



PHARMACY COVERAGE GUIDELINES
SECTION: DRUGS

ORIGINAL EFFECTIVE DATE: 4/01/19
LAST REVIEW DATE: 11/21/19
LAST CRITERIA REVISION DATE: 11/21/19
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BIOLOGIC AND IMMUNOLOGICAL AGENTS

ACTEMRA® (tocilizumab) intravenous and subcutaneous injection (IV&SQ)

CIMZIA® (certolizumab pegol) subcutaneous injection

COSENTYX® (secukinumab) subcutaneous injection

ENBREL® (etanercept) subcutaneous injection

HUMIRA® (adalimumab) subcutaneous injection

KEVZARA® (sarilumab) subcutaneous injection

KINERET® (anakinra) subcutaneous injection

OLUMIANT® (baricitinib) oral tablet

ORENCIA® (abatacept) intravenous and subcutaneous injection (IV&SQ)

OTEZLA® (apremilast) oral tablet

RINVOQ™ (upadactinib) extended release tablet

SILIQ™ (brodalumab) subcutaneous injection

SIMPONI® (golimumab) subcutaneous injection

SIMPONI ARIA® (golimumab) intravenous solution

SKYRIZI™ (risankizumab-rzaa) subcutaneous injection

STELARA® (ustekinumab) intravenous and subcutaneous injection (IV&SQ)

TALTZ® (ixekizumab) subcutaneous injection

TREMFYA® (guselkumab) subcutaneous injection

XELJANZ® (tofacitinib citrate) oral tablet

XELJANZ® XR (tofacitinib citrate) extended-release tablet

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Pharmacy Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Pharmacy Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Pharmacy Coverage Guidelines are subject to change as new information becomes available.



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For purposes of this Pharmacy Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

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This Pharmacy Coverage Guideline does not apply to FEP or other states' Blues Plans.

Information about medications that require precertification is available at www.azblue.com/pharmacy.

Some large (100+) benefit plan groups may customize certain benefits, including adding or deleting precertification requirements.

All applicable benefit plan provisions apply, e.g., waiting periods, limitations, exclusions, waivers and benefit maximums.

Precertification for medication(s) or product(s) indicated in this guideline requires completion of the [request form](#) in its entirety with the chart notes as documentation. **All requested data must be provided.** Once completed the form must be signed by the prescribing provider and faxed back to BCBSAZ Pharmacy Management at (602) 864-3126 or emailed to Pharmacyprecert@azblue.com. **Incomplete forms or forms without the chart notes will be returned.**

Section A. Applies for all indications and uses:

- **Criteria for initial therapy:** Biologic and Immunological Agents is considered *medically necessary* and will be approved when **ALL** of the following criteria are met:
1. Prescriber is a physician specializing in or is in consultation with a Rheumatologist, Dermatologist, Gastroenterologist, or Ophthalmologist, depending upon indication or use
 2. Meets other initial criteria per indication or use as described below in Sections B-N below
 3. Serologic tests for hepatitis B and C (HB surface Ag, anti-HB surface Ab, anti-HB core Ab, and hepatitis C antibody tests) have been done within the previous 12 months (**Does not apply for Otezla**)
 4. There is no evidence of active serious infections, including clinically important localized infections or sepsis when initiating or continuing therapy (**Does not apply for Otezla**)
 5. Individual does not have untreated latent or active tuberculosis (**Does not apply for Otezla**)
 6. Individual does not have untreated Chronic or Acute Hepatitis B or C (**Does not apply for Otezla**)



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7. There is no concurrent use of live vaccines (**Does not apply for Otezla**)
 8. There is no concurrent use with other biologic and immunologic agents
 9. Requested medication is prescribed in accordance with the prescribing information and does not have any significant interacting drugs and/or disease states (i.e. abnormal labs)
- **Criteria for continuation of coverage (renewal request):** Biologic and Immunological Agents is considered **medically necessary** and will be approved when **ALL** of the following criteria are met:
1. Individual continues to be seen by a physician specializing in or is in consultation with a Rheumatologist, Dermatologist, Gastroenterologist, or Ophthalmologist depending upon indication or use
 2. Meets other continuation criteria per indication or use as described in Sections B-N below
 3. Individual has been adherent with the medication
 4. Individual has not developed any contraindications or other significant level 4 adverse drug effects that may exclude continued use
 5. There is no evidence of active serious infections, including clinically important localized infections or sepsis when initiating or continuing therapy (**Does not apply for Otezla**)
 6. Individual does not have untreated latent or active tuberculosis (**Does not apply for Otezla**)
 7. Individual does not have untreated Chronic or Acute Hepatitis B or C (**Does not apply for Otezla**)
 8. Concomitant disease states have been evaluated for risk potential and symptoms will be monitored
 9. There is no evidence of lupus-like syndrome while on therapy
 10. There is no concurrent use of live vaccines (**Does not apply for Otezla**)
 11. There is no concurrent use with other biologic and immunologic agents
 12. There are no significant interacting drugs



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Section B. Moderately to severely active Rheumatoid Arthritis (RA):

- **Criteria for initial therapy:** Biologic and Immunological Agents is considered *medically necessary* and will be approved when **ALL** of the following criteria are met for moderately to severely active rheumatoid arthritis:
1. Request is for **ONE** of the following: Actemra (SC), Cimzia, Enbrel, Humira, Kevzara, Kineret, Olumiant, Orencia (IV&SQ), Rinvoq, Simponi, Simponi Aria, Xeljanz IR, Xeljanz XR
 2. Prescriber is a Rheumatologist
 3. Meets other initial criteria per indication or use as described in Section A above
 4. Individual is 18 years of age or older
 5. Diagnosis of rheumatoid arthritis identified by **ONE** of the following:
 - Clinical Disease Activity Index (CDAI) score greater than 10
 - Disease Activity Score 28 (DAS28) of greater than 3.2
 - Patient Activity Scale (PAS) of greater than 3.7
 - Patient Activity Scale II (PASII) of greater than 3.7
 - Routine Assessment of Patient Index Data 3 (RAPID-3) score greater than 2
 - Simplified Disease Activity Index (SDAI) score greater than 11
 6. Individual has failure (used for ≥ 3 consecutive months), contraindication or intolerance to **methotrexate**
 7. Individual has failure (used for ≥ 3 consecutive months), contraindication or intolerance to **ONE** of the following (unless individual has already failed another TNF-inhibitor):
 - Leflunomide
 - Sulfasalazine
 8. For **non-preferred agents** for rheumatoid arthritis:
 - Actemra, Orencia (IV&SQ):**
 - Individual has failure (used for ≥ 3 consecutive months), contraindication or intolerance to **TWO** of the following preferred agents:
 - Cimzia
 - Humira
 - Rinvoq
 - Simponi or Simponi Aria
 - Xeljanz IR or Xeljanz XR
 - Enbrel, Kevzara, Kineret, Olumiant:**
 - **ALL** of the following:
 - Individual has failure (used for ≥ 3 consecutive months), contraindication or intolerance to **TWO** of the following preferred agents:
 - Cimzia

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- Humira
 - Rinvoq
 - Simponi or Simponi Aria
 - Xeljanz IR or Xeljanz XR
- Individual has failure (used for ≥ 3 consecutive months), contraindication or intolerance to **BOTH** of the following:
 - Actemra
 - Orencia (IV&SQ)

Approval Duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Biologic and Immunological Agents considered **medically necessary** and will be approved when **ALL** of the following criteria are met:

1. Meets other continuation criteria as described in Section A above
2. Individual's condition responded while on therapy
 - Response is defined as AT LEAST a 20% improvement in any of the following: CDAI, DAS28, PAS, PASII, RAPID-3, SDAI (see Definition section)

Renewal Duration: 12 months

Section C. Moderately to severely active Psoriatic Arthritis (PsA):

- **Criteria for initial therapy:** Biologic and Immunological Agents considered **medically necessary** and will be approved when **ALL** of the following criteria are met for moderately to severely active psoriatic arthritis:

1. Request is for **ONE** of the following: Cimzia, Cosentyx, Enbrel, Humira, Orencia (IV&SQ), Otezla, Simponi, Stelara, Taltz, Xeljanz IR, Xeljanz XR
2. Prescriber is a Rheumatologist
3. Meets other initial criteria per indication or use as described in Section A above
4. Individual is 18 years of age and older
5. Diagnosis of moderate to severe active psoriatic arthritis is identified by **ONE or more** of the following:
 - Predominantly axial disease (i.e. sacroiliitis or spondylitis) as indicated by **ALL** of the following:
 - Radiographic evidence of axial disease (e.g., sacroiliac joint space narrowing or erosions, vertebral syndesmophytes)



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- Symptoms (e.g., limited spinal range of motion, spinal morning stiffness more than 30 minutes) present for more than 3 months' duration
- Failure or intolerance of 1 or more different NSAIDs (at maximum recommended doses) over total period of at least 4 or more weeks of therapy
- Predominantly non-axial disease, and failure (used for ≥ 3 consecutive months), intolerance, or contraindication to methotrexate or NSAIDs

6. For **non-preferred agents** for psoriatic arthritis:

Taltz:

- Individual has failure (used for ≥ 3 consecutive months), contraindication or intolerance to **ONE** of the following preferred agents:
 - Cimzia
 - Humira
 - Simponi and Simponi Aria
 - Stelara

Orencia (IV&SQ), Xeljanz IR, Xeljanz XR:

- Individual has failure (used for ≥ 3 consecutive months), contraindication or intolerance to **TWO** of the following preferred agents:
 - Cimzia
 - Humira
 - Simponi and Simponi Aria
 - Stelara

Cosentyx:

- **ALL** of the following:
 - Individual has failure (used for ≥ 3 consecutive months), contraindication or intolerance to **TWO** of the following preferred agents:
 - Cimzia
 - Humira
 - Simponi or Simponi Aria
 - Stelara
 - Individual has failure (used for ≥ 3 consecutive months), contraindication or intolerance to **BOTH** of the following:
 - Taltz
 - Orencia (IV&SQ) or Xeljanz IR or Xeljanz XR

Enbrel:

- **ALL** of the following:
 - Individual has failure (used for ≥ 3 consecutive months), contraindication or intolerance to **TWO** of the following preferred agents:
 - Cimzia
 - Humira

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- Simponi or Simponi Aria
- Stelara
- Individual has failure (used for ≥ 3 consecutive months), contraindication or intolerance to **Two** of the following:
 - Taltz
 - Orencia (IV&SQ)
 - Xeljanz IR or Xeljanz XR

Approval Duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Biologic and Immunological Agents is considered *medically necessary* and will be approved when **ALL** of the following criteria are met:

1. Meets other continuation criteria as described in Section A above
2. Individual's condition responded while on therapy
 - Response is defined as AT LEAST a 20% improvement in any of the following: CDAI, DAS28, PAS, PASII, RAPID-3, SDAI (see Definition section)

Renewal Duration: 12 months

Section D. Moderately to severely active Ankylosing Spondylitis (AS):

- **Criteria for initial therapy:** Biologic and Immunological Agents is considered *medically necessary* and will be approved when **ALL** of the following criteria are met for moderately to severely active ankylosing spondylitis:

1. Request is for **ONE** of the following: Cimzia, Cosentyx, Enbrel, Humira, Simponi, Simponi Aria, Taltz
2. Prescriber is a Rheumatologist
3. Meets other initial criteria per indication or use as described in Section A above
4. Individual is 18 years of age or older
5. Clinical and diagnostic imaging evidence of ankylosing spondylitis as indicated by **ALL** of the following:
 - Back pain of 3 months or more duration and age of onset of 45 years or younger
 - Sacroiliitis on imaging
 - Spondyloarthritis signs or symptoms as indicated by **ONE or more** of the following:
 - Arthritis
 - Elevated serum C-reactive protein
 - Enthesitis (e.g., inflammation of Achilles tendon insertion)
 - HLA-B27

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- Limited chest expansion
 - Morning stiffness for one hour or more
6. Disease activity and treatment scenario as indicated by **ONE or more** of the following:
- Axial (spinal) disease
 - Failure of or intolerance to treatment with anti-tumor necrosis factor-alpha drug
 - Peripheral arthritis without axial involvement, and failure or intolerance of 4 or more months of therapy with sulfasalazine
7. Individual has failure, contraindication or intolerance to **TWO or more** different NSAIDs (at maximum recommended doses) over a total period of at least 4 or more weeks of therapy
8. For **non-preferred agents** for ankylosing spondylitis:
- Taltz:**
- Individual has failure (used for ≥ 3 consecutive months), contraindication or intolerance to **ONE** of the following preferred agents:
 - Cimzia
 - Humira
 - Simponi or Simponi Aria
- Cosentyx, Enbrel:**
- Individual has failure (used for ≥ 3 consecutive months), contraindication or intolerance to **TWO** of the following preferred agents:
 - Cimzia
 - Humira
 - Simponi or Simponi Aria
 - Individual has failure (used for ≥ 3 consecutive months), contraindication or intolerance to the following:
 - Taltz

Approval duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Biologic and Immunological Agents is considered **medically necessary** and will be approved when **ALL** of the following criteria are met:
1. Meets other continuation criteria as described in Section A above
 2. Individual's condition responded while on therapy
 - Response is defined as AT LEAST a 20% improvement in BASDAI (see Definition section)

Renewal Duration: 12 months

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Section E. Moderately to severely active Crohn's Disease (CD):

➤ **Criteria for initial therapy:** Biologic and Immunological Agents is considered *medically necessary* and will be approved when **ALL** of the following criteria are met for moderately to severely active Crohn's disease:

1. Request is for **ONE** of the following: Cimzia, Humira, Stelara
2. Prescriber is a Gastroenterologist
3. Meets other initial criteria per indication or use as described in Section A above
4. Age of individual meets FDA-approved label
5. Diagnosis of moderate to severe active Crohn disease as indicated by **ONE or more** of the following:
 - Abdominal abscess
 - Anemia
 - Dehydration
 - Elevated serum C-reactive protein level
 - Fever
 - Intermittent vomiting
 - Intestinal obstruction
 - Weight loss of greater than 10% of body weight
6. Individual has failure (used for ≥ 3 consecutive months), contraindication or intolerance to **ONE or more** of the following:
 - 6-mercaptopurine
 - Azathioprine
 - Methotrexate
 - Oral corticosteroids

Approval Duration: 6 months

➤ **Criteria for continuation of coverage (renewal request):** Biologic and Immunological Agents is considered *medically necessary* and will be approved when **ALL** of the following criteria are met:

1. Meets other continuation criteria as described in Section A above
2. Individual's condition responded while on therapy
 - Response is defined as AT LEAST a 20% improvement in the signs and symptoms of Crohn's disease

Renewal Duration: 12 months

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Section F. Moderately to severely active Ulcerative Colitis (UC):

- **Criteria for initial therapy:** Biologic and Immunological Agents is considered *medically necessary* and will be approved when **ALL** of the following criteria are met for moderately to severely active ulcerative colitis (UC):
1. Request is for **ONE** of the following: Humira, Simponi (not Simponi Aria), Stelara, Xeljanz IR
 2. Prescriber is a Gastroenterologist
 3. Meets other initial criteria per indication or use as described in Section A above
 4. Individual is 18 years of age and older
 5. Diagnosis of moderate to severe active ulcerative colitis, as indicated by **ONE or more** of the following:
 - Anemia
 - Bowel movements 4 or more times per day
 - Fever
 - Nocturnal stools
 - Persistent abdominal pain
 - Tachycardia
 - Visible blood in stool
 6. Individual has failure (used for ≥ 3 consecutive months), contraindication or intolerance to **ONE or more** of the following:
 - 6-mercaptopurine
 - Azathioprine
 - Oral corticosteroids
 - Salicylates
 7. For **non-preferred agents** for ulcerative colitis (UC):
Xeljanz IR
 - Individual has failure (used for ≥ 3 consecutive months), contraindication or intolerance to **TWO** of the following preferred agents:
 - Humira
 - Simponi
 - Stelara

Approval Duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Biologic and Immunological Agents is considered *medically necessary* and will be approved when **ALL** of the following criteria are met:
1. Meets other continuation criteria as described in Section A above

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2. Individual's condition responded while on therapy
 - Response is defined as AT LEAST a 20% improvement in signs and symptoms of ulcerative colitis

Renewal Duration: 12 months

Section G. Polyarticular Juvenile Idiopathic Arthritis (pJIA):

- **Criteria for initial therapy:** Biologic and Immunological Agents is considered *medically necessary* and will be approved when **ALL** of the following criteria are met for polyarticular juvenile idiopathic arthritis:
 1. Request is for **ONE** of the following: Actemra, Enbrel, Humira, Orencia (IV&SQ)
 2. Prescriber is a Rheumatologist
 3. Meets other initial criteria per indication or use as described in Section A above
 4. Individual is 2 years of age and older
 5. Treatment needed for disease severity, as indicated by **ONE or more** of the following:
 - Four or fewer joints involved and inadequate response to **ALL** of the following:
 - Glucocorticosteroid injection or NSAIDs
 - Methotrexate
 - Five or more joints involved and intolerance of or inadequate response to methotrexate
 - Sacroiliitis, and intolerance of or inadequate response to methotrexate
 - Uveitis, and inadequate response to **ALL** of the following:
 - Systemic corticosteroids
 - Systemic immunosuppressant (e.g., azathioprine or methotrexate)
 - Topical ophthalmic corticosteroids
 6. For **non-preferred agents** for polyarticular juvenile idiopathic arthritis:
 - **Actemra, Orencia (IV&SQ):**
 - Individual has failure (used for ≥ 3 consecutive months), contraindication or intolerance to Humira
 - **Enbrel:**
 - Individual has failure (used for ≥ 3 consecutive months), contraindication or intolerance to the following preferred agent:
 - Humira
 - Individual has failure (used for ≥ 3 consecutive months), contraindication or intolerance to **ALL** of the following:
 - Actemra
 - Orencia (IV&SQ)

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Approval Duration: 6 months

➤ **Criteria for continuation of coverage (renewal request):** Biologic and Immunological Agents is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

1. Meets other continuation criteria as described in Section A above
2. Individual's condition responded while on therapy
 - Response is defined as AT LEAST a 30% improvement in JIA Core Set (see Definition section)

Renewal Duration: 12 months

Section H. Moderate to severe chronic Plaque Psoriasis (PP):

➤ **Criteria for initial therapy:** Biologic and Immunological Agents is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met for moderate to severe chronic plaque psoriasis:

1. Request is for **ONE** of the following: Cimzia, Cosentyx, Enbrel, Humira, Otezla, Stelara, Siliq, Skyrizi, Taltz, Tremfya
2. Prescriber is a Dermatologist
3. Meets other initial criteria per indication or use as described in Section A above
4. Individual is 18 years of age and older
5. Diagnosis of moderate to severe plaque psoriasis, as indicated by **ALL** of the following:
 - Is a candidate for photochemotherapy or phototherapy
 - Plaque psoriasis involves $\geq 10\%$ body surface area (BSA) **or** plaque psoriasis involves $< 10\%$ BSA but includes sensitive areas or areas that significantly impact daily function (e.g. palms, soles of feet, head/neck, or genitalia)
 - A Psoriasis Area and Index (PASI) of at least 10
6. Individual has failure (used for ≥ 3 consecutive months), contraindication or intolerance to a treatment regimen that includes **ALL** of the following:
 - A trial of least **TWO** topical agents (e.g., anthralin, calcipotriene, coal tars, corticosteroids, tazarotene)
 - A trial of **ONE** immunosuppressive treatment (e.g., cyclosporine, methotrexate)
 - A trial of Ultraviolet Light therapy (e.g., Photochemotherapy (i.e., psoralen plus ultraviolet A therapy), Phototherapy (i.e., ultraviolet light therapy), or Excimer laser)
7. No concomitant systemic therapy or phototherapy

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8. For **non-preferred agents** for plaque psoriasis:

Taltz:

- Individual has failure (used for ≥ 3 consecutive months), contraindication or intolerance to **ONE** of the following preferred agents:
 - Cimzia
 - Humira
 - Skyrizi
 - Stelara
 - Tremfya

Cosentyx, Enbrel, Siliq:

- **ALL** of the following:
 - Individual has failure (used for ≥ 3 consecutive months), contraindication or intolerance to **THREE** of the following preferred agents:
 - Cimzia
 - Humira
 - Skyrizi
 - Stelara
 - Tremfya
 - Individual has failure (used for ≥ 3 consecutive months), contraindication or intolerance to:
 - Taltz

Approval Duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Biologic and Immunological Agents is considered **medically necessary** and will be approved when **ALL** of the following criteria are met:

1. Meets other continuation criteria as described in Section A above
2. Individual's condition responded while on therapy
 - Response is defined as AT LEAST a 20% improvement in PASI (see Definition section)

Renewal Duration: 12 months

Section I. Moderate to severe Hidradenitis Suppurativa:

- **Criteria for initial therapy:** Biologic and Immunological Agents is considered **medically necessary** and will be approved when **ALL** of the following criteria are met for moderate to severe hidradenitis suppurativa:

1. Request is for Humira



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2. Prescriber is a Dermatologist
3. Meets other initial criteria per indication or use as described in Section A above
4. Individual is 18 years of age and older
5. Diagnosis of moderate to severe disease as indicated by **ONE or more** of the following:
 - Multiple interconnected tracts and abscesses in single anatomic area
 - Widely separated and recurrent abscesses with sinus tracts and scarring
6. Individual has failure, contraindication or intolerance to oral antibiotics (at maximum recommended doses) for at least 3 consecutive months (i.e. clindamycin, minocycline, doxycycline, rifampin)

Approval Duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Biologic and Immunological Agents is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

1. Meets other continuation criteria as described in Section A above
2. Individual's condition responded while on therapy
 - Response is defined as AT LEAST a 20% improvement in the signs and symptoms of hidradenitis suppurativa

Renewal Duration: 12 months

Section J. Moderate Non-infectious Intermittent Uveitis, Non-infectious posterior Uveitis, or Non-infectious Panuveitis:

- **Criteria for initial therapy:** Biologic and Immunological Agents is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met for moderate non-infectious intermediate uveitis, non-infectious posterior uveitis or non-infectious panuveitis:

1. Request is for Humira
2. Prescriber is an Ophthalmologist
3. Meets other initial criteria per indication or use as described in Section A above
4. Individual is 2 years of age and older
5. Individual has failure, contraindication or intolerance to **ONE** agent for **BOTH** categories:

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- Corticosteroids (> 2 week trial at up to maximally indicated doses)
- Systemic immunosuppressant (i.e. methotrexate, cyclosporine, azathioprine, mycophenolate, cyclophosphamide, leflunomide, hydroxychloroquine, sulfasalazine, tacrolimus, sirolimus, or chlorambucil)

Approval Duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Biologic and Immunological Agents is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

1. Meets other continuation criteria as described in Section A above
2. Individual's condition responded while on therapy
 - Response is defined as AT LEAST a 20% improvement in the signs and symptoms of uveitis or panuveitis

Renewal Duration: 12 months

Section K. Moderate Giant Cell Arteritis:

- **Criteria for initial therapy:** Biologic and Immunological Agents is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met for moderate giant cell arteritis:

1. Request is for Actemra
2. Prescriber is a Rheumatologist
3. Meets other initial criteria per indication or use as described in Section A above
4. Individual is 18 years of age or older
5. Diagnosis is confirmed by temporal artery biopsy
6. Individual has failure (used for ≥ 3 consecutive months), contraindication or intolerance to glucocorticoids

Approval Duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Biologic and Immunological Agents is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

1. Meets other continuation criteria as described in Section A above

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2. Individual's condition responded while on therapy
 - Response is defined as AT LEAST 20% improvement in signs and symptoms of giant cell arteritis

Renewal duration: 12 months

Section L. Cytokine Release Syndrome:

- **Criteria for initial therapy:** Biologic and Immunological Agents is considered **medically necessary** and will be approved when **ALL** of the following criteria are met for chimeric antigen receptor (CAR) T cell-induced severe or life-threatening cytokine release syndrome:

1. Request is for Actemra
2. No concurrent treatment with any other biological DMARDs such as TNF antagonists, IL-1R (interleukin 1) antagonists, anti-CD-20 monoclonal antibodies or co-stimulation modulators

Approval Duration: One time only

Section M. Behcet's Disease:

- **Criteria for initial therapy:** Otezla is considered **medically necessary** and will be approved when **ALL** of the following criteria are met for oral ulcers associated with Behcet's Disease

1. Request is for Otezla
2. Prescriber is a Rheumatologist
3. Individual is 18 years of age or older
4. Diagnosis is confirmed by meeting International Study Group (ISG) criteria for Behcet's Disease ([see table](#)) with **ALL** of the following:
 - Two or more active oral ulcer without major organ involvement
 - Oral ulcers that occurred 3 or more times in previous 12 months
 - Does not require systemic immunosuppressants (e.g. biologics, corticosteroids, azathioprine)
 - No concurrent therapy with topical corticosteroids
5. Individual has failure (used for ≥ 3 consecutive months), contraindication or intolerance to **TWO** of the following:
 - Oral or topical corticosteroids
 - Nonsteroidal anti-inflammatory drugs (NSAIDs)
 - Colchicine
 - Immunosuppressant



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Approval Duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Biologic and Immunological Agents is considered **medically necessary** and will be approved when **ALL** of the following criteria are met:
1. Meets other continuation criteria as described in Section A above
 2. Individual's condition responded while on therapy
 - Response is defined as AT LEAST 20% improvement in signs and symptoms of oral ulcers

Renewal duration: 12 months

Section N. Measurement of Antibodies to Biologic/Immunologic Agents:

- Measurement of antibodies for biologic or immunologic agents in an individual receiving treatment, either alone or as a combination test, which includes the measurement of serum levels for the biologic or immunologic agents is considered **experimental or investigational** based upon:
1. Insufficient scientific evidence to permit conclusions concerning the effect on health outcomes, and
 2. Insufficient evidence to support improvement of the net health outcome.

These measurements include, *but are not limited to*:

- Anser™ ADA

- **Biologic and Immunological Agents therapy for all other indications not previously listed** is considered **experimental or investigational** based upon:
1. Lack of final approval from the Food and Drug Administration, and
 2. Insufficient scientific evidence to permit conclusions concerning the effect on health outcomes, and
 3. Insufficient evidence to support improvement of the net health outcome, and
 4. Insufficient evidence to support improvement of the net health outcome as much as, or more than, established alternatives, and
 5. Insufficient evidence to support improvement outside the investigational setting.

These indications include, *but are not limited to*:

- Treatment with dosing or frequency outside the FDA-approved dosing and frequency

BIOLOGIC AND IMMUNOLOGICAL AGENTS

Definitions:

Preferred and Non-Preferred Agents:

| Disease State | Preferred Agents | Non-Preferred Agents |
|-------------------------------|---|--|
| Rheumatoid Arthritis (RA) | Cimzia Humira Rinvoq Simponi Simponi Aria Xeljanz IR Xeljanz XR | Actemra DSE Enbrel QSE Kevzara QSE Kineret QSE Olumiant QSE Orencia (IV&SQ) DSE |
| Psoriatic Arthritis (PsA) | Cimzia Humira Otezla Simponi Simponi Aria Stelara | Cosentyx QSE Enbrel QSE Orencia (IV&SQ) DSE Taltz SSE Xeljanz IR, Xeljanz XR DSE |
| Psoriasis (PsO) | Cimzia Humira Otezla Skyrizi Stelara Tremfya | Cosentyx QSE Enbrel QSE Siliq QSE Taltz SSE |
| Ankylosing Spondylitis | Cimzia Humira Simponi Simponi Aria | Cosentyx TSE Enbrel TSE Taltz SSE |
| Juvenile Idiopathic Arthritis | Humira | Actemra SSE Enbrel TSE Orencia SSE |
| All other indications | | DSE through two preferred agents |

SSE: Single Step Edit. Individual has failure, contraindication or intolerance to at least **one** preferred agent with a specific duration.
DSE: Double Step Edit. Individual has failure, contraindication or intolerance to at least **two** preferred agents with a specific duration.
TSE: Triple Step Edit. Individual has failure, contraindication or intolerance to at least **three** preferred agents with a specific duration
QSE: Quadruple Step Edit. Individual has failure, contraindication or intolerance to at least **four** preferred agents with a specific duration.

Adult: Age 18 years and older.

Uveitis: Uveitis is characterized by inflammation of the uvea, which is the middle portion of the eye made up of the iris, ciliary body and choroid. The anterior portion of the uvea includes the iris and ciliary body, the posterior portion of the uvea is known as the choroid. There are several types of uveitis, defined by the part of the eye where it occurs:

- Iritis also called anterior uveitis, is the most common type of uveitis
- Intermediate uveitis or pars planitis is inflammation of the uvea in the middle or intermediate region of the eye
- Posterior uveitis affects the back parts of your eye
- Panuveitis occurs when all layers of the uvea are inflamed

**PHARMACY COVERAGE GUIDELINES
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Rheumatoid Arthritis Disease Activity Measurement Instruments:

| Instrument | Threshold of Disease Activity |
|---|--|
| Clinical Disease Activity Index (CDAI) | Range: 0 to 76 Remission: ≤ 2.8 Low activity: >2.8 to ≤ 10 Moderate activity: >10 to ≤ 22 High activity: >22 |
| Disease Activity Score 28 (DAS28) | Range: 0.5 to 9 Remission: < 2.6 Low activity: > 2.6 to ≤ 3.2 Moderate activity: > 3.2 to ≤ 5.1 High activity: > 5.1 |
| Patient Activity Scale (PAS) Patient Activity Scale II (PASII) | Range 0 to 10 Remission: 0 to 0.25 Low activity: >0.25 to 3.7 Moderate activity: > 3.7 to < 8.0 High activity: > 8.0 |
| Routine Assessment of Patient Index Data 3 (RAPID-3) | Range: 0 to 10 Remission: 0 to 1.0 Low activity: > 1.0 to 2.0 Moderate activity: > 2.0 to 4.0 High activity: > 4.0 to 10 |
| Simplified Disease Activity Index (SDAI) | Range: 0 to 90 Remission: ≤ 3.3 Low activity: > 3.3 to ≤ 11.0 Moderate activity: > 11.0 to ≤ 26 High activity: > 26 |

American College of Rheumatology 20 Percent Improvement Criteria (ACR20):

| |
|--|
| At least 20 percent improvement in the following: |
| 1. Swollen joint count |
| 2. Tender joint count |
| And three of the following five variables: |
| 3. Patient-assessed global disease activity (e.g., by VAS) |
| 4. Evaluator-assessed global disease activity (e.g., by VAS) |
| 5. Patient pain assessment (e.g., by VAS) |
| 6. Functional disability (e.g., by HAQ) |
| 7. Acute phase response (ESR or CRP) |
| A 50 and 70 percent ACR response (ACR50 and ACR70, respectively) represents respective improvement of at least 50 or 70 percent ¹ . |
| © 2018 UpToDate, Inc. |
| 1. Felson DT, Anderson JJ, Lange ML, et al. Should improvement in rheumatoid arthritis clinical trials be defined as fifty percent or seventy percent improvement in core set measures, rather than twenty percent?. <i>Arthritis Rheum</i> 1998; 41:1564. |
| 2. Felson DT, Anderson JJ, Boers M, et al. American College of Rheumatology preliminary definition of improvement in rheumatoid arthritis. <i>Arthritis Rheum</i> 1995; 38:727. |



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JIA Core Set 30%:

| |
|---|
| At least 30 percent improvement in at least 3 of the 6 core set variables with no more than 1 remaining variable worsening by > 30% |
| 1. Physician's global assessment of overall disease activity measured on a visual analog scale (VAS) |
| 2. Parent or patient global assessment of overall well-being measured on VAS |
| 3. Functional ability |
| 4. Number of joints with active arthritis |
| 5. Number of joints with limited range of motion |
| 6. Erythrocyte sedimentation rate (ESR) |
| <i>Giannini, EH, Ruperto, N, Ravelli A, et al. Preliminary Definition of Improvement in Juvenile Arthritis. Arthritis & Rheumatism 1997</i> |

Bath Ankylosing Spondylitis Disease Activity Index (BASDAI):

| |
|---|
| 1. How would you describe the overall level of fatigue/tiredness you have experienced? None 0 1 2 3 4 5 6 7 8 9 10 Very Severe |
| 2. How would you describe the overall level of ankylosing spondylitis neck, back or hip pain you have had? None 0 1 2 3 4 5 6 7 8 9 10 Very Severe |
| 3. How would you describe the overall level of pain/swelling you have had in joints other than neck, back and hips? None 0 1 2 3 4 5 6 7 8 9 10 Very Severe |
| 4. How would you describe the level of discomfort you have had from an area tender to touch or pressure? None 0 1 2 3 4 5 6 7 8 9 10 Very Severe |
| 5. How would you describe the level of morning stiffness you have had from the time you wake up? None 0 1 2 3 4 5 6 7 8 9 10 Very Severe |
| 6. How long does your morning stiffness last from the time you wake up? 0 hours 0 1 2 3 4 5 6 7 8 9 10 2 or more hours |
| Calculation of BASDAI: Compute the mean of questions 5 and 6 Calculate the sum of the values of question 1-4 and add the result to the mean of questions 5 and 6 |
| <small>© 2018 UpToDate, Inc. Originally published in: Garrett S, Jenkinson T, Kennedy LG, et al. A new approach to defining disease status in ankylosing spondylitis: the Bath Ankylosing Spondylitis Disease Activity Index. J Rheumatol 1994; 21:2286. Reproduced with permission from: the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust, Bath. www.mhrd.nhs.uk. Copyright ©</small> |

Psoriasis Area and Severity Index (PASI):

| | Head | Upper Extremities | Trunk | Lower extremities |
|---|---------------------|---------------------|---------------------|---------------------|
| 1. Redness ¹ | | | | |
| 2. Thickness ¹ | | | | |
| 3. Scale ¹ | | | | |
| 4. Sum of rows 1,2 and 3 | | | | |
| 5. Area score ² | | | | |
| 6. Score of row 4 x row 5 x the area multiplier | row 4 x row 5 x 0.1 | row 4 x row 5 x 0.2 | Row 4 x row 5 x 0.3 | Row 4 x row 5 x 0.4 |
| 7. Sum row 6 for each column for PASI score | | | | |

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Steps in generating PASI score:

- (a) Divide body into four areas: head, arms, trunk to groin, and legs to top of buttocks.
- (b) Generate an average score for the erythema, thickness, and scale for each of the 4 areas (0 = clear; 1–4 = increasing severity)¹.
- (c) Sum scores of erythema, thickness, and scale for each area.
- (d) Generate a percentage for skin covered with psoriasis for each area and convert that to a 0–6 scale (0 = 0%; 1 = <10%; 2 = 10–<30%; 3 = 30–<50%; 4 = 50–<70%; 5 = 70–<90%; 6 = 90–100%).
- (e) Multiply score of item (c) above times item (d) above for each area and multiply that by 0.1, 0.2, 0.3, and 0.4 for head, arms, trunk, and legs, respectively.
- (f) Add these scores to get the PASI score.

¹ Erythema, induration and scale are measured on a 0–4 scale (none, slight, mild, moderate, severe)

² Area scoring criteria (score: % involvement)

0: 0 (clear)

1: <10%

2: 10–<30%

3: 30–<50%

4: 50–<70%

5: 70–<90%

6: 90–<100%

Feldman, SR and Krueger, GG. Psoriasis assessment tools in clinical trials. Ann Rheum Dis 2005; 64 (Suppl III): ii65-ii68.

Diagnostic criteria for Behçet's syndrome

| Criterion | Required features |
|---------------------------------------|---|
| Recurrent oral ulceration | Aphthous (idiopathic) ulceration, observed by clinician or patient, with at least three episodes in any 12-month period |
| Plus any two of the following: | |
| Recurrent genital ulceration | Aphthous ulceration or scarring, observed by clinician or patient |
| Eye lesions | Anterior or posterior uveitis cells in vitreous in slit-lamp examination; or retinal vasculitis documented by ophthalmologist |
| Skin lesions | Erythema nodosum-like lesions observed by clinician or patient; papulopustular skin lesions or pseudofolliculitis with characteristic acneiform nodules observed by clinician |
| Pathergy test | Interpreted at 24 to 48 hours by clinician |

Adapted from International Study Group for Behcet's Disease. Criteria for diagnosis of Behcet's disease. Lancet 1990; 335:1078.

Resources:

1. 2.04.84 BCBS Association Medical Policy Reference Manual. Measurement of Serum Antibodies to Infliximab and Adalimumab. Re-issue date 11/09/2017, issue date 08/09/2012.
2. 5.01.24 BCBS Association Medical Policy Reference Manual. Nononcologic Uses of Rituximab. Re-issue date 10/12/2017, issue date 10/09/2014.
3. American Academy of Ophthalmology. What is Uveitis? 03/10/2014.

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4. Bartelds GM, Krieckaert CL, Nurmohamed MT, et al. Development of antidrug antibodies against adalimumab and association with disease activity and treatment failure during long-term follow-up. *JAMA*. Apr 13 2011;305(14):1460-1468.
5. Foeldvari I, Nielsen S, Kummerle-Deschner J, et al. Tumor necrosis factor-alpha blocker in treatment of juvenile idiopathic arthritis-associated uveitis refractory to second-line agents: results of a multinational survey. *J Rheumatol*. 2007 May 2007;34(5):1146-1150.
6. Magli A, Forte R, Navarro P, et al. Adalimumab for juvenile idiopathic arthritis-associated uveitis. *Graefes Arch Clin Exp Ophthalmol*. Jun 2013;251(6):1601-1606.
7. Rifkin LM, Birnbaum AD, Goldstein DA. TNF Inhibition for Ophthalmic Indications: Current Status and Outlook. *BioDrugs*. Aug 2013;27(4):347-357.
8. Sen ES, Sharma S, Hinchcliffe A, Dick AD, Ramanan AV. Use of adalimumab in refractory non-infectious childhood chronic uveitis: efficacy in ocular disease--a case cohort interventional study. *Rheumatology (Oxford)*. Dec 2012;51(12):2199-2203.
9. Simonini G, Taddio A, Cattalini M, et al. Prevention of flare recurrences in childhood-refractory chronic uveitis: an open-label comparative study of adalimumab versus infliximab. *Arthritis Care Res (Hoboken)*. Apr 2011;63(4):612-618.
10. Suhler EB, Lowder CY, Goldstein DA, et al. Adalimumab therapy for refractory uveitis: results of a multicentre, open-label, prospective trial. *Br J Ophthalmol*. Apr 2013;97(4):481-486.
11. UpToDate.com. Uveitis: Etiology, clinical manifestations, and diagnosis. 02/24/2017.
12. Vazquez-Cobian LB, Flynn T, Lehman TJ. Adalimumab therapy for childhood uveitis. *J Pediatr*. Oct 2006;149(4):572-575.
13. UpToDate.com: Clinical manifestations and diagnosis of Behçet syndrome. 11/20/2019.

[Section A. Applies for all indications and uses](#)

[Section B. Moderately to severely active Rheumatoid Arthritis \(RA\)](#)

[Section C. Moderately to severely active Psoriatic Arthritis \(PsA\)](#)

[Section D. Moderately to severely active Ankylosing Spondylitis \(AS\)](#)

[Section E. Moderately to severely active Crohn's Disease \(CD\)](#)

[Section F. Moderately to severely active Ulcerative Colitis \(UC\)](#)

[Section G. Polyarticular Juvenile Idiopathic Arthritis \(pJIA\)](#)

[Section H. Moderate to severe chronic Plaque Psoriasis \(PP\)](#)

[Section I. Moderate to severe Hidradenitis Suppurativa](#)

[Section J. Moderate Non-infectious Intermittent Uveitis, Non-infectious posterior Uveitis, or Non-infectious Panuveitis](#)

[Section K. Moderate Giant Cell Arteritis](#)



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[Section L. Cytokine Release Syndrome](#)

[Section M. Behcet's Disease](#)

[Section N. Measurement of Antibodies to Biologic/Immunologic Agents](#)
