with MTX plus placebo (Table 1). Of patients treated with Orencia plus MTX who achieved DAS28-CRP less than 2.6, 54% had no active joints, 17% had one active joint, 7% had two active joints, and 22% had three or more active joints, where an active joint was a joint that was rated as tender or swollen or both.

In Study SC-1, the main outcome measure was ACR 20 at 6 months. The pre-specified non-inferiority margin was a treatment difference of -7.5%. As shown in Table 2, the study demonstrated non-inferiority of Orencia administered subcutaneously to intravenous infusions

of Orencia with respect to ACR 20 responses up to 6 months of treatment. ACR 50 and 70 responses are also shown in Table 1. No major differences in ACR responses were observed between intravenous and subcutaneous treatment groups in subgroups based on weight categories (less than 60 kg, 60 to 100 kg, and more than 100 kg; data not shown).

Table 1. Clinical Responses in Controlled Trials in Patients with Rheumatoid Arthritis (RA)

	Percent of Patients									
	Intravenous Administration								Subcutaneous or Intravenous Administration	
	Inadequate Response to DMARDs		Inadequate Response to MTX		Inadequate Response to TNF Antagonists		MTX-Naïve		Inadequate Response to MTX	
	Study I		Study III		Study IV		Study VI		Study SC-1	
Response Rate	ORN ^a n = 32	PBO ^b n = 32	ORN ^b + MTX n = 424	PBO + MTX n = 214	ORN ^b + DMARDs n = 256	PBO + DMARDs n = 133	ORN ^b + MTX n = 256	PBO + MTX n = 253	ORN ^e SC + MTX n = 693	ORN ^e IV + MTX n = 678
ACR 20										
Month 3	53%	31%	62% ^h	37%	46% ^h	18%	64% ^f	53%	68%	69%
Month 6	NA	NA	68% ^h	40%	50% ^h	20%	75% ^g	62%	76% ⁱ	76%
Month 12	NA	NA	73% ^h	40%	NA	NA	76% ^h	62%	NA	NA
ACR 50										
Month 3	16%	6%	32% ^h	8%	18% ^g	6%	40% ^h	23%	33%	39%
Month 6	NA	NA	40% ^h	17%	20% ^h	4%	53% ^h	38%	52%	50%
Month 12	NA	NA	48% ^h	18%	NA	NA	57% ^h	42%	NA	NA
ACR 70										
Month 3	6%	0	13% ^h	3%	6% ^f	1%	19% ^g	10%	13%	16%
Month 6	NA	NA	20% ^h	7%	10% ^g	2%	32% ^g	20%	26%	25%
Month 12	NA	NA	29% ^h	6%	NA	NA	43% ^h	27%	NA	NA
Major Clinical Response^c	NA	NA	14% ^h	2%	NA	NA	27% ^h	12%	NA	NA
DAS28-CRP <2.6^d										
Month 12	NA	NA	NA	NA	NA	NA	41% ^h	23%	NA	NA

ORN: Orencia; PBO: placebo; TNF: tumor necrosis factor; DMARDs: disease modifying antirheumatic drugs; SC: subcutaneous; IV: intravenous; MTX: methotrexate; ACR: American College of Rheumatology; NA: not applicable; DAS28-CRP: disease activity score 28 with C-reactive protein.

^a 10 mg/kg.

^b Dosing based on weight range.

^c Major clinical response is defined as achieving an ACR 70 response for a continuous 6-month period.

^d Refer to text for additional description of remaining joint activity.

^e Per protocol data is presented in table. For ITT; n=736, 721 for SC and IV ORENCIA, respectively.

^f p<0.05, ORENCIA (ORN) vs placebo (PBO) or MTX.

^g p<0.01, ORENCIA vs placebo or MTX.

^h p<0.001, ORENCIA vs placebo or MTX.

ⁱ 95% CI: -4.2, 4.8 (based on prespecified margin for non-inferiority of -7.5%).

The results of the components of the ACR response criteria for Studies III, IV, and SC-1 are shown in Table 2 (results at Baseline [BL] and 6 months [6 M]). In Orencia-treated patients, greater improvement was seen in all ACR response criteria components through 6 and 12 months than in placebo-treated patients.

Table 2. Components of ACR Responses at 6 Months in Adult Patients with RA

	Intravenous Administration								Subcutaneous (SC) or Intravenous (IV) Administration			
	Inadequate Response to Methotrexate (MTX)				Inadequate Response to TNF Antagonists				Inadequate Response to MTX			
	Study III				Study IV				Study SC-1 ^c			
	ORN + MTX n = 424		PBO + MTX n = 214		ORN + DMARDs n = 256		PBO + DMARDs n = 133		ORN SC + MTX n = 693		ORN IV + MTX n = 678	
Component (median)	BL	6 M	BL	6 M	BL	6 M	BL	6 M	BL	6 M	BL	6 M
Number of tender joints (0-68)	28	7 ^e	31	14	30	13 ^e	31	24	27	5	27	6
Number of swollen joints (0-66)	19	5 ^e	20	11	21	10 ^e	20	14	18	4	18	3
Pain ^a	67	27 ^e	70	50	73	43 ^d	74	64	71	25	70	28
Patient global assessment ^a	66	29 ^e	64	48	71	44 ^e	73	63	70	26	68	27
Disability index ^b	1.75	1.13 ^e	1.75	1.38	1.88	1.38 ^e	2.00	1.75	1.88	1.00	1.75	1.00
Physician global assessment ^a	69	21 ^e	68	40	71	32 ^e	69	54	65	16	65	15
CRP (mg/dL)	2.2	0.9 ^e	2.1	1.8	3.4	1.3 ^e	2.8	2.3	1.6	0.7	1.8	0.7

ACR: American College of Rheumatology, BL: Baseline, DMARDs: disease-modifying antirheumatic drugs, M: months, MTX: methotrexate; ORN: ORENCIA, PBO: placebo; TNF: tumor necrosis factor; CRP: C-reactive protein.

^a Visual analog scale: 0 = best, 100 = worst.

^b Health Assessment Questionnaire: 0 = best, 3 = worst; 20 questions; 8 categories: dressing and grooming, arising, eating, walking, hygiene, reach, grip, and activities.

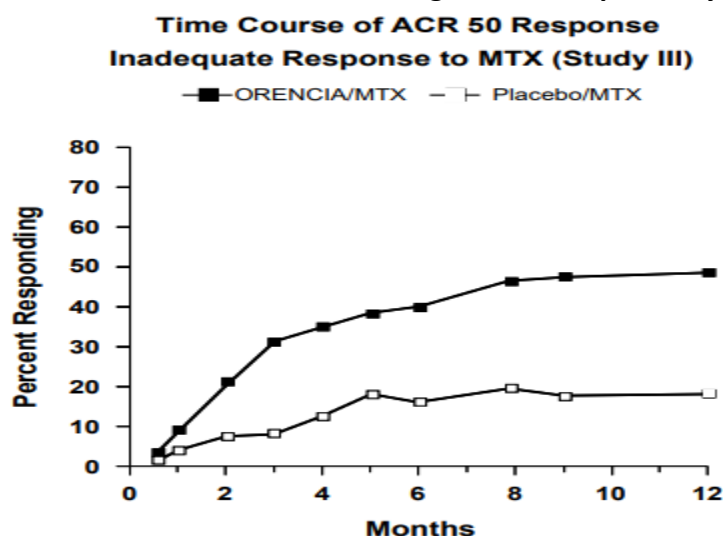
^c SC-1 is a non-inferiority study. Per protocol data is presented in table.

^d $p < 0.01$, ORENCIA (ORN) vs placebo (PBO), based on mean percent change from baseline.

^e $p < 0.001$, ORENCIA vs placebo, based on mean percent change from baseline.

The percent of patients achieving the ACR 50 response for Study III by visit is shown in Figure 1. The time course for the Orencia group in Study VI was similar to that in Study III.

Figure 1: Percent of Patients Achieving ACR 50 Response by Visit* (Study III)



*The same patients may not have responded at each time point.

ACR: American College of Rheumatology; MTX: methotrexate.

The percent of patients achieving the ACR 50 response for Study SC-1 in the Orencia subcutaneous (SC) and intravenous (IV) treatment arms at each treatment visit was as follows: Day 15—SC 3%, IV 5%; Day 29—SC 11%, IV 14%; Day 57—SC 24%, IV 30%; Day 85—SC 33%, IV 38%; Day 113—SC 39%, IV 41%; Day 141—SC 46%, IV 47%; Day 169—SC 51%, IV 50%.

Radiographic Response in Adult RA Patients

In Study III and Study VI, structural joint damage was assessed radiographically and expressed as change from baseline in the Genant-modified Total Sharp Score (TSS) and its components, the Erosion Score (ES) and Joint Space Narrowing (JSN) score. Orencia/MTX slowed the progression of structural damage compared to placebo/MTX after 12 months of treatment as shown in Table 3.

Table 3. Mean Radiographic Changes in Study III^a and Study VI^b

Parameter	Orencia/MTX	Placebo/MTX	Differences	P-value ^d
Study III				
First Year				
TSS	1.07	2.43	1.36	<0.01

ES	0.61	1.47	0.86	<0.01
JSN score	0.46	0.97	0.51	<0.01
Study III				
Second Year				
TSS	0.48	0.74 ^c	-	-
ES	0.23	0.22 ^c	-	-
JSN score	0.25	0.51 ^c	-	-
Study VI				
First Year				
TSS	0.6	1.1	0.5	0.04

MTX: methotrexate; TSS: total sharp score; ES: erosion score; JSN: joint space narrowing score.

^a Patients with an inadequate response to MTX.

^b MTX-naïve patients.

^c Patients received 1 year of placebo/MTX followed by 1 year of Orenzia/MTX.

^d Based on a nonparametric ANCOVA model.

In the open-label extension of Study III, 75% of patients initially randomized to Orenzia/MTX and 65% of patients initially randomized to placebo/MTX were evaluated radiographically at Year 2. As shown in Table 3, progression of structural damage in Orenzia/MTX-treated patients was further reduced in the second year of treatment.

Following 2 years of treatment with Orenzia/MTX, 51% of patients had no progression of structural damage as defined by a change in the TSS of zero or less compared with baseline. Fifty-six percent (56%) of Orenzia/MTX-treated patients had no progression during the first year compared to 45% of placebo/MTX-treated patients. In their second year of treatment with Orenzia/MTX, more patients had no progression than in the first year (65% vs 56%).

Physical Function Response and Health-Related Outcomes in Adult RA Patients

Improvement in physical function was measured by the Health Assessment Questionnaire Disability Index (HAQ-DI). In the HAQ-DI, Orenzia demonstrated greater improvement from baseline versus placebo in Studies II-V and versus MTX in Study VI. In Study SC-1, improvement from baseline as measured by HAQ-DI at 6 months and over time was similar between subcutaneous and intravenous Orenzia administration. The results from Studies II and III are shown in Table 4. Similar results were observed in Study V compared to placebo and in Study VI compared to MTX. During the open-label period of Study II, the improvement in physical function has been maintained for up to 3 years.

Table 4. Mean Improvement from Baseline in Health Assessment Questionnaire Disability Index (HAQ-DI) in Adult Patients with RA

	Inadequate Response to Methotrexate (MTX)			
	Study II		Study III	
HAQ Disability Index	Orenzia ^a + MTX (n = 115)	Placebo + MTX (n = 119)	Orenzia ^b + MTX (n = 422)	Placebo + MTX (n = 212)
Baseline (Mean)	0.98 ^c	0.97 ^c	1.69 ^d	1.69 ^d

Mean Improvement Year 1	0.40 ^{c,***}	0.15 ^c	0.66 ^{d,***}	0.37 ^d
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*** p<0.001, Orencia vs placebo.

^a 10 mg/kg.

^b Dosing based on weight range.

^c Modified Health Assessment Questionnaire: 0 = best, 3 = worst; 8 questions; 8 categories: dressing and grooming, arising, eating, walking, hygiene, reach, grip, and activities.

^d Health Assessment Questionnaire: 0 = best, 3 = worst; 20 questions; 8 categories: dressing and grooming, arising, eating, walking, hygiene, reach, grip, and activities.

Health-related quality of life was assessed by the SF-36 questionnaire at 6 months in Studies II, III, and IV and at 12 months in Studies II and III. In these studies, improvement was observed in the Orencia group as compared with the placebo group in all 8 domains of the SF-36 as well as the Physical Component Summary (PCS) and the Mental Component Summary (MCS).

Psoriatic Arthritis (PsA) (1)

The efficacy of Orencia was assessed in 594 patients with psoriatic arthritis (PsA), in two randomized, double-blind, placebo-controlled studies (Studies PsA-I [NCT00534313] and PsA-II [NCT01860976]) in adult patients, age 18 years and older. Patients had active PsA (≥3 swollen joints and ≥3 tender joints) despite prior treatment with DMARD therapy and had one qualifying psoriatic skin lesion of at least 2 cm in diameter. In PsA-I and PsA-II, 37% and 61% of patients, respectively, were treated with tumor necrosis factor antagonists previously.

During the initial 24-week, double-blind period of Study PsA-I, 170 patients were randomized to receive one of four intravenous treatments on Days 1, 15, 29, and then every 28 days (there was no escape during the 24-week period):

- Placebo
- Orencia 3 mg/kg
- Orencia A 500 mg for patients weighing less than 60 kg, Orencia 750 mg for patients weighing 60 to 100 kg, and Orencia 1,000 mg for patients weighing greater than 100 kg (weight-range-based dosing), or
- Orencia 30 mg/kg on Days 1 and 15 followed by weight range-based Orencia dosing (i.e., 500 mg for patients weighing less than 60 kg, 750 mg for patients weighing 60 to 100 kg, and 1,000 mg for patients weighing greater than 100 kg).

After the 24-week double blind period in Study PsA-I, patients received open-label intravenous Orencia every 28 days.

Patients were allowed to receive stable doses of concomitant MTX, low dose corticosteroids (equivalent to ≤10 mg of prednisone) and/or NSAIDs during the trial. At enrollment, approximately 60% of patients were receiving MTX. At baseline, the mean (SD) CRP for ORENCIA IV was 17 mg/L (33.0) and mean number (SD) of tender joints and swollen joints was 22.2 (14.3) and 10.9 (7.6), respectively.

In PsA-II, 424 patients were randomized 1:1 to receive weekly doses of SC placebo or Orenzia 125 mg without a loading dose for 24 weeks in a double-blind manner, followed by open-label Orenzia 125 mg SC weekly. Patients were allowed to receive stable doses of concomitant MTX, sulfasalazine, leflunomide, hydroxychloroquine, low dose corticosteroids (equivalent to ≤ 10 mg of prednisone) and/or NSAIDs during the trial. At randomization, 60% of patients were receiving MTX. The baseline disease characteristics included presence of joint erosion on X-rays in 84% (341/407) with a mean (SD) PsA-modified Sharp van der Heijde erosion score (SHS) of 10.8 (24.2), elevated serum C reactive protein (CRP) in 66% (277/421) with a mean (SD) of 14.1 mg/L (25.9), and polyarticular disease in 98% (416/424) of patients with a mean number (SD) of tender joints and swollen joints of 20.2 (13.3) and 11.6 (7.5), respectively. Patients who had not achieved at least a 20% improvement from baseline in their swollen and tender joint counts by Week 16 escaped to open-label SC Orenzia 125 mg weekly.

The primary endpoint for both PsA-I and PsA-II was the proportion of patients achieving ACR 20 response at Week 24 (Day 169).

Clinical Response in Adults with PsA

A greater proportion of adult patients with PsA achieved an ACR 20 response after treatment with Orenzia 10 mg/kg IV (weight range-based dosing as described above) or 125 mg SC compared to placebo at Week 24. Responses were seen regardless of prior TNF antagonist treatment and regardless of concomitant non-biologic DMARD treatment. The percent of patients achieving ACR 20, 50, or 70 responses in Studies PsA-I and PsA-II are presented in Table 5 below.

Table 5. Proportion of Patients with ACR Responses at Week 24 in Studies PsA-I and PsA-II^a

	PsA-I		PsA-II	
	Orenzia Weight-Range-Based Intravenous Dosing^b N = 40	Placebo N = 42	Orenzia 125 mg Subcutaneous N = 213	Placebo N = 211
ACR 20	47.5% ^c	19.0%	39.4% ^c	22.3%
ACR 50	25.0%	2.4%	19.2%	12.3%
ACR 70	12.5%	0%	10.3%	6.6%

ACR: American College of Rheumatology, Mg: milligram; KG: Kilogram.

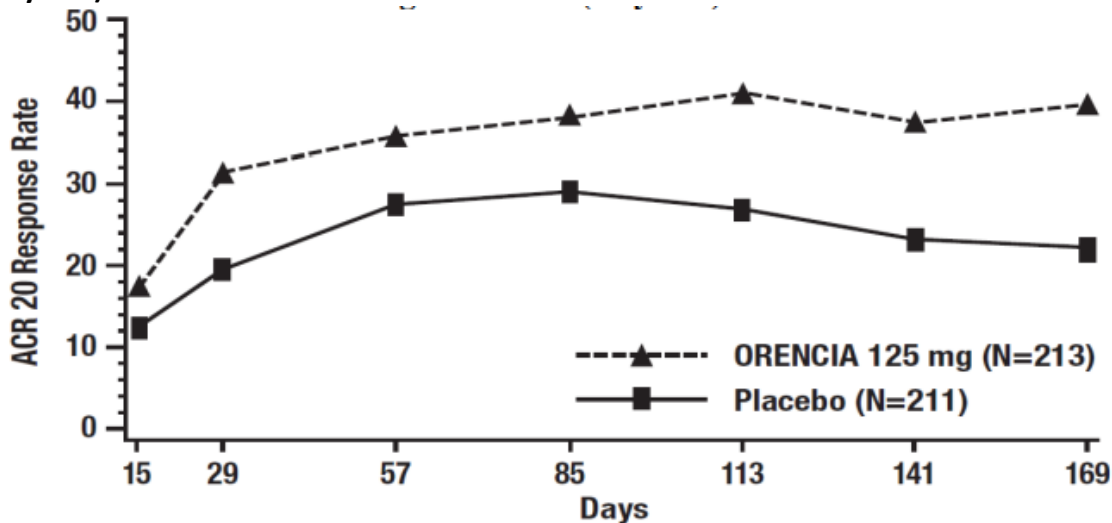
^a Patients who had less than 20% improvement in tender or swollen joint counts at Week 16 met escape criteria and were considered non-responders.

^b Weight range-based dosing. ORENCIA 500 mg for patients weighing less than 60 kg, ORENCIA 750 mg for patients weighing 60 to 100 kg, and ORENCIA 1,000 mg for patients weighing greater than 100 kg.

^c $p < 0.05$ versus placebo.

The percentage of patients in PsA-II achieving ACR 20 response through Week 24 is shown below in Figure 2.

Figure 2: Percent of Patients Achieving ACR 20 Response in PsA-II Study Through Week 24 (Day 169)



^a Non-responder imputation for early escape subjects at Day 141 and 169

ACR: American College of Rheumatology.

Results were generally consistent across the ACR components in Studies PsA-I and PsA-II. Improvements in enthesitis and dactylitis were seen with Orencia treatment at Week 24 in both PsA-I and PsA-II.

Physical Function Response

In study PsA-I, there was a higher proportion of patients with at least a 0.30 decrease from baseline in Health Assessment Questionnaire-Disability Index (HAQ-DI) score at Week 24, with an estimated difference for Orencia 10 mg/kg (weight range-based dosing) (45%) vs. placebo (19%) of 26.1 (95% confidence interval [CI]: 6.8, 45.5). In study PsA-II, the proportion of patients with at least a 0.35 decrease from baseline in HAQ-DI on Orencia was 31%, as compared to 24% on placebo (estimated difference: 7%; 95% CI: -1%, 16%). There was a higher adjusted mean change from baseline in HAQ-DI on Orencia (-0.33) vs. placebo (-0.20) at Week 24, with an estimated difference of -0.13 (95% CI: -0.25, -0.01).

Polyarticular Juvenile Idiopathic Arthritis (pJIA) (1)

Polyarticular Juvenile Idiopathic Arthritis-Intravenous Administration

The safety and efficacy of Orencia with intravenous administration were assessed in Study JIA-1 (NCT00095173), a three-part study including an open-label extension in pediatric patients with pJIA. Patients 6 to 17 years of age (n=190) with moderately to severely active pJIA who had an inadequate response to one or more DMARDs, such as MTX or TNF antagonists, were treated. Patients had a disease duration of approximately 4 years with moderately to severely active disease at study entry, as determined by baseline counts of active joints (mean, 16) and joints with loss of motion (mean, 16); patients had elevated C-reactive protein (CRP) levels (mean, 3.2 mg/dL) and ESR (mean, 32 mm/h). The patients enrolled had subtypes of JIA that at disease

onset included oligoarticular (16%), polyarticular (64%; 20% were rheumatoid factor positive), and systemic JIA without systematic manifestations (20%). At study entry, 74% of patients were receiving MTX (mean dose, 13.2 mg/m² per week) and remained on a stable dose of MTX (those not receiving MTX did not initiate MTX treatment during the study).

In Period A (open-label, lead-in), patients received 10 mg/kg (maximum 1,000 mg per dose) intravenously on days 1, 15, 29, and monthly thereafter. Response was assessed utilizing the ACR Pediatric 30 definition of improvement, defined as $\geq 30\%$ improvement in at least 3 of the 6 JIA core set variables and $\geq 30\%$ worsening in not more than 1 of the 6 JIA core set variables. Patients demonstrating an ACR Pedi 30 response at the end of Period A were randomized into the double-blind phase (Period B) and received either Orencia or placebo for 6 months or until disease flare. Disease flare was defined as a $\geq 30\%$ worsening in at least 3 of the 6 JIA core set variables with $\geq 30\%$ improvement in not more than 1 of the 6 JIA core set variables; ≥ 2 cm of worsening of the Physician or Parent Global Assessment was necessary if used as 1 of the 3 JIA core set variables used to define flare, and worsening in ≥ 2 joints was necessary if the number of active joints or joints with limitation of motion was used as 1 of the 3 JIA core set variables used to define flare.

At the conclusion of Period A, pediatric ACR 30/50/70 responses were 65%, 50%, and 28%, respectively. Pediatric ACR 30 responses were similar in all subtypes of JIA studied.

During the double-blind randomized withdrawal phase (Period B), Orencia-treated patients experienced significantly fewer disease flares compared to placebo-treated patients (20% vs 53%); 95% CI of the difference (15%, 52%). The risk of disease flare among patients continuing on intravenous Orencia was less than one-third than that for patients withdrawn from Orencia treatment (hazard ratio=0.31, 95% CI [0.16, 0.59]). Among patients who received intravenous Orencia throughout the study (Period A, Period B, and the open-label extension Period C), the proportion of pediatric ACR 30/50/70 responders has remained consistent for 1 year.

Prophylaxis of Acute Graft versus Host Disease (aGVHD) (1)

Study GVHD-1

The efficacy of Orencia, in combination with a calcineurin inhibitor (CNI) and methotrexate (MTX), for the prophylaxis of acute graft versus host disease (aGVHD), was based on a multicenter, two cohort clinical study (GVHD-1, NCT01743131) in patients aged 6 years and older who underwent hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated donor (URD). The two cohorts in GVHD-1 included:

- 1) An open-label, single-arm study of 43 patients who underwent a 7 of 8 Human Leukocyte Antigen (HLA)-matched HSCT (7 of 8 cohort); and
- 2) A randomized (1:1), double-blind, placebo-controlled study of patients who underwent an 8 of 8 HLA-matched HSCT who received Orencia or placebo in combination with a CNI and MTX (8 of 8 cohort).

In both the 7/8 and 8/8 cohorts, Orencia was administered at a dose of 10 mg/kg (1,000 mg maximum dose) as an intravenous infusion over 60 minutes, beginning on the day before

transplantation (Day -1), followed by administration on Days 5, 14, and 28 after transplantation. Baseline demographic and clinical characteristics of both the 7 of 8 and 8 of 8 cohorts are outlined below in Table 6.

Table 6. Baseline Demographic and Clinical Characteristics: 7 of 8 and 8 of 8 Cohort Treated Analysis Population in Study GVHD-1

	7 of 8 Cohort	8 of 8 Cohort	
	ORENCIA (+ CNI and MTX) N=43	ORENCIA (+ CNI and MTX) N=73	Placebo (+ CNI and MTX) N=69
Age – Median	38	44	40
Age – Range	6-76	6-71	7-74
Gender - Male	27 (63)	41 (56)	37 (54)
White	31 (72)	63 (86)	61 (88)
Black or African American	7 (16)	3 (4.1)	2 (2.9)
Asian	2 (4.7)	4 (6)	2 (2.9)
Hispanic	7 (16)	4 (6)	2 (2.9)
Malignancy type			
Acute Myeloid Leukemia (AML)	15 (35)	30 (41)	22 (32)
Myelodysplastic Syndrome (MDS)	11 (26)	15 (21)	12 (17)
Acute Lymphoblastic Leukemia (ALL)	8 (19)	20 (27)	22 (32)
Acute leukemia or ambiguous lineage	1 (2.3)	0	1 (1.4)
Hodgkin and Non-Hodgkin lymphoma	1 (2.3)	1 (1.4)	1 (1.4)
Acute Lymphoblastic Lymphoma in 2nd or Greater Complete Remission	1 (2.3)	4 (6)	1 (1.4)
Chronic Myelomonocytic leukemia	1 (2.3)	1 (1.4)	4 (6)
Chronic Myelogenous leukemia	4 (9)	1 (1.4)	5 (7)
Not reported	1 (2.3)	1 (1.4)	1 (1.4)
GVHD Prophylaxis			
Cyclosporine	16 (37)	11 (15)	11 (16)
Tacrolimus	27 (63)	62 (85)	58 (84)
Type of Graft			
Bone Marrow	21 (49)	33 (45)	26 (38)

Cytokine Mobilized Peripheral Blood (PBSC)	22 (51)	40 (55)	43 (62)
Conditioning Regimen			
TBI and Chemotherapy	11 (26)	20 (27)	26 (38)
Busulfan and Cyclophosphamide	13 (30)	28 (38)	21 (30)
Busulfan and Fludarabine	8 (19)	7 (10)	2 (2.9)
Melphalan and Fludarabine	11 (26)	18 (25)	20 (29)

CNI: calcineurin inhibitor; GVHD: graft versus host disease; MTX: methotrexate; TBI: total body irradiation.

Efficacy was established based on overall survival (OS) and grade II-IV aGVHD free survival (GFS) results assessed at Day 180 post-transplantation. Ocrencia + CNI and MTX did not significantly improve grade III-IV GFS versus placebo + CNI and MTX at Day 180 post-transplantation. The efficacy results of the GVHD-1 8 of 8 cohort are shown in Table 7.

Table 7. Efficacy Results in 8 of 8 Cohort in Study GVHD-1 at Day 180 Post-Transplantation

Endpoint	ORENCIA (+CNI and MTX) n=73	Placebo (+CNI and MTX) n=69
Gr III-IV aGVHD Free Survival^a Rate (95% CI)	87% (77%, 93%)	75% (63%, 84%)
Hazard Ratio (95% CI)	0.55 (0.26, 1.18)	
Gr II-IV aGVHD Free Survival^b Rate (95% CI)	50% (38%, 61%)	32% (21%, 43%)
Hazard Ratio (95% CI)	0.54 (0.35, 0.83)	
Overall Survival Rate (95% CI)	97% (89%, 99%)	84% (73%, 91%)
Hazard Ratio (95% CI)	0.33 (0.12, 0.93)	

CNI: calcineurin inhibitor; MTX: methotrexate; CI: confidence interval; aGVHD: Acute Graft versus Host Disease.

^a Gr III-IV aGVHD Free Survival was measured from the date of transplantation until the onset of documented Grade III-IV aGVHD, or death by any cause up to Day 180 post-transplantation.

^b Gr II-IV aGVHD Free Survival was measured from the date of transplantation until the onset of documented Grade II-IV aGVHD, or death by any cause up to Day 180 post-transplantation.

In an exploratory analysis of the 7 of 8 cohort of Ocrencia-treated patients (n=43), the rates of Grade III-IV GVHD-free survival, Grade II-IV GVHD-free survival, and OS at day 180 post-transplantation were 95% (95% CI 83%, 99%), 53% (95% CI 38%, 67%), and 98% (95% CI 85%, 100%), respectively.

Study GVHD-2

Graft versus host disease (GVHD)-2 (NCT05421299) was a clinical study that used data from the Center for International Blood and Marrow Transplant Research (CIBMTR). The study analyzed

outcomes of Orencia in combination with a CNI and MTX, versus a CNI and MTX alone, for the prophylaxis of aGVHD, in patients 6 years of age or older who underwent HSCT from a 1 allele-mismatched URD between 2011 and 2018. The Orencia + CNI and MTX-treated group (n=54) included 42 patients from GVHD-1, in addition to 12 patients treated with Orencia outside of GVHD-1. The comparator group (n=162) was randomly selected in a 3:1 ratio to the Orencia-treated group from the CIBMTR registry from patients who had not received Orencia during the study period. Analyses used propensity score matching and inverse probability of treatment weighting to help address the impact of selection bias.

Efficacy was based on OS at Day 180 post-HSCT. The OS rate at Day 180 in the Orencia in combination with CNI and MTX group was 98% (95% CI: 78, 100) and the OS rate at Day 180 in the CNI and MTX group was 75% (95% CI: 67, 82).

Coding

Procedure codes on Medical Policy documents are included **only** as a general reference tool for each policy. **They may not be all-inclusive.**

The presence or absence of procedure, service, supply, or device codes in a Medical Policy document has no relevance for determination of benefit coverage for members or reimbursement for providers. **Only the written coverage position in a Medical Policy should be used for such determinations.**

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member's benefit contract or Summary Plan Description (SPD) for defined coverage vs. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

CPT Codes	None
HCPCS Codes	J0129

*Current Procedural Terminology (CPT®) ©2025 American Medical Association: Chicago, IL.

References

U.S. Food and Drug Administration Label:

1. U.S. Food and Drug Administration, Drugs @ FDA. Highlights of Prescribing Information: Orencia. (Revised 5/24). Available at <<https://www.accessdata.fda.gov>> (accessed January 5, 2026).

Other:

2. Centers for Disease Control and Prevention. Rheumatoid Arthritis (January 25, 2024). Available at <<https://www.cdc.gov>> (accessed January 5, 2026).
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Centers for Medicare and Medicaid Services (CMS)

The information contained in this section is for informational purposes only. HCSC makes no representation as to the accuracy of this information. It is not to be used for claims adjudication for HCSC Plans.

The Centers for Medicare and Medicaid Services (CMS) does not have a national Medicare coverage position. Coverage may be subject to local carrier discretion.

A national coverage position for Medicare may have been developed since this medical policy document was written. See Medicare's National Coverage at <<https://www.cms.hhs.gov>>.

Policy History/Revision	
Date	Description of Change
04/01/2026	Document updated. The following change was made to Coverage: Other Indications header removed from “Abatacept (Orenzia®) is considered experimental, investigational and/or unproven for all other non-Food and Drug Administration approved indications.” statement. Reference 5 added; others updated.
11/01/2025	Document updated with literature review. The following changes were made to the Coverage section: 1) Coverage statements revised to align with FDA label. 2) The following statement was removed: “Chronic graft-versus-host disease (cGVHD) as additional therapy in conjunction with systemic corticosteroids following no response (steroid-refractory disease) to first-line therapy options.” 3) NOTE 2 (title only) added to “Abatacept (Orenzia®) may be self-administered. Refer to the applicable pharmacy benefit plan when self-administered.” 4) NOTE 3 changed to read: “Orenzia may not be used concomitantly with Janus kinase (JAK) inhibitors or biologic DMARDs (e.g., tumor necrosis factor (TNF) antagonists.” 5) NOTE 3 removed (Orenzia may be used as monotherapy or concomitantly with methotrexate.) and 6) Added: “Other Indications. Abatacept (Orenzia®) is considered experimental, investigational and/or unproven for all other non-FDA approved indications.” No new references added; 2 removed.

01/01/2025	Document updated with literature review. The following changes were made to the Coverage section: 1) Criteria was added to the medically necessary coverage statement for the indication of moderately to severely active rheumatoid arthritis in adults, and 2) Moderately to severely active polyarticular juvenile idiopathic arthritis was changed from patients 2 years of age or older to individuals 6 years of age or older and criteria was added. Updated the following references: 1, 4, 7 and 8.
07/15/2023	Reviewed. No changes.
02/15/2023	Document updated with literature review. The following changes were made to the Coverage section: 1) Added NOTE 1; 2) Added "Abatacept (Orencia®) may be self-administered. Refer to the applicable pharmacy benefit plan when self-administered"; and 3) Added "Prophylaxis of acute graft versus host disease (aGVHD), in combination with a calcineurin inhibitor and methotrexate, in adults and pediatric patients 2 years of age and older undergoing hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated donor and chronic graft-versus-host disease (cGVHD) as additional therapy in conjunction with systemic corticosteroids following no response (steroid-refractory disease) to first-line therapy options" to the medically necessary coverage statement. References 6-8 added, and others updated.
09/15/2021	Reviewed. No changes.