Regence BlueShield serves select counties in the state of Washington
And is an Independent licensee of the Blue Cross and Blue Shield Association

**UMP Medication Policy Manual**

**Policy No:** dru900

**Topic**: Provider-Administered Drugs for Chronic Inflammatory Diseases (for UMP plans)

**Date of Origin**: January 1, 2020

- Actemra (tocilizumab); biosimilars Avtozma, Tofidence, Tyenne
- Cimzia (certolizumab lyophilized powder vial)
- Cosentyx (secukinumab intravenous)
- Entyvio (vedolizumab)
- Ilumya (tildrakizumab-asmn)
- Omvoh (mirkizumab)
- Orencia (abatacept intravenous)
- Simponi Aria (golimumab intravenous)
- Skyrizi (risankizumab)
- Spevigo (spesolimab)
- Tremfya (guselkumab)
- Stelara (ustekinumab); Ustekinumab (unbranded); biosimilars: Imuldosa (ustekinumab-srlf), Otulfi (ustekinumab-aauz), Pyzchiva (ustekinumab-ttwe), Selarsdi (ustekinumab-aekn), Starjemza (ustekinumab-hmny), Steqeyma (ustekinumab-stba), Ustekinumab-srlf (unbranded), Ustekinumab-stba (unbranded), Wezlana (ustekinumab-auub), Yesintek (ustekinumab-kfce)

**Committee Approval Date**: April 2, 2026

**Next Review Date**: 2026

**Effective Date**: July 1, 2026

## IMPORTANT REMINDER

This Medication Policy has been developed through consideration of medical necessity, generally accepted standards of medical practice, and review of medical literature and government approval status.

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

The purpose of medication policy is to provide a guide to coverage. Medication Policy is not intended to dictate to providers how to practice medicine. Providers are expected to exercise their medical judgment in providing the most appropriate care.

### Description

Therapies included in this policy are used to treat a group of diseases that may be caused or worsened by an overactive immune system such as rheumatoid arthritis, psoriasis, and ulcerative colitis.

***This policy applies to the Washington State Health Care Authority (HCA) Uniform Medical Plan (UMP) only. The UMP is a self-funded health plan offered through the Washington State HCA's Public Employees Benefits Board (PEBB) Program and School Employees Benefits Board (SEBB) Program and administered by Regence BlueShield.***

**Table of Contents**

**Disease Modifying Antirheumatic Drugs (DMARDs)**

| Targeted DMARD | | | Conventional synthetic DMARDs |
|---|---|---|---|
| Tumor necrosis factor inhibitor (TNF) biologics | Non-TNF inhibitors | Targeted synthetic DMARD (tsDMARD) | 5-ASAs<br>Antimalarials<br>Antimetabolites<br>Calcineurin inhibitors |
| | IL-6 inhibitors<br>IL-12/23 inhibitors<br>IL-17 inhibitors<br>IL-23 inhibitors<br>Integrin inhibitors<br>Other: IL-I, rituximab, abatacept | JAK inhibitors<br>PDE-4 inhibitors<br>S1P receptor modulators | |

| **Drug List** | | |
|---|---|---|
| TNF inhibitors | | - Cimzia (certolizumab pegol)<br>- Enbrel and biosimilars Erelzi, Eticovo (etanercept)<br>- Humira and biosimilars Abrilada, Adalimumab-aacf (unbranded), Adalimumab-aaty (unbranded), Adalimumab-adaz (unbranded), Adalimumab-adbm (unbranded), Adalimumab-fkjp (unbranded), Adalimumab-ryvk (unbranded), Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry (adalimumab)<br>- Remicade, Infliximab (unbranded Janssen product), and biosimilars Avsola, Inflectra, Ixifi, Renflexis, Zymfentra (infliximab)<br>- Simponi, Simponi Aria (golimumab) |
| IL-6 inhibitors | | - Actemra and biosimilars Avtozma, Tofidence, Tyenne (tocilizumab)<br>- Kevzara (sarilumab) |
| IL-12, IL-23 inhibitors | | - Stelara, Ustekinumab (unbranded Janssen product), and biosimilars Imuldosa, Otulfi, Pyzchiva, Selarsdi, Starjemza, Steqeyma, Ustekinumab-srlf (unbranded), Ustekinumab-stba (unbranded), Wezlana, Yesintek (ustekinumab) |
| IL-13 inhibitors | | - Adbry (tralokinumab-ldrm) [a] |
| IL-17 Inhibitors | | - Bimzelx (bimekizumab-bkzx) IL-17A, IL-17F inhibitor<br>- Cosentyx (secukinumab)<br>- Siliq (brodalumab)<br>- Taltz (ixekizumab) |
| IL-23 inhibitors | | - Ilumya (tildrakizumab-asmn)<br>- Skyrizi (risankizumab)<br>- Omvoh (mirikizumab-mrkz)<br>- Tremfya (guselkumab) |
| IL-36 inhibitors | | - Spevigo (spesolimab) |
| Integrin inhibitors | | - Entyvio (vedolizumab)<br>- Tysabri (natalizumab) [a] |
| Other non-TNF inhibitor biologics | T-lymphocyte inhibitor | - Orencia (abatacept) |

| | | |
|---|---|---|
| | B-lymphocyte depleter | - Rituxan, Rituxan Hycela, and biosimilars Riabni, Ruxience, Truxima (rituximab) [a] |
| | IL-1 | - Ilaris (canakinumab) [a]<br>- Kineret (anakinra) |
| JAK Inhibitors | JAK1/2/3 | - Cibinqo (abrocitinib)<br>- Litfulo (ritlecitinib)<br>- Olumiant (baricitinib)<br>- Rinvoq (upadacitinib)<br>- Xeljanz, Xeljanz XR (tofacitinib) |
| | TYK2 | - Sotyktu (deucravacitinib) |
| PDE-4 Inhibitor | | - Otezla, Otezla XR (apremilast) |
| S1P receptor modulator | | - Velsipity (etrasimod)<br>- Zeposia (ozanimod) |
| Conventional synthetic DMARDs (csDMARD) (i.e., conventional immunomodulators) | | - 5-ASAs [sulfasalazine (generic, SSZ), mesalamine, balsalazide]<br>- 6-mercaptopurine (generic, 6-MP)<br>- Acitretin (generic, Accutane)<br>- Azathioprine (generic, Imuran)<br>- Cyclosporine (CSA; Gengraf, Neoral, Sandimmune)<br>- Hydroxychloroquine (HCQ; generic, Plaquenil)<br>- Leflunomide (generic, Arava)<br>- Methotrexate (generic, MTX)<br>- Mycophenolate (MMF; generic, CellCept, Myfortic)<br>- Tacrolimus (generic, Prograf) |

[a] See Cross References table for associated policy for this medication

**Policy/Criteria**

Most contracts require pre-authorization approval of drugs for chronic inflammatory diseases prior to coverage.

**I.** For self-administered therapies, please refer to coverage policies administered by ArrayRx.

**II.** Continuation of therapy (COT): Provider-administered therapies in this policy may be considered medically necessary for COT when criteria A and B below are met.

**A.** One of the following (1, 2, or 3):

**1.** For diagnoses NOT listed in the coverage criteria below, full policy criteria must be met for coverage.

**OR**

**2.** For diagnoses listed in the coverage criteria below, criteria a through c must be met:

**a.** The patient was established on therapy prior to current health plan membership AND attestation that the medication was covered by another health plan.

**AND**

**b.** There is documentation of clinical benefit, such as disease stability as detailed in the reauthorization criteria.

**AND**

**c.** For Imuldosa (ustekinumab-srlf), Otulfi (ustekinumab-aauz), Pyzchiva (ustekinumab-ttwe), Selarsdi (ustekinumab-aekn), Starjemza (ustekinumab-hmny), Stelara (ustekinumab), Ustekinumab (unbranded Janssen product), Ustekinumab-srlf (unbranded), Ustekinumab-stba (unbranded), Wezlana (ustekinumab-auub) only: There is documented intolerance or contraindication to **both** of the following: Steqeyma (ustekinumab-stba) and Yesintek (ustekinumab-kfce).

**OR**

**3.** The medication was initiated for acute disease management, as part of an acute unscheduled, inpatient hospital admission.

**AND**

**B.** Site of care administration requirements are met [refer to Medication Policy Manual, Site of Care Review, dru408].

***Please note**: Medications obtained as samples, coupons, or promotions, paying cash for a prescription ("out-of-pocket") as an eligible patient, or any other method of obtaining medications outside of an established health plan benefit (from your insurance) does NOT necessarily establish medical necessity. Medication policy criteria apply for coverage, per the terms of the member contract with the health plan.*

**III.** New starts (treatment-naïve patients): Provider-administered therapies in the policy may be considered medically necessary when the criteria below are met.

## A. Acute Graft Versus Host Disease (aGVHD), Prophylaxis

**1.** Provider-administered products may be considered medically necessary when criteria a through c below are met.

| FOR UMP MEMBERS | |
|---|---|
| **Preferred self-administered products** Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Non-preferred self-administered products** Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Provider-administered products** | Orencia (abatacept) IV |

**a.** Abatacept will be used for prophylaxis of aGVHD.

**AND**

**b.** Patient will undergo a hematopoietic cell transplant (HCT) from an unrelated donor (either 8/8 HLA matched or 7/8 HLA mismatch).

**AND**

**c.** Abatacept will be used in combination with methotrexate and a calcineurin inhibitor (cyclosporine or tacrolimus).

## B. Ankylosing Spondylitis (AS)

**1.** For provider-administered products, site of care administration requirements must be met [refer to Medication Policy Manual, Site of Care Review, dru408].

**2.** Infliximab products: Refer to Medication Policy Manual, Products with Therapeutically Equivalent Biosimilars/Reference Products, dru620.

**3.** Other provider-administered products may be considered medically necessary when criteria a and b below are met.

| **FOR UMP MEMBERS** | |
|---|---|
| **Preferred self-administered products**<br>Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Non-preferred self-administered products**<br>Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Infliximab products** | Refer to Medication Policy Manual, Products with Therapeutically Equivalent Biosimilars/Reference Products, dru620.<br>**Preferred**<br>• Avsola (infliximab-axxq)<br>• Inflectra (infliximab-dyyb)<br>**Non-preferred**<br>• Infliximab (unbranded Janssen product)<br>• Ixifi (infliximab-qbtx)<br>• Remicade (infliximab)<br>• Renflexis (infliximab-abda) |
| **Other provider-administered products** | • Cimzia (certolizumab) vial<br>• Simponi Aria (golimumab) IV<br>• Cosentyx (secukinumab) IV |

**a.** A diagnosis of axial spondyloarthritis (axSpA), including AS, is established by or in consultation with a specialist in rheumatology.

**AND**

**b.** There is clinical documentation that treatment with at least **two** preferred self-administered therapies were ineffective after at least a 12-week treatment course unless each were not tolerated or are contraindicated (including but not limited to contraindications listed in *Appendix 6*).

## C. Antibody Mediated Rejection (AMR) of Transplant (Solid Organ)

**1.** Preferred provider-administered products may be considered medically necessary when criteria a and b below are met.

**2.** Other provider-administered products may be considered medically necessary when criteria a through c below are met.

| **FOR UMP MEMBERS** | |
|---|---|
| **Preferred self-administered products** Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Non-preferred self-administered products** Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Preferred provider-administered products** | • Tyenne (tocilizumab-aazg) IV |
| **Other provider-administered products** | • Actemra (tocilizumab) IV<br>• Avtozma (tocilizumab-anoh) IV<br>• Tofidence (tocilizumab-bavi) IV |

**a.** Medication will be used for one of the following indications (i or ii):

**i.** Prevention of AMR: Prior to solid organ transplant and in the peri-operative period, for patients at high risk for AMR, including highly sensitized patients, and those receiving an ABO-incompatible organ.

**OR**

**ii.** Treatment of AMR (i.e., vascular rejection, humoral rejection): Following solid organ transplant and confirmed by either biopsy or presence of panel reactive antibodies (PRAs).

**AND**

**b.** Treatment with immunoglobulin (IVIG), plasma exchange/pheresis (PLEX), and rituximab has been ineffective or is contraindicated.

**AND**

**c.** There is clinical documentation that treatment with **all** preferred provider-administered therapies were ineffective unless each were not tolerated or are contraindicated.

## D. Non-Radiographic Axial Spondyloarthritis (NR-axSpA)

**1.** For provider-administered products, site of care administration requirements must be met [refer to Medication Policy Manual, Site of Care Review, dru408].

**2.** Provider-administered products may be considered medically necessary when criteria a and b below are met.

**3.** Provider-administered biosimilar reference products may be considered medically necessary when criteria a and b below are met.

| **FOR UMP MEMBERS** | |
|---|---|
| **Preferred self-administered products**<br>Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Non-preferred self-administered products**<br>Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Provider-administered products** | • Cimzia (certolizumab) vial<br>• Cosentyx (secukinumab) IV |

**a.** A diagnosis of NR-axSpA is established by or in consultation with a specialist in rheumatology.

**AND**

**b.** Treatment with at least **one** preferred self-administered therapy was ineffective after at least a 12-week treatment course unless each were not tolerated or are contraindicated (including but not limited to contraindications listed in *Appendix 6*).

## E. Chronic Plaque Psoriasis (PsO)

1. For provider-administered products, site of care administration requirements must be met [refer to Medication Policy Manual, Site of Care Review, dru408].
2. Infliximab products: Refer to Medication Policy Manual, Products with Therapeutically Equivalent Biosimilars/Reference Products, dru620.
3. Preferred provider-administered products may be considered medically necessary when criteria a and b below are met.
4. Other provider-administered products may be considered medically necessary when criteria a through c below are met.

| **FOR UMP MEMBERS** | |
|---|---|
| **Preferred self-administered products**<br>Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Non-preferred self-administered products**<br>Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Infliximab products** | Refer to Medication Policy Manual, Products with Therapeutically Equivalent Biosimilars/Reference Products, dru620.<br>**Preferred**:<br>• Avsola (infliximab-axxq)<br>• Inflectra (infliximab-dyyb)<br>**Non-preferred**:<br>• Infliximab (unbranded Janssen product)<br>• Ixifi (infliximab-qtbx)<br>• Remicade (infliximab)<br>• Renflexis (infliximab-abda) |
| **Preferred provider-administered products** | • Steqeyma (ustekinumab-stba)<br>• Yesintek (ustekinumab-kfce) |
| **Other provider-administered products** | • Cimzia (certolizumab) vial<br>• Ilumya (tildrakizumab-asmn)<br>• Imuldosa (ustekinumab-srlf)<br>• Otulfi (ustekinumab-aauz)<br>• Pyzchiva (ustekinumab-ttwe)<br>• Selarsdi (ustekinumab-aekn)<br>• Starjemza (ustekinumab-hmny)<br>• Stelara (ustekinumab)<br>• Ustekinumab (unbranded Janssen product)<br>• Ustekinumab-srlf (unbranded)<br>• Ustekinumab-stba (unbranded)<br>• Wezlana (ustekinumab-auub) |

**a.** A diagnosis of PsO is established by or in consultation with a specialist in dermatology or rheumatology.

**AND**

**b.** One of the following criteria (i, ii, or iii) below is met.

**i.** There is involvement of ≥ 10% of the body surface area (BSA) OR there is significant functional disability due to PsO.

**OR**

**ii.** Treatment with phototherapy (e.g., UVB) or photochemotherapy was ineffective, not tolerated, or is contraindicated (such as lesions on the face, scalp, hands, feet, nailbeds, or groin area; see *Appendix 1*).

**OR**

**iii.** Treatment with at least **one** conventional agent was ineffective after at least 6 to 12

weeks of treatment, or not tolerated, unless all are contraindicated. Conventional agents for the treatment of PsO include: acitretin, anthralin, calcipotriene, calcitriol, coal tar products, cyclosporine, methotrexate, pimecrolimus, tacrolimus, tazarotene, or a topical corticosteroid.

**AND**

**c.** There is clinical documentation that treatment with at least **two** preferred self-administered therapies were ineffective after at least a 12-week treatment course unless each were not tolerated or are contraindicated (including but not limited to contraindications listed in *Appendix 6*).

**AND**

**d.** For Imuldosa (ustekinumab-srlf), Otulfi (ustekinumab-aauz), Pyzchiva (ustekinumab-ttwe), Selarsdi (ustekinumab-aekn), Starjemza (ustekinumab-hmny), Stelara (ustekinumab), Ustekinumab (unbranded Janssen product), Ustekinumab-srlf (unbranded), Ustekinumab-stba (unbranded), Wezlana (ustekinumab-auub) only: There is documented intolerance or contraindication to **both** of the following: Steqeyma (ustekinumab-stba) and Yesintek (ustekinumab-kfce).

**F. Crohn's Disease (CD)**

**1.** **Site of care requirements**: For provider-administered therapies, site of care administration requirements must be met [refer to Medication Policy Manual, Site of Care Review, dru408.

**2.** **Diagnostic criteria**: A diagnosis of CD established by or in consultation with a specialist in gastroenterology.

**3.** **Severity criteria**: Either criterion a or b below is met.

**a.** At least one of the following criteria 1 through 6 below are met.

**1.** Fistulizing CD.

**2.** Previous hospitalization for CD.

**3.** Extensive anatomic involvement.

**4.** Deep ulcers.

**5.** Prior surgical resection.

**6.** Stricturing and/or penetrating behavior.

**OR**

**b.** Acute treatment of an exacerbation when at least one of criterion 1, 2, or 3 below is met.

**1.** Treatment with an adequate course of corticosteroids (e.g., prednisone 40 to 60 mg/day, oral budesonide 9 mg/day, or budesonide rectal for 7 to 14 days) has been ineffective or is contraindicated.

**OR**

**2.** The patient has been unable to taper an adequate course of corticosteroids without experiencing worsening of disease.

**OR**

**3.** The patient is experiencing breakthrough disease (e.g., active disease flares) while stable for at least 8 weeks on a conventional immunomodulator. Conventional immunomodulators for CD include azathioprine, mercaptopurine, methotrexate, balsalazide, mesalamine, cyclosporine, and sulfasalazine.

| FOR UMP MEMBERS | | |
|---|---|---|
| **Product Group** | **Products** | **Criteria Requirements** |
| **Preferred self-administered products** | Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Non-preferred self-administered products** | Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Preferred provider-administered products** | • Entyvio (vedolizumab)<br>• Skyrizi (risankizumab)<br>• Steqeyma (ustekinumab-stba)<br>• Tremfya (guselkumab)<br>• Yesintek (ustekinumab-kfce) | **1.** Site of Care Requirements *(Entyvio only)*<br>**2.** Diagnostic Criteria<br>**3.** Severity Criteria |
| | • Avsola (infliximab-axxq)<br>• Inflectra (infliximab-dyyb) | Refer to Medication Policy Manual, Products with Therapeutically Equivalent Biosimilars/Reference Products, dru620. |
| **Non-preferred provider-administered products** | • Cimzia (certolizumab) vial<br>• Omvoh (mirikizumab)<br>• Imuldosa (ustekinumab-srlf)<br>• Otulfi (ustekinumab-aauz)<br>• Pyzchiva (ustekinumab-ttwe)<br>• Selarsdi (ustekinumab-aekn)<br>• Starjemza (ustekinumab-hmny)<br>• Stelara (ustekinumab)<br>• Ustekinumab (unbranded Janssen product)<br>• Ustekinumab-srlf (unbranded)<br>• Ustekinumab-stba (unbranded)<br>• Wezlana (ustekinumab-auub) | **1.** Site of Care Requirements *(Cimzia only)*<br>**2.** Diagnostic Criteria<br>**3.** Severity Criteria<br>**4.** Treatment with at least **two** preferred self-administered therapies have been ineffective after at least a 12-week treatment course unless each were not tolerated or are contraindicated (including but not limited to contraindications listed in *Appendix 6*).<br>**5.** For ustekinumab products only: There is documented intolerance or contraindication to **both** of the following: Steqeyma (ustekinumab-stba) and Yesintek (ustekinumab-kfce). |
| **Non-preferred infliximab products** | • Infliximab (unbranded Janssen product)<br>• Ixifi (infliximab-qtbx)<br>• Remicade (infliximab)<br>• Renflexis (infliximab-abda) | Refer to Medication Policy Manual, Products with Therapeutically Equivalent Biosimilars/Reference Products, dru620. |

## G. Cryopyrin-Associated Periodic Syndrome (CAPS)

**1.** For self-administered products, please refer to coverage policies administered by ArrayRx.

| FOR UMP MEMBERS | |
|---|---|
| **Preferred self-administered products**<br>Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Non-preferred self-Administered products**<br>Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Provider-administered products** | Refer to Interleukin-1 Antagonists, Medication Policy Manual, Policy No. dru677 |

## H. Cytokine Release Syndrome (CRS)

**1.** Preferred provider-administered products may be considered medically necessary when criterion a below is met.

**2.** Other provider-administered products may be considered medically necessary when criteria a and b below are met.

| **FOR UMP MEMBERS** | |
|---|---|
| **Preferred self-administered products** Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Non-preferred self-administered products** Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Preferred provider-administered products** | • Tyenne (tocilizumab-aazg) IV |
| **Other provider-administered products** | • Actemra (tocilizumab) IV<br>• Avtozma (tocilizumab-anoh) IV<br>• Tofidence (tocilizumab-bavi) IV |
| **a.** Medication will be used for CRS.<br>**AND**<br>**b.** There is clinical documentation that treatment with **all** preferred provider-administered therapies were ineffective unless each were not tolerated or are contraindicated. | |

## I. Enthesitis-related Arthritis (ERA)

**1.** For provider-administered products, site of care administration requirements must be met [refer to Medication Policy Manual, Site of Care Review, dru408].

**2.** Provider-administered products may be considered medically necessary when criterion a below is met.

| **FOR UMP MEMBERS** | |
|---|---|
| **Preferred self-administered products** Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Non-preferred self-administered products** Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Provider-administered products** | None |
| **a.** A diagnosis of ERA is established by or in consultation with a specialist in rheumatology. | |

## J. Generalized Pustular Psoriasis (GPP)

1. Infliximab products: Refer to Medication Policy Manual, Products with Therapeutically Equivalent Biosimilars/ Reference Products, dru620.
2. Other provider-administered products may be considered medically necessary when criteria a and b below are met.

| FOR UMP MEMBERS | |
|---|---|
| **Preferred self-administered products** Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Non-preferred self-administered products** Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Infliximab products** | Refer to Medication Policy Manual, Products with Therapeutically Equivalent Biosimilars/Reference Products, dru620.<br>**Preferred**<br>• Avsola (infliximab-axxq)<br>• Inflectra (infliximab-dyyb)<br>**Non-preferred**<br>• Infliximab (unbranded Janssen product)<br>• Ixifi (infliximab-qtbx)<br>• Remicade (infliximab)<br>• Renflexis (infliximab-abda) |
| **Other provider-administered products** | Spevigo (spesolimab) |

**a.** A diagnosis of GPP established by or in consultation with a specialist in dermatology.

**AND**

**b.** One of the following criteria i or ii below is met.

**i.** Treatment of GPP flare (IV formulation only) when all of the following are met:

**1.** Documentation of disease progression despite usual treatment with cyclosporine OR infliximab unless not tolerated, or both are contraindicated.

**2.** There is involvement of ≥ 5% of body surface area (BSA) with erythema and the presence of pustules.

**OR**

**ii.** Maintenance treatment for GPP (SC loading dose only) when all of the following are met:

**1.** History of at least two moderate-to-severe flares, with at least one associated with fever, elevated C-reactive protein level, elevated white blood cell count, asthenia, or myalgia.

**2.** Currently not experiencing a flare.

**3.** Treatment with acitretin and methotrexate for at least eight weeks has been ineffective or not tolerated, unless both are contraindicated.

## K. Giant Cell Arteritis (GCA)

**1.** For provider-administered products, site of care administration requirements must be met [refer to Medication Policy Manual, Site of Care Review, dru408].

**2.** Preferred provider-administered products may be considered medically necessary when criteria a and b below are met.

**3.** Other provider-administered products may be considered medically necessary when criteria a through c below are met.

| **FOR UMP MEMBERS** | |
|---|---|
| **Preferred self-administered products** Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Non-preferred self-administered products** Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Preferred provider-administered products** | • Tyenne (tocilizumab-aazg) IV |
| **Other provider-administered products** | • Actemra (tocilizumab) IV<br>• Avtozma (tocilizumab-anoh) IV<br>• Tofidence (tocilizumab-bavi) IV |
| **a.** A diagnosis of GCA when established by or in consultation with a specialist in rheumatology.<br>**AND**<br>**b.** Requested medication will be given in combination with high-dose corticosteroids (prednisone 20 to 60 mg per day or equivalent) unless contraindicated or not tolerated.<br>**AND**<br>**c.** There is clinical documentation that treatment with **all** preferred provider administered options were ineffective unless each were not tolerated or are contraindicated. | |

## L. Hidradenitis Suppurativa (HS)

**1.** For provider-administered products, site of care administration requirements must be met [refer to Medication Policy Manual, Site of Care Review, dru408].

**2.** Infliximab products: Refer to Medication Policy Manual, Products with Therapeutically Equivalent Biosimilars/Reference Products, dru620.

**3.** Other provider-administered therapies may be considered medically necessary when criteria a and b below are met.

| **FOR UMP MEMBERS** | |
|---|---|
| **Preferred self-administered options**<br>Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Non-preferred self-administered options**<br>Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Infliximab products** | Refer to Medication Policy Manual, Products with Therapeutically Equivalent Biosimilars/Reference Products, dru620.<br>**Preferred**<br>• Avsola (infliximab-axxq)<br>• Inflectra (infliximab-dyyb)<br>**Non-preferred**<br>• Infliximab (unbranded Janssen product)<br>• Ixifi (infliximab-qtbx)<br>• Remicade (infliximab)<br>• Renflexis (infliximab-abda) |
| **Other provider-administered options** | None |
| **a.** A diagnosis of HS is established by or in consultation with a specialist in dermatology.<br>**AND**<br>**b.** Treatment with at least **one** conventional agent was ineffective after 12 weeks, not tolerated, or all are contraindicated. Conventional agents for the treatment of HS include topical antibiotics, systemic antibiotics (e.g., oral tetracyclines, clindamycin, rifampin, moxifloxacin, metronidazole), intralesional corticosteroids (e.g., triamcinolone), hormonal therapies (e.g., oral contraceptives, spironolactone), cyclosporine, finasteride, metformin, or oral retinoids. | |

## M. Immune-Mediated Colitis

1. For infliximab products: Refer to Medication Policy Manual, Products with Therapeutically Equivalent Biosimilars/Reference Products, dru620.
2. Other provider-administered therapies may be considered medically necessary when criteria a and b below are met.

| FOR UMP MEMBERS | |
|---|---|
| **Preferred self-administered options**<br>Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Non-preferred self-administered options**<br>Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Infliximab products** | Refer to Medication Policy Manual, Products with Therapeutically Equivalent Biosimilars/Reference Products, dru620.<br>**Preferred**<br>• Avsola (infliximab-axxq)<br>• Inflectra (infliximab-dyyb)<br>**Non-preferred**<br>• Infliximab (unbranded Janssen product)<br>• Ixifi (infliximab-qtbx)<br>• Remicade (infliximab)<br>• Renflexis (infliximab-abda) |
| **Other provider-administered options** | Entyvio (vedolizumab) |

**a.** A diagnosis of colitis due to a checkpoint inhibitor, such as Yervoy (ipilimumab) or an anti-PD1/PD-L1 agent [e.g., Tecentriq (atezolizumab), Bavencio (avelumab), Libtayo (cemiplimab), Jemperli (dostarlimab), Imfinzi (durvalumab), Opdivo (nivolumab), or Keytruda (pembrolizumab) or Zynyz (retifanlimab)]. [a]

**AND**

**b.** Treatment with an adequate course of corticosteroids (e.g., prednisone 40 to 60 mg/day, oral budesonide mg/day, or budesonide rectal for 7 days) has been ineffective or is contraindicated.

[a] Or as listed on the FDA.gov website.

## N. Polyarticular Juvenile Idiopathic Arthritis (PJIA)

1. For provider-administered therapies, site of care administration requirements must be met [refer to Medication Policy Manual, Site of Care Review, dru408].
2. For infliximab products: Refer to Medication Policy Manual, Products with Therapeutically Equivalent Biosimilars/Reference Products, dru620.
3. Preferred provider-administered therapies may be considered medically necessary when criteria a through c below are met.
4. Other provider-administered therapies may be considered medically necessary when criteria a through d below are met.

| **FOR UMP MEMBERS** | |
|---|---|
| **Preferred self-administered options**<br>Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Non-preferred self-administered options**<br>Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Infliximab products** | Refer to Medication Policy Manual, Products with Therapeutically Equivalent Biosimilars/Reference Products, dru620.<br>**Preferred**<br>• Avsola (infliximab-axxq)<br>• Inflectra (infliximab-dyyb)<br>**Non-preferred**<br>• Infliximab (unbranded Janssen product)<br>• Ixifi (infliximab-qtbx)<br>• Remicade (infliximab)<br>• Renflexis (infliximab-abda) |
| **Preferred provider-administered options** | • Orencia (abatacept) IV<br>• Simponi Aria (golimumab IV)<br>• Tyenne (tocilizumab-aazg) IV<br>• Cimzia (certolizumab pegol) vials for patients weighing <40 kg. Please note: For patients weighing ≥40 kg, provider-administered Cimzia (certolizumab pegol) vials are not medically necessary. Prefilled syringes for self-administration are available for doses of 200 mg or greater. |
| **Other provider-administered options** | • Actemra (tocilizumab) IV<br>• Avtozma (tocilizumab-anoh) IV<br>• Tofidence (tocilizumab-bavi) IV |

**a.** A diagnosis of PJIA is established by or in consultation with a specialist in rheumatology.

**AND**

**b.** Treatment with a conventional immunomodulator (e.g., leflunomide, methotrexate, or sulfasalazine) was ineffective after at least 6 weeks, or that a conventional immunomodulator was not tolerated, or all conventional immunomodulators are contraindicated.

**AND**

**c.** There is clinical documentation that treatment with at least **two** preferred self-administered therapies were ineffective after at least a 12-week treatment course unless each were not tolerated or are contraindicated (including but not limited to contraindications listed in *Appendix 6*).

**AND**

**d.** There is clinical documentation that treatment with **all** preferred provider-administered **tocilizumab options** were ineffective after at least a 12-week treatment course unless each was not tolerated or are contraindicated.

## O. Psoriatic Arthritis (PsA)

1. For provider-administered therapies, site of care administration requirements must be met [refer to Medication Policy Manual, Site of Care Review, dru408].
2. For infliximab products: Refer to Medication Policy Manual, Products with Therapeutically Equivalent Biosimilars/Reference Products, dru620.
3. Preferred provider-administered therapies may be considered medically necessary when criterion a below is met.
4. Other provider-administered therapies may be considered medically necessary when criteria a and b below are met.

| **FOR UMP MEMBERS** | |
|---|---|
| **Preferred self-administered options**<br>Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Non-preferred self-administered options**<br>Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Infliximab products** | Refer to Medication Policy Manual, Products with Therapeutically Equivalent Biosimilars/Reference Products, dru620.<br>**Preferred**<br>• Avsola (infliximab-axxq)<br>• Inflectra (infliximab-dyyb)<br>**Non-preferred**<br>• Infliximab (unbranded Janssen product)<br>• Ixifi (infliximab-qtbx)<br>• Remicade (infliximab)<br>• Renflexis (infliximab-abda) |
| **Preferred provider-administered options** | • Steqeyma (ustekinumab-stba)<br>• Yesintek (ustekinumab-kfce) |
| **Other provider-administered options** | • Cimzia (certolizumab) vial<br>• Cosentyx (secukinumab) IV<br>• Imuldosa (ustekinumab-srlf)<br>• Orencia (abatacept) IV<br>• Otulfi (ustekinumab-aauz)<br>• Pyzchiva (ustekinumab-ttwe)<br>• Selarsdi (ustekinumab-aekn)<br>• Simponi Aria (golimumab) IV<br>• Starjemza (ustekinumab-hmny)<br>• Stelara (ustekinumab)<br>• Ustekinumab (unbranded Janssen product)<br>• Ustekinumab-srlf (unbranded)<br>• Ustekinumab-stba (unbranded)<br>• Wezlana (ustekinumab-auub) |
| **a.** A diagnosis of PsA when established by or in consultation with a specialist in dermatology or rheumatology.<br>**AND**<br>**b.** There is clinical documentation that treatment with at least **two** preferred self-administered therapies were ineffective after at least a 12-week treatment course unless each were not tolerated or are contraindicated (including but not limited to contraindications listed in *Appendix 6*).<br>**AND**<br>**c.** For Imuldosa (ustekinumab-srlf), Otulfi (ustekinumab-aauz), Pyzchiva (ustekinumab-ttwe), | |

| |
|---|
| Selarsdi (ustekinumab-aekn), Starjemza (ustekinumab-hmny), Stelara (ustekinumab), Ustekinumab (unbranded Janssen product), Ustekinumab-srlf (unbranded), Ustekinumab-stba (unbranded), Wezlana (ustekinumab-auub) only: There is documented intolerance or contraindication to **both** of the following: Steqeyma (ustekinumab-stba) and Yesintek (ustekinumab-kfce). |

## P. Rheumatoid Arthritis (RA)

1. For provider-administered therapies, site of care administration requirements must be met [refer to Medication Policy Manual, Site of Care Review, dru408].
2. For infliximab products: Refer to Medication Policy Manual, Products with Therapeutically Equivalent Biosimilars/Reference Products, dru620.
3. Preferred provider-administered therapies may be considered medically necessary when criteria a through c below are met.
4. Other provider-administered therapies may be considered medically necessary when criteria a through d below are met.

| **FOR UMP MEMBERS** | |
|---|---|
| **Preferred self-administered options**<br>Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Non-preferred self-administered options**<br>Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Infliximab products** | Refer to Medication Policy Manual, Products with Therapeutically Equivalent Biosimilars/Reference Products, dru620.<br>**Preferred**<br>• Avsola (infliximab-axxq)<br>• Inflectra (infliximab-dyyb)<br>**Non-preferred**<br>• Infliximab (unbranded Janssen product)<br>• Ixifi (infliximab-qtbx)<br>• Remicade (infliximab)<br>• Renflexis (infliximab-abda) |
| **Preferred provider-administered options** | • Cimzia (certolizumab) vial<br>• Orencia (abatacept) IV<br>• Simponi Aria (golimumab IV)<br>• Tyenne (tocilizumab-aazg) IV |
| **Other provider-administered options** | • Actemra (tocilizumab) IV<br>• Avtozma (tocilizumab-anoh) IV<br>• Tofidence (tocilizumab-bavi) IV |

**a.** A diagnosis of RA is established by or in consultation with a specialist in rheumatology (see *Appendix 3*).

**AND**

**b.** Treatment with a conventional synthetic DMARD (csDMARD) was ineffective after at least a 6 to 12-week treatment course based on one or more of the assessment components listed in *Appendix 4*, or that a csDMARD was not tolerated or all csDMARDs are contraindicated. csDMARDs for RA include hydroxychloroquine, leflunomide, methotrexate, and sulfasalazine.

**AND**

**c.** There is clinical documentation that treatment with at least **two** preferred self-administered therapies were ineffective after at least a 12-week treatment course unless each were not tolerated or are contraindicated (including but not limited to contraindications listed in *Appendix 6*).

**AND**

**d.** There is clinical documentation that treatment with **all** preferred provider-administered **tocilizumab options** were ineffective after at least a 12-week treatment course unless each were not tolerated or are contraindicated.

## Q. Takayasu Arteritis

1. For provider-administered therapies, site of care administration requirements must be met [refer to Medication Policy Manual, Site of Care Review, dru408].
2. For infliximab products: Refer to Medication Policy Manual, Products with Therapeutically Equivalent Biosimilars/Reference Products, dru620.
3. Preferred provider-administered options may be considered medically necessary when criteria a and b below are met.
4. Other provider-administered options may be considered medically necessary when criteria a through c below are met.

| FOR UMP MEMBERS | |
|---|---|
| **Preferred self-administered options**<br>Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Non-preferred self-administered options**<br>Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Infliximab products** | Refer to Medication Policy Manual, Products with Therapeutically Equivalent Biosimilars/Reference Products, dru620.<br>**Preferred**<br>• Avsola (infliximab-axxq)<br>• Inflectra (infliximab-dyyb)<br>**Non-preferred**<br>• Infliximab (unbranded Janssen product)<br>• Ixifi (infliximab-qbtx)<br>• Remicade (infliximab)<br>• Renflexis (infliximab-abda) |
| **Preferred provider-administered options** | • Tyenne (tocilizumab-aazg) IV |
| **Other provider-administered options** | • Actemra (tocilizumab) IV<br>• Avtozma (tocilizumab-anoh) IV<br>• Tofidence (tocilizumab-bavi) IV |

**a.** A diagnosis of Takayasu arteritis is established by or in consultation with a specialist in rheumatology or immunology.

**AND**

**b.** One of the following i or ii below are met.

**i.** The patient has been unable to taper corticosteroids without experiencing worsening of disease (e.g., unable to achieve doses of 15-20 mg per day or less of prednisone or equivalent after 8 weeks).

**OR**

**ii.** The patient is experiencing breakthrough disease (e.g., relapses or active disease flares) while stable on a conventional immunomodulator, for at least 8 weeks.

**AND**

**c.** There is clinical documentation that treatment with **all** preferred provider-administered therapies were ineffective unless each were not tolerated or are contraindicated.

## R. Systemic Juvenile Idiopathic Arthritis (SJIA; Still's disease)

1. For provider-administered therapies, site of care administration requirements must be met [refer to Medication Policy Manual, Site of Care Review, dru408].
2. Preferred provider-administered therapies may be considered medically necessary when criteria a through d below are met.
3. Other provider-administered therapies may be considered medically necessary when criteria a through e below are met.

| FOR UMP MEMBERS | |
|---|---|
| **Preferred self-administered options**<br>Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Non-preferred self-administered options**<br>Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Preferred provider-administered options** | • Tyenne (tocilizumab-aazg) IV |
| **Other provider-administered options** | • Actemra (tocilizumab) IV<br>• Avtozma (tocilizumab-anoh) IV<br>• Tofidence (tocilizumab-bavi) IV |

**a.** A diagnosis of SJIA (Still's disease) is established by or in consultation with a specialist in rheumatology.

**AND**

**b.** There is disease activity greater than 6 weeks.

**AND**

**c.** One of the following i or ii below is met.

**i.** Treatment with at least one oral conventional agent was ineffective after 12 weeks, not tolerated, or is contraindicated. Conventional agents for the treatment of SJIA include azathioprine, cyclosporine, leflunomide, methotrexate, systemic corticosteroids, or tacrolimus.

**OR**

**ii.** Treatment with at least one NSAID (e.g., ibuprofen, celecoxib) was ineffective after 4 weeks, not tolerated, or all are contraindicated.

**AND**

**d.** There is clinical documentation that treatment with at least **one** preferred self-administered therapy was ineffective after at least a 12-week treatment course unless each were not tolerated or are contraindicated (including but not limited to contraindications listed in *Appendix 6*).

**AND**

**e.** There is clinical documentation that treatment with **all** preferred provider-administered therapies were ineffective after at least a 12-week treatment course unless each were not tolerated or are contraindicated.

## S. Ulcerative Colitis (UC)

1. **Site of care requirements**: For provider-administered therapies, site of care administration requirements are met [refer to Medication Policy Manual, Site of Care Review, dru408].
2. **Diagnostic criteria**: A diagnosis of UC when established by or in consultation with a specialist in gastroenterology.
3. **Severity criteria**: At least one of the following criteria (a, b, or c) below is met.
   - **a.** Treatment with an adequate course of corticosteroids (for example, prednisone 40 to 60 mg/day, oral budesonide 9 mg/day, or budesonide rectal for 7 to 14 days) was ineffective or is contraindicated; **OR**
   - **b.** The patient has been unable to taper an adequate course of corticosteroids without experiencing worsening of disease; **OR**
   - **c.** The patient is experiencing breakthrough disease (for example, active disease flares) while stable on a conventional immunomodulator for at least 8 weeks. Conventional immunomodulators for UC include azathioprine, balsalazide, cyclosporine, mercaptopurine, mesalamine, and sulfasalazine.

| **FOR UMP MEMBERS** | | |
|---|---|---|
| **Product Group** | **Products** | **Criteria Requirements** |
| **Preferred self-administered options** | Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Non-preferred self-administered options** | Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Preferred provider-administered options** | • Entyvio (vedolizumab)<br>• Skyrizi (risankizumab)<br>• Steqeyma (ustekinumab-stba)<br>• Tremfya (guselkumab)<br>• Yesintek (ustekinumab-kfce) | **1.** Site of Care Requirements<br>**2.** Diagnostic Criteria<br>**3.** Severity Criteria |
| | • Avsola (infliximab-axxq)<br>• Inflectra (infliximab-dyyb) | Refer to Medication Policy Manual, Products with Therapeutically Equivalent Biosimilars/Reference Products, dru620. |
| **Non-preferred provider-administered options** | • Omvoh (mirikizumab)<br>• Imuldosa (ustekinumab-srlf)<br>• Otulfi (ustekinumab-aauz)<br>• Pyzchiva (ustekinumab-ttwe)<br>• Selarsdi (ustekinumab-aekn)<br>• Starjemza (ustekinumab-hmny)<br>• Stelara (ustekinumab)<br>• Ustekinumab (unbranded Janssen product)<br>• Ustekinumab-srlf (unbranded)<br>• Ustekinumab-stba (unbranded)<br>• Wezlana (ustekinumab-auub) | **1.** Diagnostic Criteria<br>**2.** Severity Criteria<br>**3.** Treatment with **all** preferred self-administered therapies have been ineffective after at least a 12-week treatment course unless each were not tolerated or are contraindicated (including but not limited to contraindications listed in *Appendix 6*).<br>**4.** For ustekinumab products only: There is documented intolerance or contraindication to **both** of the following: Steqeyma (ustekinumab-stba) and Yesintek (ustekinumab-kfce). |
| **Non-preferred infliximab products** | • Infliximab (unbranded Janssen product)<br>• Ixifi (infliximab-qbtx)<br>• Remicade (infliximab)<br>• Renflexis (infliximab-abda) | Refer to Medication Policy Manual, Products with Therapeutically Equivalent Biosimilars/Reference Products, dru620. |

## T. Uveitis

**1.** For provider-administered therapies, site of care administration requirements must be met [refer to Medication Policy Manual, Site of Care Review, dru408].

**2.** For infliximab products: Refer to Medication Policy Manual, Products with Therapeutically Equivalent Biosimilars/Reference Products, dru620.

**3.** Other provider-administered therapies may be considered medically necessary when criteria a through c below are met.

| **FOR UMP MEMBERS** | |
|---|---|
| **Preferred self-administered options**<br>Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Non-preferred self-administered options**<br>Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Infliximab products** | Refer to Medication Policy Manual, Products with Therapeutically Equivalent Biosimilars/Reference Products, dru620.<br>**Preferred**<br>• Avsola (infliximab-axxq)<br>• Inflectra (infliximab-dyyb)<br>**Non-preferred**<br>• Infliximab (unbranded Janssen product)<br>• Ixifi (infliximab-qbtx)<br>• Remicade (infliximab)<br>• Renflexis (infliximab-abda) |
| **Other provider-administered options** | None |

**a.** A diagnosis of uveitis is established by or in consultation with a specialist in ophthalmology.

**AND**

**b.** Treatment with corticosteroids (oral, periocular, or intravitreal injections) was:

**i.** Ineffective after two weeks of therapy (for example, prednisone 40 to 60 mg/day).

**OR**

**ii.** Unable to be tapered following an adequate course without disease worsening.

**OR**

**iii.** Not tolerated or is contraindicated.

**AND**

**c.** Treatment with at least **one** conventional agent was ineffective after a 6-week treatment course, not tolerated, or all are contraindicated. Conventional agents for treatment of uveitis include azathioprine, cyclosporine, methotrexate, mycophenolate, or tacrolimus.

## U. Other Immunologic Conditions: Pyoderma Gangrenosum, Sarcoidosis

1. For provider-administered therapies, site of care administration requirements must be met [refer to Medication Policy Manual, Site of Care Review, dru408].
2. For infliximab products: Refer to Medication Policy Manual, Products with Therapeutically Equivalent Biosimilars/Reference Products, dru620.
3. Other provider-administered therapies may be considered medically necessary when criteria a and b below are met.

| FOR UMP MEMBERS | |
|---|---|
| **Preferred self-administered options**<br>Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Non-preferred self-administered options**<br>Refer to ArrayRx. | Refer to coverage policies administered by ArrayRx. |
| **Infliximab products** | Refer to Medication Policy Manual, Products with Therapeutically Equivalent Biosimilars/Reference Products, dru620.<br>**Preferred**<br>• Avsola (infliximab-axxq)<br>• Inflectra (infliximab-dyyb)<br>**Non-preferred**<br>• Infliximab (unbranded Janssen product)<br>• Ixifi (infliximab-qbtx)<br>• Remicade (infliximab)<br>• Renflexis (infliximab-abda) |
| **Other provider-administered options** | None |

**a.** A diagnosis of pyoderma gangrenosum or sarcoidosis has been established by or in consultation with a specialist in pulmonology, rheumatology, immunology, or other specialist for the disease state.

**AND**

**b.** Treatment with a conventional immunomodulator (e.g., methotrexate, azathioprine, cyclosporine, hydroxychloroquine, leflunomide, or mycophenolate) was ineffective, or not tolerated. (See *Appendix 2* for additional conventional agents.)

## IV. Administration, Quantity Limitations, and Authorization Periods

**A.** Pharmacy Services considers medications in this policy to be self-administered, provider-administered, or both, as listed in *Table 1*.

**B.** When pre-authorization is approved, each drug may be covered in the following quantities and for the following authorization periods outlined in *Table 2*.

**C.** Unless specifically noted in *Table 2*, authorization **may** be reviewed at least annually to confirm that current medical necessity criteria are met and that the medication is effective, with documented disease stability or improvement.

**Table 1: Administration**

| Drug | Route | Pharmacy Services Benefit Coverage |
|---|---|---|
| Intravenously (IV) administered medications | IV | Coverable only under the medical benefit (as a provider-administered medication). |
| Subcutaneous (SC) medications *(exceptions below)* | SC | Coverable only under the pharmacy benefit (as a self-administered medication). |
| *Exceptions* | | |
| Cimzia (certolizumab) lyophilized powder formulation | SC | Coverable only under the medical benefit (as a provider-administered medication). |
| Ilumya (tildrakizumab-asmn) prefilled syringes | SC | Coverable only under the medical benefit (as a provider-administered medication). |
| Skyrizi (risankizumab) prefilled syringes and prefilled pens | SC | Coverable under the pharmacy benefit (as self-administered medications) OR coverable under the medical benefit (as provider-administered medications). |
| Spevigo (spesolimab-sbzo) | SC | Coverable only under the medical benefit (as a provider-administered medication) for GPP **loading dose only** OR coverable under the pharmacy benefit (as a self-administered medication) for GPP **maintenance only**. |
| Stelara, Ustekinumab (unbranded Janssen product), and biosimilars Imuldosa, Otulfi, Pyzchiva, Selarsdi, Starjemza, Steqeyma, Ustekinumab-srlf (unbranded), Ustekinumab-stba (unbranded), Wezlana, Yesintek (ustekinumab) | SC | Coverable under the pharmacy benefit (as a self-administered medication) OR coverable under the medical benefit (as a provider-administered medication). |

**Table 2: Authorization Limits**

| Product | Route | Authorization Limit |
|---|---|---|
| Actemra and biosimilars Avtozma, Tofidence, Tyenne (tocilizumab) | IV | **AMR**: Up to 7 infusions (up to 8 mg/kg with an 800 mg per infusion maximum) in a 6-month period based on a recommended infusion interval of every 4 weeks. Authorization **shall** be reviewed at least every 6 months to confirm that current medical necessity criteria are met, and the medication is effective.<br><br>**RA, Takayasu arteritis**: Up to 13 infusions (up to 8 mg/kg) in a 12-month period based on a recommended infusion interval of every 4 weeks.<br><br>**PJIA**: Up to 13 infusions (up to 10 mg/kg) in a 12-month period based on a recommended infusion interval of every 4 weeks.<br><br>**GCA**: Up to 13 infusions (up to 6 mg/kg) in a 12-month period based on a recommended infusion interval of every 4 weeks.<br><br>**SJIA**: Up to 26 infusions (up to 12 mg/kg) in a 12-month period based on a recommended infusion interval of every 2 weeks.<br><br>**CRS**: Up to 4 infusions (up to 12 mg/kg). No additional doses will be authorized. |
| Cimzia (certolizumab) | SC<br>(vial only) | **CD, RA, PsA, AS, NR-axSpA**: Up to 3 doses (six 200 mg vials) in the first month based on an initial dose of 400 mg SC at weeks 0, 2, and 4 followed by 200 mg every two weeks or 400 mg every four weeks for maintenance. (27 doses in the first 12-month period followed by up to 26 doses per 12-month period, thereafter).<br><br>**PJIA (≥20 kg to <40 kg weight)**: Up to 3 doses (six 200 mg vials) in the first month based on an initial dose of 200 at weeks 0, 2, and 4 followed by 100 mg every two weeks (27 doses in the first 12-month period followed by up to 26 doses per 12-month period, thereafter). **Note**: There is no dosage form for Cimzia that allows for patient self-administration for doses below 200 mg.<br><br>**PJIA (10 kg to 20 kg weight)**: Up to 3 vials in the first month based on an initial dose of 100 mg at weeks 0, 2, and 4 followed by 50 mg every two weeks (27 doses in the first 12-month period followed by up to 26 doses per 12-month period, thereafter). **Note:** doses less than 200 mg require administration by a health care professional using the vial kit.<br><br>**PsO**: Up to 400 mg (two 200 mg vials) every other week (up to 26 doses per 12-month period).<br><br>Note: Certolizumab is available in pre-filled syringes and as a lyophilized powder vial (for SC injection). Both forms are given subcutaneously; however, only the vials are considered provider-administered. |
| Cosentyx (secukinumab) | IV | **AS, NR-axSpA, PsA**: Up to 13 infusions (with loading dose: 6 mg/kg at week 0, followed by 1.75 mg/kg every 4 weeks thereafter; without loading dose: 1.75 mg/kg every 4 weeks; both dosing regimens with a maximum maintenance dose 300 mg per infusion). |

| Product | Route | Authorization Limit |
|---|---|---|
| Entyvio (vedolizumab) | IV | **CD, UC**: Up to 6 doses (six 300 mg infusions) in a 6-month period based on a recommended starting interval of 300 mg infusions at zero, two and six weeks, then every eight weeks thereafter (9 infusions in the first 12-month period followed by up to 7 infusions per 12-month period, thereafter).<br><br>Dose escalation: A dosing interval of every 4 weeks (up to 13 infusions per 12-month period) may be considered medically necessary in patients who have had an inadequate response to every 8-week dosing given for at least 24 weeks. Dosing more frequent than every 4 weeks is considered investigational (see Table 4 *Investigational Uses: Dosing or Dose Escalation* for more information)**.** |
| | IV | **Immune-mediated colitis**: Up to 6 doses (six 300 mg infusions) in a 6-month period based on a recommended starting interval of 300 mg infusions at zero, two and six weeks, then every eight weeks thereafter. |
| Ilumya (tildrakizumab -asmn) | SC | **PsO**: Up to two doses (two 100 mg syringes) in the initial four-week period followed by one dose (one 100 mg syringes) every 12 weeks thereafter based on an initial dose of 100 mg at weeks 0 and 4 followed by maintenance dosing of 100 mg every 12 weeks (up to five 100 mg syringes in the first 12-month period followed by four 100 mg syringes per 12-month period thereafter).<br>Higher dosing is considered not medically necessary [see *Table 3 Not Medically Necessary Uses*, for more information]. |
| Omvoh (mirikizumab) | IV induction | **CD**: Up to 3 doses (three 900 mg infusions) in the first 8-week period based on a recommended starting interval of 900 mg infusions at 0, 4, and 8 weeks.<br><br>**UC**: Up to 3 doses (three 300 mg infusions) in the first 8-week period based on a recommended starting interval of 300 mg infusions at 0, 4, and 8 weeks. |
| Orencia (abatacept) | IV | **aGVHD**: Up to 4 infusions (up to 10 mg/kg) in a 4-week period based on a dose of 10 mg/kg/ dose given on days −1, +5, +14, and +28 post-transplant.<br><br>**RA, PJIA, PsA**: Up to 3 infusions (up to 1000 mg) in the first 4-week period, based on weight-based loading doses at weeks 0, 2 and 4, followed by maintenance dosing of up to 13 infusions in a 12-month period, based on a dose of one infusion (up to 1000 mg) every 4 weeks (14 infusions in the first 12-month period followed by up to 13 infusions per 12-month period, thereafter).<br><br>**RA**: A single IV loading dose (up to 1000 mg) may be authorized, if required prior to administration of self-administered Orencia SC. |

| Product | Route | Authorization Limit |
|---|---|---|
| Simponi Aria (golimumab) | IV | **AS, PsA, RA**: Up to 2 infusions (up to 2 mg/kg) in the first 4-week period, based on weight-based loading doses at weeks 0 and 4, followed by maintenance dosing of up to 7 infusions in a 12-month period, based on a dose of one infusion (up to 2 mg/kg) every 8 weeks (8 infusions in the first 12-month period followed by up to 7 infusions per 12-month period, thereafter).<br><br>**PJIA**: Up to 2 infusions (up to 80 mg/m$^2$) in the first 4-week period, based on body-surface-area-based loading doses at weeks 0 and 4, followed by maintenance dosing of up to 7 infusions in a 12-month period, based on a dose of one infusion (up to 80 mg/m$^2$) every 8 weeks (8 infusions in the first 12-month period followed by up to 7 infusions per 12-month period, thereafter).<br><br>Dose escalation: Dosing interval of up to every 6 weeks may be considered medically necessary in patients who have had an inadequate response to every 8-week dosing given for at least 24 weeks. |
| Spevigo (spesolimab) | IV | **GPP flare**: Up to two 900 mg infusions given within a 4-week approval period, based on a single dose of 900 mg. A second additional 900 mg dose, given one week after the initial dose, may be given once if symptoms persist, within the 4-week approval period. *NOTE: no more than two doses are coverable for any one flare.*<br><br>For consideration of treatment of a new flare (after at least 4 weeks): Authorization **shall** be reviewed to confirm that current medical necessity criteria are met, including flare criteria, and that the medication was effective for the previously treated flare. Each additional flare authorization is for a maximum of two 900 mg doses over a 4-week approval period. |
| | SC | **GPP maintenance when not experiencing a flare (loading dose only)**: A single 600 mg SC loading dose (four 150 mg prefilled syringes or two 300 mg prefilled syringes) may be authorized, if required prior to administration of self-administered Spevigo SC. |
| Skyrizi (risankizumab) | SC (PsA, PsO) | **PsA, PsO**: Up to 2 doses (four 75 mg syringes or two 150 mg syringes) in the initial four-week period followed by 150 mg (two 75 mg syringes or one 150 mg syringe) every 12 weeks based on dosing of 150 mg SC at weeks 0 and 4 followed by maintenance dosing of 150 mg every 12 weeks (up to twelve 75 mg syringes or six 150 mg syringes in the first 12-month period followed by up to ten 75 mg syringes or five 150 mg syringes per 12-month period, thereafter). |
| | Induction | **CD**: Up to 3 doses (three 600 mg infusions) in the first-8-week period based on a recommended starting interval of 600 mg infusions at zero, four, and 8 weeks, then up to 6 (six 180 mg or 360 mg cartridges; OR six 180 mg syringes) in the first 12-month period based on a maintenance dose of 180 mg or 360 mg given at week 12 and every 8 weeks thereafter.<br><br>**UC**: Up to 3 doses (1,200 mg infusions) in the first 8-week period based on a recommended starting interval of 1200 mg infusions at zero, four, and 8 weeks, then up to 6 (six 180 mg or 360 mg cartridges; OR six 180 mg syringes) in the first 12-month period based on a maintenance dose of 180 mg or 360 mg given at week 12 and every 8 weeks thereafter). |
| | SC maintenance dosing | **CD, UC**: Up to 7 doses (seven 180 mg or 360 mg cartridges; OR seven 180 mg syringes) per 12- month period based on maintenance dosing of 180 mg or 360 mg SC every 8 weeks. |

<table>
<tr><th>Product</th><th>Route</th><th>Authorization Limit</th></tr>
<tr><td rowspan="3">Stelara, Ustekinumab (unbranded Janssen product), and biosimilars Imuldosa, Otulfi, Pyzchiva, Selarsdi, Starjemza, Steqeyma, Ustekinumab-srlf (unbranded), Ustekinumab-stba (unbranded), Wezlana, Yesintek (ustekinumab)</td><td>SC</td><td>PsO, PsA: For all patients, regardless of weight, up to five doses (five 45 mg syringes or vials) in a 48-week period based on dosing of 45 mg at week 0 and 4, then 45 mg every 12 weeks thereafter (up to five 45 mg syringes or vials in the first 12-month period followed by four 45 mg syringes or vials per 12-month period thereafter).<br>Dose escalation: For patients in whom the 45 mg dose has shown benefit, but who have not achieved clinical remission after at least a 12-week trial, doses of up to 90 mg every 12 weeks may be considered medically necessary. Dosing more frequent than 90 mg every 12 weeks is considered investigational (see Table 4 Investigational Uses: Dosing or Dose Escalation for more information).</td></tr>
<tr><td>IV induction</td><td>CD, UC: Initial: A single, weight-based IV infusion initially (vials, see chart below for details), then up to 6 doses (six 90 mg syringes or twelve 45 mg vials) based on maintenance dosing of 90 mg SC every 8 weeks. Initial IV dosing is as follows:
<table>
<tr><th>Weight</th><th>Dose</th></tr>
<tr><td>55 kg or less</td><td>260 mg (2 x 130 mg vial)</td></tr>
<tr><td>More than 55 kg to 85 kg</td><td>390 mg (3 x 130 mg vial)</td></tr>
<tr><td>More than 85 kg</td><td>520 mg (4 x 130 mg vial)</td></tr>
</table>
Additional IV induction courses doses may be considered medically necessary in patients who have previously had an inadequate response to every 8-week dosing given for at least 24 weeks or who have had a break in therapy.</td></tr>
<tr><td>SC maintenance</td><td>CD: Up to 7 doses (seven 90 mg syringes or fourteen 45 mg vials) in a one-year based on maintenance dosing of 90 mg SC every 8 weeks.<br><br>Dose escalation/re-induction: A dosing interval of up to every 4 weeks be or additional IV doses may be considered medically necessary in patients who have had an inadequate response to every 8-week dosing given for at least 24 weeks.</td></tr>
<tr><td>Tremfya (guselkumab)</td><td>IV induction</td><td>CD, UC: Up to 3 doses (200mg infusions) within an 8-week period based on a recommended starting interval of 200 mg at weeks 0, 4, and 8. Induction to be followed by the recommended SC maintenance doses up to FDA-recommended dose, duration, and frequency limits described in its prescribing information.</td></tr>
</table>

aGVHD: Acute graft versus host disease; AMR: Antibody mediated rejection; AS: Ankylosing spondyloarthritis, CD: Crohn's disease, CRS: Cytokine release syndrome, ERA: Enthesitis-related arthritis; GCA: Giant cell arteritis; PJIA: Polyarticular juvenile idiopathic arthritis, NR-axSpA: Non-radiographic axial spondyloarthritis, PsA: Psoriatic arthritis, PsO: Plaque psoriasis, RA: Rheumatoid arthritis, SJIA: Systemic juvenile idiopathic arthritis; SpA: Spondyloarthritis, UC: Ulcerative colitis

## V. Not Medically Necessary Uses

**A.** Therapies included in this policy are considered not medically necessary (NMN) when used according to *Table 3*.

**Table 3: Not Medically Necessary Uses**

| Medication | NMN Use | Description |
|---|---|---|
| Cimzia (certolizumab pegol) | Provider-administered doses ≥200 mg for PJIA | In patients ≥40 kg with PJIA, the loading dose is 400 mg at week 0, 2, and 4 with a maintenance dose of 200 mg every 2 weeks. Cimzia (certolizumab pegol) is available in a prefilled syringe for self-administration for doses 200 mg or greater. |
| Ilumya (tildrakizumab-asmn) | Doses > 100 mg every 12 weeks | Ilumya (tildrakizumab-asmn) is considered not medically necessary when used in doses exceeding 100 mg every 12 weeks.<br>- Ilumya (tildrakizumab-asmn) is FDA approved for PsO at a dose of 100 mg subcutaneously every 12 weeks. While clinical trials of Ilumya (tildrakizumab-asmn) in PsO evaluated doses 100 mg and 200 mg subcutaneously every 12 weeks, both doses appeared to have similar efficacy. Therefore, the use of doses higher than 100 mg every 12 weeks is considered not medically necessary. [1] |
| Stelara, Ustekinumab (unbranded Janssen product), and biosimilars Imuldosa, Otulfi, Pyzchiva, Selarsdi, Starjemza, Steqeyma, Ustekinumab-srlf (unbranded), Ustekinumab-stba (unbranded), Wezlana, Yesintek (ustekinumab) | Initial doses of 90 mg for PsO/PsA | Ustekinumab is considered not medically necessary at initial doses of 90 mg per every 12 weeks regardless of weight.<br>- Given that more than half of all patients respond to the 45 mg dose and given the significant cost difference between the 45 mg and 90 mg doses, a trial of 45 mg for all patients regardless of weight represents the best treatment value for PsO/PsA.<br>- Note: For patients in whom the 45 mg dose has shown benefit, but who have not achieved clinical remission after at least a 12-week trial, doses of up to 90 mg every 12 weeks may be considered medically necessary.<br>- Dosing for ustekinumab was established through a post-hoc analysis of the results of the Phoenix 1 and Phoenix 2 trials. The recommended weight-based dosing scheme was not studied in a prospective manner. [2 3] Patients greater than 100 kg were found to have on average, a better response to treatment when receiving a dose of 90 mg every 12 weeks compared with 45 mg every 12 weeks.<br>* In Phoenix 1, 68.5% and 54.0% of patients greater than 100 kg achieved PASI75 in the 90 mg and 45 mg groups, respectively.<br>* In Phoenix 2, 71.1% and 49.1% of patients greater than 100 kg achieved PASI75 in the 90 mg and 45 mg groups, respectively.<br>* When treatment with 45 mg has resulted in some benefit, but has not achieved clinical remission, a continuation of treatment with 90 mg may be appropriate.<br>- There is no evidence to support the need for re-induction when the dose is escalated from 45 mg to 90 mg is made. |

## VI. Investigational Uses

**A.** Combination use of targeted DMARDs.

**B.** Unless otherwise specified in Section I, therapies included in this policy are considered investigational when used for all other conditions, due to lack of published data, lack of high-quality data, or lack of positive data details of select Investigational Uses are listed below in *Tables 4* and *5*.

**C.** Unless specified in the Administration, Quantity Limitations, and Authorization Periods or Not Medically Necessary Uses, all dose escalations above the quantity limit (additional details are in *Table 5*).

**Table 4: Investigational Uses – Indications**

| | |
|---|---|
| Blau's syndrome (familial juvenile systemic granulomatosis) | - There is no reliable evidence to establish the efficacy or safety of targeted DMARDs in the treatment of Blau's syndrome.<br>- No randomized, controlled trials have been published evaluating the use of adalimumab in patients with Blau's syndrome. |
| Extraintestinal complications of IBD: Arthritis | - Arthritis is a common extraintestinal complication of IBD (either UC or CD). However, there is no reliable evidence to establish the efficacy or safety of targeted DMARDs in patients with arthritis associated with IBD who do not otherwise require targeted therapy.<br>- The evidence is limited to small, short-term, open-label trials and case studies with infliximab. Given the lack of blinding and lack of control arm, the incremental benefit of infliximab therapy is uncertain. [4]<br>- There are no reliable published clinical trials with any other targeted DMARDs for treatment of arthritis associated with IBD (in the absence of active bowel disease).<br>- Of note: Patients with IBD and a confirmed diagnosis of CD or UC with active bowel disease may be covered per Section I for management of IBD symptoms (active bowel disease). However, isolated arthritis symptoms (in the absence of active bowel disease) are not coverable. |
| Graft versus host disease (GVHD) | - Except as noted in the coverage criteria, there is no reliable evidence to establish the efficacy or safety of targeted DMARDs in the *treatment* of GVHD.<br>- In one open-label clinical trial (N=62) incidences of GVHD-related mortality, non-relapse mortality, and overall survival were not different between patients treated with infliximab or placebo. [5] |
| Granuloma annulare | - There is no reliable evidence to establish the efficacy or safety of targeted DMARDs in the treatment of granuloma annulare.<br>- While case reports have been published describing the treatment of granuloma annulare with etanercept, other reports have been published describing no effect, or an association with the formation of granuloma annulare and treatment with TNF-alfa inhibitors, including etanercept. Additional information is necessary to the benefit of etanercept in this population. [6] |
| Guttate psoriasis | - Guttate psoriasis is a type of cutaneous psoriasis. It is characterized by the presence of small, erythematous papules whereas plaque psoriasis is |

| | |
|---|---|
| | characterized itchy, red, scaly, raised lesions on the skin. Guttate psoriasis is typically managed with topical agents or UV light therapy.<br>- There is no evidence to establish the efficacy or safety of targeted DMARDs in the treatment of guttate psoriasis. |
| Immune-mediated reactions (other than colitis or CRS with CAR-T cell therapy) due to immunotherapy | - Except as noted in the coverage criteria, there is no reliable evidence to establish the efficacy of safety of targeted DMARDs in the treatment of immune-mediated reactions, including but not limited to pneumonitis, hepatitis, or arthritis, due to PD-1, PDL-1, or CTLA4 inhibitors.<br>- PD-1, PDL-1, and CTLA4 inhibitors contain warnings for immune-mediated hepatitis. In clinical trials, patients who experienced immune-mediated hepatitis were managed with systemic corticosteroids and mycophenolate.<br>- For immune-mediated hepatitis, NCCN guidelines state that mycophenolate is recommended instead of infliximab due to the concern for hepatotoxicity with infliximab. |
| Reactive arthritis/Reiter's syndrome | - There is no reliable evidence to establish the efficacy or safety of targeted DMARDs in the treatment of reactive arthritis/Reiter's syndrome. |
| Sciatica | - There is no reliable evidence to establish the efficacy or safety of targeted DMARDs in the treatment of sciatica.<br>- Evidence for infliximab in the treatment of sciatica is limited to a randomized controlled trial in 40 patients. At 52 weeks, 67% of patients who received infliximab reported no pain compared with 63% of patients who received placebo ($p = 0.72$). This difference was not statistically significant. [7 8]<br>- There are no randomized controlled trials that evaluate the efficacy and safety of a commercially available formulation of etanercept in the treatment of sciatica.<br>- Evidence for adalimumab in the treatment of sciatica is limited to a small randomized, controlled trial evaluated adalimumab in 61 patients. There was a modest improvement in pain as measured by a 10-point visual analog scale and at three years, the need for back surgery was reduced in adalimumab-treated patients; however, larger clinical trials are needed to confirm the benefit of adalimumab in this population. [9 10] |
| Scleroderma | - There is insufficient evidence to support the use of tocilizumab for scleroderma. The evidence is limited to one small, placebo-controlled, phase 2 trial using subcutaneous tocilizumab (N=88). The trial found a change in modified Rodan skin score, but no significant difference in skin thickening, disability, fatigue, itching, or patient or clinician global disease severity. Larger phase 3 trials are needed to establish the safety and efficacy of tocilizumab for scleroderma. [11] |
| Sjögren's syndrome | - There is no reliable evidence to establish the efficacy or safety of targeted DMARDs in the treatment of Sjögren's syndrome.<br>- Evidence for etanercept in Sjögren's syndrome is limited a small trial, in which there were no significant differences in the subjective measures of disease severity. [12]<br>- Evidence for anakinra is limited to a placebo-controlled trial in which patients |

| | |
|---|---|
| | with Sjögren's syndrome failed to find a statistically significant improvement in fatigue as measured by a visual analog scale in patient receiving anakinra compared with placebo. An ad-hoc analysis found suggestions of a clinically relevant effect, but larger, well-designed trials are needed to establish safety and efficacy for Sjögren's syndrome. [13] |
| Systemic lupus erythematous (SLE) | - There is no reliable evidence to establish the efficacy or safety of targeted DMARDs in the treatment of SLE.<br>- A small uncontrolled clinical trial reported modest efficacy with infliximab in patients with systemic lupus erythematosus, though larger, better designed trials are needed to confirm these results. [14]<br>- A small preliminary study assessing the use of tocilizumab in patients with SLE found promising signs of response, but larger, controlled studies will be needed to establish the efficacy and safety in this population. [15]<br>- One small randomized, placebo-controlled trial evaluated the use of abatacept in patients with non–life-threatening SLE and polyarthritis. The primary endpoint (proportion of patients with a new flare of SLE) was not met but was suggestive of a positive effect in certain exploratory measures. Further study is needed to establish the safety and efficacy of abatacept in SLE. [16]<br>- One 24-week, phase 2 study evaluated the use of baricitinib in patients with SLE. Results demonstrated that baricitinib 4 mg once may reduce SLE disease activity; however, results for the 2 mg dose were not significant. Larger, longer-term studies are needed to clarify the benefit of baricitinib in SLE. [17] |
| Wegener's granulomatosis | - There is no reliable evidence to establish the efficacy or safety of targeted DMARDs in the treatment of Wegener's granulomatosis.<br>- Evidence for infliximab is limited to one small clinical trial in 17 patients. Both infliximab and rituximab appeared to provide benefit in achieving complete or partial response; however, there was a trend favoring rituximab. Additionally, rituximab was better able to maintain remission during the long-term follow-up. [18] |

**Table 5: Investigational Uses – Dosing or Dose Escalation**

| | |
|---|---|
| Combination use of targeted immunomodulators | - Combination use of targeted DMARD therapy, such as adalimumab) Otezla/Otezla XR (apremilast), Xeljanz/Xeljanz XR (tofacitinib), or Entyvio (vedolizumab), is considered investigational (includes all medications included in this policy).<br><br>*Combination use of apremilast and other targeted immunomodulators*<br>- There is no reliable evidence to establish the efficacy or safety of the combined use of apremilast and other targeted DMARDs (such as biologics) in the treatment of PsO or PsA.<br>- There are no randomized, controlled trials evaluating the combined use of apremilast and any other targeted DMARD. The evidence is limited to retrospective studies in small numbers of patients. Additional studies are needed to establish long-term efficacy and the overall risk-benefit profile of combination use. |
| Secukinumab – Maintenance doses higher than 300 mg every 4 weeks for PsA or PsO | - There is insufficient evidence to support the use of secukinumab at maintenance doses higher than 300 mg every 4 weeks for PsO.<br>- Phase 3 clinical trials of secukinumab for PsA and PsO evaluated maintenance dosing regimens of 150 mg or 300 mg every 4 weeks. Higher or more frequent doses have not been evaluated. It is uncertain if there is any additional benefit with increased dosing and the safety profile has not been evaluated. |
| Ustekinumab – Doses higher than 90 mg every 12 weeks for PsO or PsA | - There is insufficient evidence to support the use of ustekinumab at maintenance doses higher than 90 mg every 12 weeks for PsO or PsA.<br>- There are no randomized, controlled trials to support doses higher than 90 mg every 12 weeks in PsO or PsA. |
| Vedolizumab - Doses higher than 300 mg every 4 weeks | - There is insufficient evidence to support the use of vedolizumab at maintenance doses higher than 300 mg every 4 weeks for CD and UC.<br>- In phase 3 clinical studies of vedolizumab in CD and UC the highest dose of vedolizumab used was 300 mg every four weeks. Higher or more frequent doses have not been evaluated. |

**Position Statement**

- ArrayRx's preferred self-administered products can be found at: UMP (ArrayRx) Preferred Drug List (PDL) 2026.
- There are many treatments for chronic inflammatory conditions that are effective, have known long-term safety profiles, and are recommended by national treatment guidelines.
- FDA-approved biosimilar medications are not meaningfully different clinically than their reference products (i.e., therapeutically equivalent). Although small differences in clinically inactive portions of the molecule may exist, the FDA approval certifies that the manufacturer has shown their product to be identical in function. There is no scientific basis to prefer one FDA-approved product over another (reference product or biosimilar). Given similar efficacy and safety, most contracts consider more costly products not medically necessary.
- The intent of this policy is to allow coverage of each medication in settings where it has been safe and effective, with coverage after use of lower cost standard of care therapies, including preferred targeted DMARD options.
- Non-medical therapies, such as prescribed exercise therapy, physical therapy, weight loss, and smoking cessation are important treatment plan components for patients suffering from many chronic inflammatory conditions.
- When a systemic medication therapy is needed to manage a chronic inflammatory condition, generic oral therapies usually offer the best value.
- When non-medical therapies and oral medications are inadequate, a targeted DMARD or immunomodulator [conventional synthetic DMARD (csDMARD)] may be appropriate and use is supported by guidelines. Targeted DMARDs, include non-biologics and biologics. Biologics include both anti-TNF and non-anti-TNF options.
- When there is no demonstrated difference in safety or efficacy among the studied targeted DMARDs, the medication with the lowest cost often provides the best value for members.
- Individual responses and tolerability of targeted DMARDs, including biologics, are unpredictable and may vary between patients. If one targeted DMARD provides an inadequate response, another targeted DMARD may yet be effective.
- Due to the potential for development of antibodies with anti-TNF therapies which may result in loss of efficacy, clinical practice guidelines generally recommend a trial with one to two anti-TNF therapies. [19-23] For those who have an inadequate response or intolerance to a TNF inhibitor, it is reasonable to consider a targeted treatment with an alternative mechanism of action and proven efficacy for the patient's diagnosis.
- All DMARDs, conventional and targeted, are immunosuppressants and carry a risk of increased infection. Risk and infection type varies by mechanism of action and medication.
- 2021 JAK inhibitors label updates placed their usage after other systemic therapies for the indications in which they have FDA approval due to safety concerns (which include major cardiovascular events and mortality among other concerns).
- There is significant variation in recommended dosing across indications for individual

medications, particularly with targeted agents; therefore, when multiple dosage forms of a targeted agent are available, coverage can be provided for those indications where the dosage form has been evaluated in randomized controlled trials, the dosage form has been proven safe and effective, and for which the dosage form has an established dose. For all other indications, the specific dosage form will be considered investigational.

- The medications in this policy, including loading doses, are coverable for the lowest effective doses, aligned with how they were studied in clinical trials, including use of loading doses.

**Evidence Summary**

***Rheumatic, Skin, and Gastrointestinal Conditions***

**Rheumatic Conditions – Background**

- Treatments for rheumatic conditions may include non-medical therapies, medications for the management of symptoms, medications that modify the disease course such as conventional synthetic or targeted disease modifying anti-rheumatic drugs (DMARDs).
- Medications to control inflammation such as nonsteroidal anti-inflammatory medications (NSAIDs, e.g., ibuprofen, indomethacin, and naproxen) and glucocorticoids (oral or injected into the joint) are effective for the management of symptoms, particularly during the early stages of disease.
- Generic, conventional synthetic DMARDs (csDMARDs), including methotrexate (MTX), hydroxychloroquine, leflunomide, and sulfasalazine are effective for decreasing symptoms and slowing disease progression, and are recommended by current guidelines.
    * MTX is generally the initial csDMARD for rheumatoid arthritis (RA) and juvenile idiopathic arthritis (JIA).
    * csDMARDs have known risks. The management of these risks is well established.
- Targeted DMARDs can also decrease symptoms, help preserve joint function, and slow the progression of the disease.
- In JIA, combination therapy with a csDMARD is strongly recommended for infliximab to reduce the risk of anti-drug antibodies against infliximab. [24]

**Rheumatic Conditions – Enthesitis-Related Arthritis (ERA)**

- ERA is a type of juvenile idiopathic arthritis (JIA) that causes swelling or inflammation of the entheses (tendon-to-bone insertion sites).
- 2019 ACR guidelines for JIA recommend NSAIDs as initial therapy for patients with ERA followed by TNF inhibitors. Methotrexate or sulfasalazine may be used if TNF inhibitors are contraindicated. ACR guidelines have not been updated to include secukinumab. [25]
- There is little comparative evidence to distinguish among the biologic options for ERA due to the lack of head-to-head comparisons.

- The evidence for secukinumab in ERA is based on one small placebo-controlled phase 3 withdrawal trial that demonstrated a reduced time to disease flare for those on secukinumab versus placebo. [26]

**Rheumatic Conditions – Axial Spondyloarthritis (SpA)**

- SpA is a form of inflammatory arthritis that includes ankylosing spondylitis (AS) and non-radiographic axial spondylarthritis (nr-axSpA).
- Several targeted DMARDs have been shown to be effective in the treatment of AS or nr-axSpA.
- There is moderate quality evidence to support the use of targeted DMARDs, particularly TNF inhibitors, in non-radiographic axial SpA. Clinical trials have consistently shown that treatment with TNF inhibitors reduced disease activity in this population.
- 2019 ACR guidelines do not recommended any one TNF inhibitor over another except in patients who also have inflammatory bowel disease or iritis in which case adalimumab or infliximab would be recommended over etanercept. Cosentyx (secukinumab) and Taltz (ixekizumab) are recommended as second-line options in patients who have active symptoms without response to a previous TNF inhibitor. TNF inhibitors, secukinumab, or ixekizumab are recommended over tofacitinib in patients with AS. [27]
- Because of similar efficacy among the studied targeted DMARDs, non-preferred/non-formulary options are coverable when preferred/formulary options are ineffective, as detailed in the coverage criteria .

**Rheumatic Conditions – Polyarticular Juvenile Idiopathic Arthritis (PJIA); Juvenile Rheumatoid Arthritis (JRA)**

- Several targeted DMARDs (as listed in coverage criteria) have been shown to be effective in the treatment of JIA.
- 2019 ACR guidelines for JIA recommend methotrexate, leflunomide, or sulfasalazine as initial therapy for patients with JIA. Methotrexate is recommended over leflunomide and sulfasalazine due to a larger body of evidence. Biologic agents are recommended in patients who have disease activity despite treatment with methotrexate, sulfasalazine, or leflunomide or in patients with high disease activity or have disease in high-risk joints. [24]
- Combination therapy with a targeted DMARD and a csDMARD is recommended to prevent the formation of anti-drug antibodies.
- There is little comparative evidence to distinguish among the targeted options for JIA. Guidelines state that there are mostly equivalent data for safety and efficacy between the biologics and there is a lack of head-to-head comparisons between them.
- In patients who have had an inadequate response to a TNF inhibitor, switching to a non-TNF biologic is preferred over a second TNF inhibitor. However, a second TNF inhibitor may be appropriate if patients had a good response to the initial TNF inhibitor. [24]

**Rheumatic Conditions – Psoriatic Arthritis (PsA)**

- Several targeted DMARDs (as listed in coverage criteria) have been shown to be effective in the treatment of PsA.
- ACR Guidelines recommend TNF inhibitors as the first-line treatment for PsA. However, other mechanisms can be used in patients with contraindications to TNF inhibitors. The guidelines do not specify the use of any one TNF inhibitor over another. [28]
- In patients who have failed a TNF inhibitor, a second TNF inhibitor is recommend over switching to a different mechanism of action (e.g., an IL-12/23 inhibitor, biologic, IL-17 inhibitors, abatacept, or tofacitinib). However, a different mechanism of action may be used in cases of primary TNF inhibitor failure (no response) or a serious adverse event due to a TNF inhibitor. [28]
- Because of similar efficacy among the studied targeted DMARDs, non-preferred/non-formulary options are coverable when preferred/formulary options are ineffective, as detailed in the coverage criteria.

**Rheumatic Conditions – Rheumatoid Arthritis (RA)**

- Several targeted DMARDs (as listed in coverage criteria, as well as rituximab) have been shown to be effective in the treatment of RA.
- The efficacy of these targeted DMARDs in the treatment of RA is similar. Guidelines do not recommend one specific targeted DMARD. The initial choice of therapy includes biologic DMARDs (TNF inhibitors or a non-TNF biologic) or targeted synthetic DMARDs (e.g., JAK inhibitors). However, 2021 ACR guidelines have not accounted for recent drug safety communications regarding the risk of serious heart-related events with JAK inhibitors. [29 30]
- In patients who have had an inadequate response to targeted therapy, guidelines recommend switching to a targeted DMARD of a different class rather a different targeted DMARD of the same class. [29]
- Guidelines have recommendations for specific patient populations including non-TNF inhibitors over TNF inhibitors for patients with New York Heart Association (NYHA) class III or IV heart failure. This recommendation is based on the risk of worsening heart failure observed in RCTs of TNF inhibitors in patients with heart failure. [29]
- Because of similar efficacy among the studied targeted DMARDs, non-preferred/non-formulary options are coverable when preferred/formulary options are ineffective, as detailed in the coverage criteria.

**Rheumatic Conditions – Systemic Juvenile Idiopathic Arthritis (SJIA)**

- Several targeted agents (as listed in the coverage criteria) have been shown to be effective or are recommended by clinical practice guidelines in the treatment of SJIA. [20]
- Due to lack of high-quality data, the comparative efficacy for these agents in the treatment of SJIA is uncertain.
- The efficacy of these targeted DMARDs (as listed in the coverage criteria) in the

treatment of SJIA is similar. However, there is a significant difference in the cost between these treatment options. Therefore, the costlier treatment options are coverable only when the less costly options are ineffective.

**Rheumatic Conditions – Giant Cell Arteritis (GCA)**

- Data evaluating the use of biologic agents in the treatment of GCA is limited; however, there are few treatment options for this condition, which can result in serious complications.
- Subcutaneous tocilizumab in combination with prednisone has been shown to improve remission rates compared prednisone alone in patients with *newly diagnosed or relapsing* GCA. [31]
- Intravenous tocilizumab is approved for the treatment of GCA; evidence is based primarily on pharmacokinetic exposure data and extrapolation to the efficacy established for subcutaneous tocilizumab in patients with GCA. [32]
- Evidence for the use of TNF inhibitors is lacking, as several small trials have not shown benefit in the treatment of GCA.

**Skin Conditions – Chronic Plaque Psoriasis (PsO)**

- There are many treatments for PsO that are effective, have known long-term safety profiles, and are recommended by national treatment guidelines.
- Light therapy, including UVB and PUVA, is effective and safe, and PUVA may result in long-term remission. When patients are not able to receive office-administered light therapy, light units for home use may be an appropriate alternative (see Appendix 1 for absolute and relative contraindications for phototherapy/photochemotherapy).
- AAD guidelines (2019) recommend phototherapy after failure of first-line treatment (emollients, topical steroids, and topical calcineurin inhibitors). Most patients with mild-to-moderate psoriasis can achieve adequate control with topical medications or phototherapy.
- When systemic therapy is needed to manage psoriasis, csDMARDs often provide the best value. [33]
    * Conventional synthetic DMARDS (csDMARDs), including MTX, cyclosporine, and Soriatane (acitretin), have a proven track record and have been the standard of care for many years.
    * csDMARDs typically take effect with 6 weeks though some patients may require 12 weeks to have full effect. Among these options, cyclosporine is known to work rapidly.
    * Like all immunosuppressants, including targeted DMARDs, the csDMARDs have known risks. The management of these risks is well established.
- Targeted DMARD may be appropriate for patients with moderate to severe psoriasis (e.g., at least 10% BSA and/or significant pain or functional impairment due to the PsO or when conventional topical or oral therapies, or phototherapy have been inadequate.

- Several targeted DMARDs (as listed in the coverage criteria) have been shown to be effective in the treatment of moderate to severe PsO.
- Within each drug class, efficacy of each drug is similar. In general, medications directed against IL-17 (i.e., secukinumab) or IL-23 (i.e., guselkumab) are more effective at producing skin clearance than TNF inhibitors and other mechanisms of action. [33] Because of similar efficacy within each class, non-preferred/non-formulary options are coverable when preferred/formulary options are ineffective, as detailed in the coverage criteria.

**Skin Conditions – Generalized Pustular Psoriasis (GPP) [34-36]**

- GPP is a rare subtype of psoriasis. Flares are characterized by an abrupt onset of widespread painful pustules which can coalesce into larger, "lakes of pus" overlying painful erythema. Significant flares are often accompanied by systemic symptoms, notably fever, general malaise, and extracutaneous manifestations such as arthritis, uveitis, and neutrophilic cholangitis, and may be associated with life-threatening complications.
- Acute flares may be idiopathic or may be triggered by infection, withdrawal, or administration of certain medications (including those used in the treatment of GPP such as corticosteroids, methotrexate, or TNF inhibitors), pregnancy, or stress.
- Treatment guidelines recommend the identification and management of potential triggers.
- Choice of therapy depends on disease acuity. Acitretin and methotrexate are the preferred initial treatments for adults with relatively stable GPP due to their relatively slow onset of action. They can be used for long-term maintenance treatment.
- Cyclosporine and infliximab are used for more severe, acute GPP. Cyclosporine or infliximab are often considered first line for severe GPP due to their rapid onset of action. Once control of acute disease is achieved, patients may be maintained on fast-acting therapies or transitioned to acitretin or methotrexate for long-term treatment. There is no comparative data regarding relative efficacies of agents used for GPP.

**Skin Conditions – Hidradenitis Suppurativa (HS)**

- High-quality data evaluating the use of targeted DMARDs in the treatment of HS are limited; however, there are relatively few treatment options for this condition.
- Although adalimumab is FDA approved for the treatment of HS, infliximab also has data to support use in this indication. [37]
    * A high-quality systematic review showed that weekly-dosed adalimumab improved quality of life in HS compared to placebo; although, the effect size was approximately equal to what is considered a minimally clinically important difference.
    * In the same systematic review, infliximab also improved quality of life compared to placebo, with an effect size well above the threshold for a minimally clinically important difference.

- Trials of adalimumab, secukinumab, and bimekizumab in HS only included patients with more severe disease, defined as Hurley Stage II or III disease and with at least three abscesses or inflammatory nodules. All three showed improvement of HS response rate at 12 to 16 weeks. However, the safety beyond the trial duration has not been established for the newer treatment options, secukinumab and bimekizumab. [26 38-40]
- Additional long-term randomized controlled trials are needed to understand relative efficacy of other treatments, the safety associated with weekly-dosed adalimumab, and role of oral, non-biologic/non-targeted DMARD treatments for HS.
- Evidence-based guidelines for hidradenitis suppurativa are not available, primarily due to lack of data. However, standard of care therapy reviews suggest the following:
    * Patients may benefit from non-pharmacologic interventions such as good personal hygiene, smoking cessation, and weight-loss.
    * For mild to moderate HS, topical clindamycin and tetracyclines have a proven track record of safety and have been the standard of care.
    * When systemic therapy is needed to manage refractory hidradenitis suppurativa, oral therapies often provide the best value. Options include systemic antibiotics (e.g., oral tetracyclines, clindamycin, rifampin, moxifloxacin, metronidazole), hormonal therapies (e.g., oral contraceptives, spironolactone), cyclosporine, finasteride, metformin, or oral retinoids.

**Gastrointestinal Conditions – Background**

- There are many treatments for Crohn's disease (CD) and ulcerative colitis (UC) that are effective, have known long-term safety profiles, and are recommended by national treatment guidelines. [41 42]
- Lifestyle interventions, such as smoking cessation and diet modification, are important components of a comprehensive treatment plan for patients suffering from CD. [41]
- When medication therapy is needed to manage CD and UC, oral and topical (administered rectally) therapies often provide the best value. [41]
    * First-line therapies to induce remission include:
        - Patients with CD: Oral corticosteroids, budesonide, aminosalicylates (e.g., sulfasalazine or mesalamine). [41]
        - Patients with UC: Oral aminosalicylates (5ASAs, such as sulfasalazine), topical mesalamine or corticosteroids (e.g., budesonide), or oral corticosteroids, depending on the extent and location of disease.
        - Due to the potential for severe adverse effects, the use of conventional corticosteroids such as prednisone is generally reserved for patients with moderate-to-severe disease who failed to respond to first-line therapies. Use is generally limited to one to two weeks. [41]
        - Corticosteroids such as prednisone are effective in patients with both CD UC. Dosages in the range of 40 mg – 60 mg/day or 1 mg/kg/day of prednisone or equivalent are effective for induction of remission. [41]

    * Once maintenance is induced with corticosteroids, maintenance therapy with azathioprine, 6-mercaptopurine, or methotrexate should be initiated. Azathioprine, 6-mercaptopurine, or methotrexate are slow acting and can take 8 to 12 weeks to have full effect.
    * First-line therapies to maintain remission include:
        - Patients with CD: MTX, 6-mercaptopurine, and azathioprine.
        - Patients with UC: oral aminosalicylates (e.g., sulfasalazine), topical mesalamine or corticosteroids, or oral corticosteroids, depending on the extent and location of disease.
- When non-medical therapies and oral/topical therapies (steroids or csDMARDs) are inadequate, a targeted DMARD may be appropriate for induction and/or maintenance of disease remission.

**Gastrointestinal Conditions –Crohn's Disease (CD) and Ulcerative Colitis (UC)**

- There are many treatments for CD and UC that are effective, have known long-term safety profiles, and are recommended by national treatment guidelines.[41 42]
- Several targeted DMARDs (as listed in the coverage criteria) have been shown to be effective in the treatment of CD and/or UC, for inducing and maintaining remission compared to placebo.
- Due to a lack of head-to head comparative studies, the overall comparative efficacy for these targeted DMARDs in the treatment of CD is uncertain. There is also a lack of comparative evidence for treatment of UC. Therefore, non-preferred/non-formulary options are coverable when preferred/formulary options are ineffective, as detailed in the coverage criteria.
- Although studied in UC, there are no controlled trials of golimumab in CD. Likewise, although studied in CD, there are no controlled trials of certolizumab or natalizumab in UC.
- Restorative proctocolectomy with ileal pouch–anal anastomosis (IPAA) is routinely performed in patients with UC who undergo colectomy. Idiopathic inflammation of the pouch — referred to as pouchitis — is the most common long-term complication of IPAA. Retrospective, uncontrolled studies suggest that TNF antagonists, vedolizumab, or ustekinumab may be effective in the treatment of pouchitis that is refractory to antibiotics.[43]
- Safety considerations:
    * Due to an increased risk of mortality and thrombosis with tofacitinib 10 mg twice daily or tofacitinib 22 mg daily, tofacitinib is only indicated for patients who have previously had an inadequate response or intolerance to TNF inhibitors.
    * Use of tofacitinib 10 mg twice daily or tofacitinib 22 mg daily should be limited to the shortest duration, with consideration of the benefits and risks for the individual patient. The prescribing information states that the lowest effective dose needed to maintain response should be used.

*Guidelines:* [41 42 45]

- Lifestyle interventions, such as smoking cessation and diet modification, are important components of a comprehensive treatment plan for patients suffering from CD.
- When medication therapy is needed to manage CD and UC, oral and topical (administered rectally) therapies often provide the best value.
- First-line therapies to induce remission for CD/UC vary, based on severity and anatomic distribution, but may include:
    * Oral corticosteroids, "topical" steroids (enteric-coated budesonide), oral aminosalicylates (5ASAs, such as sulfasalazine or mesalamine). Steroids are used over csDMARDs for induction of remission in moderate to severe UC. Several product formulations are specific to anatomic location of the disease, such as enteric-coated (EC) budesonide or EC mesalamine, or rectal 5ASAs.
    * In addition, topical mesalamine may be used for UC, depending on the extent and location of disease.
    * The use of conventional corticosteroids, such as prednisone, is generally reserved for patients with moderate-to-severe CD/UC refractory to first-line therapies, given the adverse events. Use is generally limited to one to two weeks.
    * Corticosteroids, such as prednisone, (40 - 60 mg/day or 1 mg/kg/day), are effective for induction of remission for CD and UC.
- Once remission is induced with corticosteroids, maintenance csDMARD therapy should be initiated. Choice of therapy varies between CD and UC, as well as response to induction therapy(s). Antimetabolite csDMARDs [such as MTX (methotrexate), 6-MP (6-mercaptopurine), azathioprine)] are slow acting and can take 8 to 12 weeks to have full effect. They are also used to decrease immunogenicity in combination with targeted DMARDs.
- First-line therapies to maintain remission include:
    * CD: 6-mercaptopurine, azathioprine, and methotrexate.
    * UC: oral 5ASAs (e.g., sulfasalazine), topical mesalamine or corticosteroids, or oral corticosteroids, depending on the extent and location of disease.
- When non-medical therapies and oral/topical medications (steroids or aminosalicylates) are inadequate, a targeted DMARD may be appropriate for induction and/or maintenance of disease remission.
- Guidelines for CD list multiple targeted DMARDs as effective treatment options. [41]
    * TNF inhibitors, including infliximab and adalimumab, are recommended in patients who are resistant to corticosteroids or whose disease is refractory to csDMARDs such as azathioprine or 6-mercaptopurine.
    * Ustekinumab is an option for moderate-to-severe CD patients who failed previous treatment with corticosteroids, thiopurines, methotrexate, or anti-TNF inhibitors or who have had no prior exposure to anti-TNF inhibitors.
    * Vedolizumab is also listed as an effective option for the induction and maintenance of remission in CD.

    * Due to the risk of progressive multifocal leukoencephalopathy (PML), a serious (sometimes fatal) adverse event, natalizumab is only recommended after other treatment options have failed.
    * Patients with fistulizing disease and severely active disease may be candidates for initial targeted DMARD. Definitions for severe disease include the following previous hospitalization for Crohn's disease, extensive anatomic involvement, deep ulcers, prior surgical resection, stricturing and/or penetrating behavior.
- Clinical practice guidelines for the treatment of UC indicate that for patients who initially respond to infliximab but lose response, an increase in dose or shortening of the interval between infusions may improve the likelihood of successful treatment. These guidelines acknowledge that these strategies have not been evaluated in a controlled manner.
- Lack of response and loss of response to TNF inhibitors is common in both CD and UC. The choice of subsequent agent after failure of a TNF inhibitor is typically guided by serum levels. ACG guidelines state that, in patients with adequate serum levels of anti-TNF antibodies switching to another TNF is unlikely to be of benefit.

**Gastrointestinal conditions – Immune-mediated Colitis [i.e., Immune Checkpoint Inhibitor (ICI)-Mediated Colitis]**

- Serious or steroid-refractory colitis is a known adverse event associated with checkpoint inhibitors such as Yervoy (ipilimumab), Opdivo (nivolumab), Keytruda (pembrolizumab), Tecentriq (atezolizumab), Bavencio (avelumab), Libtayo (cemiplimab), and Imfinzi (durvalumab). NCCN guidelines recommend prednisone or methylprednisolone as the first-line treatment for moderate colitis. Infliximab may be considered if there has been no improvement within 2-3 days of initiating glucocorticoids. [46]
- Guidelines state that:[46]
    * The duration of therapy with TNF-inhibitors is not clearly defined but is usually a single dose..
    * Vedolizumab may be used in TNF-refractory ICI-mediated colitis, or as an alternative to infliximab.
- There is not an FDA approved dose for vedolizumab when used for immune-mediate colitis. However, a retrospective analysis identified that most patients required between one and four doses to achieve resolution.[47 48]
- There is interest in the use of other targeted DMARDs, such as tofacitinib or ustekinumab, in TNF- and vedolizumab-refractory ICI-mediated colitis. However, there is insufficient evidence to establish the safety or efficacy of tofacitinib or ustekinumab in ICI-medicated colitis. The available evidence for tofacitinib or ustekinumab is limited to case reports.[49 50]

**Gastrointestinal Conditions – Collagenous Colitis**

- The European Guidelines on Microscopic Colitis (including lymphocytic colitis and collagenous colitis) recommend budesonide as front line for both induction as well as maintenance in some cases. Evidence for use of second-line therapies in patients with

microscopic colitis is scarce and based primarily on case reports. Guidelines support the use of TNF inhibitors and vedolizumab for refractory microscopic colitis. TNF inhibitors, including infliximab and adalimumab, have been reported to induce remission. Vedolizumab has been associated with clinical remission based on case reports; almost all patients were refractory to prior TNF inhibitors; however, no randomized control trials have been published to date.[51]

### *Other Immunologic Conditions*

**Acute Graft Versus Host Disease (aGVHD)[52]**

- GVHD is a common complication of allogeneic hematopoietic cell transplant (HCT) that occurs when the graft (donor) cells identify the transplant recipient cells (host) as foreign and initiates an immune reaction that may lead to organ damage or death.
- The risk for GVHD is higher when receiving a HCT from an unrelated donor.
- There are no standard guidelines for prophylaxis of acute GVHD, protocols vary by transplant center. The choice of therapy may depend on the underlying disease, degree of HLA disparity, conditioning regimen, and patient characteristics. Several regimens include a calcineurin inhibitors (tacrolimus, cyclosporine) given with either methotrexate or mycophenolate mofetil. Post-transplantation with cyclophosphamide or T-cell depletion is also used.
- At 6 months post-transplant, abatacept was shown to increase acute GVHD free survival as well as improve overall survival when used for patients with 8/8 HLA matched or 7/8 HLA mismatched unrelated donor HCT when used in combination with a calcineurin inhibitor plus methotrexate. [53]

**Antibody Mediated Rejection of Transplant (Solid-Organ)[54 55]**

- Acute allograft (organ) rejection may be cellular (T-cell mediated) or humoral (antibody-mediated).
- Pre-treatment (desensitization) may reduce the risk of antibody-mediated rejection (AMR) in highly sensitized renal transplant patients.
- Acute humoral rejection (AHR) is also an AMR and can occur outside of the peri-operative period, but most commonly within 6 months after transplant. The diagnosis is confirmed by a renal biopsy.
- The goal of therapy is early antibody elimination with IVIG, pheresis, or a combination of modalities. However, evidence for therapies used in AMR are generally of low quality and protocols vary between transplant centers. Plasmapheresis (PLEX) and IVIG are generally regarded as a standard of care for acute active AMR. Rituximab has also been suggested as a treatment option by KDIGO guidelines. [54]
- One study assessed the use of tocilizumab as rescue therapy in 36 kidney transplant patients with chronic AMR who failed standard-of-care treatment with IVIG and rituximab, with or without plasma exchange. Tocilizumab was administered as 8 mg/kg monthly, with a maximal dose of 800 mg for 6 to 25 months. Graft- and patient- survival rates were 80% and 91% at six years post treatment, respectively.

- In a small pilot study (N=10), patients who did not respond to desensitization with IVIG and rituximab (+/- plasma exchange) who were given tocilizumab 8 mg/kg on day 15 then monthly for 6 months with IVIG had a decrease in donor specific antibodies. [56]

**Pyoderma Gangrenosum (PG)[57 58]**

- PG is a rare ulcerative skin condition that is often associated with underlying systemic disease.
- First-line options for PG typically are systemic corticosteroids, cyclosporine, or tacrolimus. Infliximab is considered a second-line option when there has been an inadequate response.
- Infliximab or other targeted DMARD therapy may use when there is an underlying inflammatory condition, such as ulcerative colitis. [57 58]

**Sarcoidosis**

- Sarcoidosis is a multisystem granulomatous disorder characterized by the presence of granulomas in involved organs. It most commonly impacts the lungs and lymph nodes but may manifest in other organs. [59]
- Corticosteroid therapy is the primary therapy. Second line agents are considered for patients with corticosteroid-refractory disease. Second-line options include csDMARDs such as azathioprine, methotrexate, and leflunomide. Biologic therapy with infliximab is reserved for patients who have not responded to prior conventional agents. [59 60]

**Takayasu Arteritis**

- Takayasu arteritis is a rare type of vasculitis where inflammation damages the aorta. Takayasu arteritis is complex and requires specialist management to accurately diagnosis and manage the condition.
- High dose corticosteroids in combination with csDMARDs are recommend as the initial treatment options. Targeted DMARD therapy with tocilizumab or infliximab is recommended as second-line options in patients with persistent symptoms despite combination therapy of corticosteroids with a csDMARD, as well as for in patients who are unable to taper off oral corticosteroids. [61]
- Tocilizumab has been evaluated at doses of 8 mg/kg intravenously every 4 weeks or 162 mg subcutaneously weekly. There is limited information on the efficacy of higher doses. [61-64]

**Uveitis**

- Corticosteroids are the mainstay of therapy in uveitis. Guidelines recommend a high dose course (prednisone 1 mg/kg/day or up to 60-80 mg per day) for up to one month.
- A csDMARD is recommended if there is no response, or worsening, after two to four weeks of steroids. American Academy of Ophthalmology (AAO) guidelines recommend

mycophenolate mofetil, azathioprine, methotrexate, cyclosporine, or tacrolimus. There is insufficient comparative evidence to conclude superiority of one csDMARD over another.

- Targeted DMARDs are recommended in patients who have had an inadequate response to corticosteroids and csDMARDs.
    * Adalimumab is FDA approved for uveitis and recommended as a treatment option in AAO guidelines. Adalimumab has been shown to lower flare rates and loss of visual acuity in two phase 3 RCTs in patients with active uveitis despite high-dose corticosteroids.
    * Infliximab is also a recommended treatment option for uveitis based on evidence from several comparative, open-label trials.

**Cryopyrin-Associated Periodic Syndromes (CAPS)/Neonatal-Onset Multisystem Inflammatory Disease (NOMID)**

- CAPS are a group of rare genetic diseases affecting approximately 200 to 300 people in the United States and are attributed to a specific genetic mutation. [65]
- Three types of CAPS affect the majority of patients: [65]
    * (NOMID – Urticaria-like rash, CNS involvement [papilledema, cerebrospinal fluid (CSF) pleocytosis, or sensorineural hearing loss], elevated C-reactive protein (CRP), or epiphyseal and/or patellar overgrowth on radiographs.
    * Familial Cold Auto-Inflammatory Syndrome (FCAS) – Recurrent intermittent episodes of fever and rash that primarily followed natural, artificial (e.g., air conditioning), or both types of generalized cold exposure.
    * Muckle-Wells Syndrome (MWS) – Syndrome of chronic fever and rash that may wax and wane in intensity and is sometimes exacerbated by generalized cold exposure. This syndrome may be associated with deafness or amyloidosis.
- Therapies that affect interleukin-1 (IL-1) may be helpful in controlling the symptoms of CAPS. [65]
    * Therapies that affect IL-1 include Kineret (anakinra), Arcalyst (rilonacept), and Ilaris (canakinumab), all of which have FDA marketing approval for one of more forms of CAPS. [66-68]
    * Due to the rarity of these conditions, it is difficult to conduct high-quality scientific studies.
- There have been no head-to-head trials comparing the efficacy of Kineret (anakinra), Arcalyst (rilonacept), or Ilaris (canakinumab) against each other or any other medication in the management of CAPS.
- The efficacy of Kineret (anakinra) was evaluated in a prospective, long-term, open-label and uncontrolled study in 43 patients with NOMID aged 0.7 to 46 years who were treated for up to 60 months. [66 69]
    * Treatment with Kineret (anakinra) resulted in improvements in all individual disease symptoms measured by a disease-specific Diary Symptom Sum Score (DSSS), as well as in the serum markers of inflammation.
    * For 11 patients who went through a withdrawal phase, disease symptoms and

serum markers of inflammation worsened after withdrawal and promptly responded to reinstitution of Kineret (anakinra) therapy.

**Cytokine Release Syndrome (CRS)** [32 70 71]

- Tocilizumab IV is FDA-approved for the treatment of CRS associated with the use of chimeric antigen receptor (CAR) T cell therapy, such as Kymriah (tisagenlecleucel) and Yescarta (axicabtagene ciloleucel). It is given as a one-time weight-based dose but up to three additional doses may be administered if there is no clinical improvement.
- Subcutaneous tocilizumab and sarilumab, another IL-6 inhibitor, have not been studied in cytokine release syndrome.
- Tocilizumab IV is used for management of CRS associated with initial doses of other T-cell therapies, such as bispecific T-cell engagers (BiTE) therapies), including but not limited to BiTE therapies for:
    * B-cell lymphoma [Columvi (glofitamab), Lunsumio (mosunetuzumab), Epkinly (epcoritamab)].
    * Multiple myeloma, Tecvayli (teclistamab-cqyv) and Elrexfio (elranatamab-bcmm).
    * Small cell lung cancer (SCLC), Imdelltra (tarlatamab-dlle).
    * B-cell precursor acute lymphoblastic leukemia (ALL), Blincyto (blinatumomab).
- Similar to use with CAR T therapy, use of tocilizumab IV is used as a one-time weight-based dose but up to three additional doses may be administered if there is no clinical improvement. Use beyond four doses is not coverable.

**Safety Considerations**

- In general, the overall safety profiles of targeted DMARDs for chronic inflammatory diseases is favorable. However, several have warnings related to infection risk and hypersensitivity reactions. [41 72-74] All are immunosuppressants and increase the risk of infection, though some drugs may increase the risk more than others.
- Certain products have unique safety concerns that should be factored into the overall risk-benefit profile.
- Oral JAK inhibitors (e.g., tofacitinib, upadacitinib, and baricitinib) contain a boxed warning for increased risk of serious infections, mortality, malignancies, major cardiovascular events, and thrombosis. In a post-marketing safety study, tofacitinib did not meet its primary endpoint of non-inferiority for risk of cardiovascular events and malignancy. Results showed that patients who received tofacitinib at either 5 mg or 10 mg twice daily had a higher rate of cardiovascular events and malignancy compared to patients who received a TNF inhibitor. Though the study only evaluated tofacitinib the warning has been extended to other JAK inhibitors used in the treatment of rheumatoid arthritis (RA) and other inflammatory diseases. [30 44 75-77]
    * The boxed warning is based on a safety study designed to evaluate the safety of tofacitinib relative to TNF inhibitors. The study included patients aged 50 or older with at least one CV risk factor and all patients received background

methotrexate. Patients were randomized to one of three groups: tofacitinib 5 mg twice daily, tofacitinib 10 mg twice daily, or a TNF inhibitor.

  * The study failed to meet its pre-specified safety endpoint of non-inferiority to TNF inhibitors for risk of cardiovascular events and malignancy.
  * The prescribing information for each JAK inhibitors has been updated to clarify that each JAK inhibitor is only indicated for to certain patients who have not responded or cannot tolerate one or more TNF blockers. [44]
  * The FDA continues to investigate these safety concerns and will provide updates as additional information becomes available.
  * The risks and benefits of JAK inhibitors in patients at risk for venous thromboembolism should be carefully considered when choosing treatment strategies.

- JAK1/2/3 inhibitors have boxed warnings describing an increased risk of thrombosis. Due to this risk, the use of JAK1/2/3 inhibitors is limited to patients who have failed prior treatment options.[30] There are several alternative targeted agents for the treatment of RA that do not carry a risk for VTE and have longer records of safety experience with comparable or better efficacy than baricitinib.
- While newer agents such as IL-23 inhibitors and IL-17 inhibitors, have demonstrated favorable risk-benefit profiles in clinical studies there is limited long-term safety experience. Additionally, there is limited evidence directly comparing to existing standards of care. [41 72-74]
- New or worsening heart failure is listed as a warning and precaution for TNF inhibitors. A clinical trial evaluating etanercept for the treatment of heart failure was terminated early due to lack of efficacy and suggested higher morality in etanercept-treated patients compared to placebo. Post-market, new or worsening heart failure have been reported with TNF inhibitors.

**Dose Escalation**

- There are no randomized, controlled trials to support dose escalation of ustekinumab from every 8 to 12 weeks to every four-week dosing in any condition. It is uncertain if there is any additional benefit with increased dosing and there is limited long-term safety data.
  * The evidence supporting the use of every four weeks in Crohn's disease (CD) is limited to retrospective, observational studies. [78 79] While some patients experienced disease remission, high-quality, prospective studies are needed to identify the ideal population and clarify the risk-benefit profile. Due to limited evidence supporting use, more frequent dosing of ustekinumab for CD is limited to patients who have had an inadequate response to every 8-week dosing.
  * There are no high-quality studies evaluating the use of every 4-week dosing of ustekinumab in chronic plaque psoriasis (PsO).

    * Additional studies are also needed to clarify the role of dose escalation versus standard dosing or other mechanisms of action.
- Guidelines do not currently support the use of therapeutic drug monitoring of ustekinumab to guide dose escalation.
    * There is very limited evidence on the efficacy of different maintenance troughs for ustekinumab. [80 81]
    * While therapeutic drug monitoring may play a role in the management of TNF inhibitors, the same concepts may not apply to ustekinumab due to its different mechanism of action and pharmacokinetic properties.
- Phase 3 clinical trials of Entyvio (vedolizumab) for ulcerative colitis (UC) and CD included maintenance dosing intervals of every 4 weeks and every 8 weeks (with a dose of 300 mg). The results demonstrated that the two maintenance doses produce in similar response rates. In long-term extension studies some patients who had an inadequate response to every 8-week dosing were able to achieve a response or regain response after increasing to every four-week dosing. Therefore, the use of every four-week dosing is limited to patients who have lost response or have had an inadequate response to every 8-week dosing. [82 83]
- In PsO, there was no statistically significant difference in response for patients who were dose escalated to secukinumab 300 mg every 2 weeks vs every 4 weeks in patients who had suboptimal response to standard dosing at 16 weeks. After 16 weeks, most patients who continued with a 4-week dosing interval were able to achieve response. [84]
- Pharmacokinetic and exposure-response modeling suggest shortening the dosing interval for golimumab IV to every 6 weeks may ameliorate waning efficacy toward the end of the standard 8-week dosing interval experienced by a small proportion of patients. [75 85]

**Biosimilars and Reference Products**

- FDA-approved biosimilar medications are not meaningfully different clinically than their reference products (i.e., therapeutically equivalent). Although small differences in clinically inactive portions of the molecule may exist, the FDA approval certifies that the manufacturer has shown their product to be identical in function. There is no scientific basis to prefer one FDA-approved product over another; given similar efficacy and safety, most contracts consider more costly products not medically necessary. [86 87]
- Preferred products offer a less costly alternative to non-preferred products. Biosimilars are considered to be equally effective as their reference products.
    * There is no evidence that any one product (biosimilars vs. reference products) is safer or more effective than another.
    * Preferred products provide the best value for health plan members.
    * Non-preferred products are not coverable unless coverage criteria in this policy are met. Pricing between individual products is variable and the lowest net cost products are available for coverage.
- **Clinical trials**: Coverage of services for members enrolled in clinical trials is provided, consistent with current standards of care. FDA-approved biosimilars are not clinically

different from reference products. Use of biosimilars has been endorsed by national guidelines. Non-preferred products which are more costly than preferred products may be provided by study sponsors.

- Hospitals and health-systems have medication formularies developed independent of the health plan. The health plan is unable to cover more expensive products for the convenience of the hospital, health-system, provider, or member. Preferred products represent the lowest cost to members and the health plan; the use of more expensive products without evidence of superior efficacy or safety is not medically necessary per the member's contract.

**Appendix 1: Absolute and Relative Contraindications for Phototherapy/Photochemotherapy**

| |
|---|
| History of melanoma or squamous-cell carcinoma |
| History of photosensitivity |
| Increased risk of photosensitivity due to concomitant disease state (e.g., porphyria, systemic lupus erythematosus) or chronic medication use (e.g., tetracycline or sulfonamide antibiotics) |
| Physical inability to stand for the required exposure time |
| Presence of premalignant lesions (e.g., actinic keratosis) |
| Presence of psoriatic arthritis |
| Treatment of facial or scalp lesions |
| Treatment of lesions in the groin area |
| Treatment of lesions on the palms of the hands or soles of the feet, or on nail beds |
| Type 1 or type 2 skin |

**Appendix 2: Select List of Conventional Synthetic Disease Modifying Anti-Rheumatic Drugs (csDMARDs)**

| ***Conventional Synthetic DMARDS for Rheumatic and Skin Conditions and Uveitis*** | |
|---|---|
| Azathioprine (AZA; Imuran) | Methotrexate (oral, injectable)* |
| Cyclosporine (CSA; Gengraf, Neoral, Sandimmune)* | Mycophenolate (MMF; CellCept, Myfortic) |
| Hydroxychloroquine (HCQ; Plaquenil) | Sulfasalazine (SSZ; Azulfidine) |
| Arava (leflunomide) | Soriatane (acitretin)* |
| ***Conventional Synthetic DMARDs for Gastrointestinal conditions*** | |
| Azathioprine (AZA; Imuran) | Mercaptopurine (6-MP; Purinethol) |
| Balsalazide (Colazal, Giazo) | Mesalamine (Apriso, Asacol HD, Delzicol, Lialda, Pentasa) |
| Cyclosporine (CSA; Gengraf, Neoral, Sandimmune) | Sulfasalazine (SSZ; Azulfidine) |

*: Therapies used in the treatment of dermatologic conditions

**Appendix 3: American College of Rheumatology (ACR) Classification Criteria for Establishing the Diagnosis of Rheumatoid Arthritis (RA) [77 78]**

| Diagnosis of RA requires the presence of at least 4 of 7 criteria below: |
|---|
| 1. Morning stiffness in and around joints lasting more than 1 hour.<br>2. Arthritis in at least 1 area in a wrist or proximal interphalangeal (PIP) joint (hands or fingers) for > 6 weeks.<br>3. Simultaneous swelling or fluid accumulation in 3 or more joints for > 6 weeks.<br>4. Symmetric (bilateral joint) involvement for > 6 weeks.<br>5. Presence of rheumatoid nodules.<br>6. Positive serum rheumatoid factor.<br>7. Radiographic changes typical of RA (erosion or unequivocal bony decalcification in or adjacent to the involved joint) on hand and wrist present. |

**Appendix 4: American College of Rheumatology (ACR) Assessment Components for Improvement in Rheumatoid Arthritis (RA) [79]**

- Tender joint count.
- Swollen joint count.
- Patient's assessment of pain.
- Patient's global assessment of disease activity.
- Physician's global assessment of disease activity.
- Patient's assessment of physical function.
- Acute phase reactant measures (erythrocyte sedimentation rate or C-reactive protein levels).

**Appendix 5: American College of Rheumatology (ACR) Classification Criteria for Establishing the Diagnosis of Giant Cell Arteritis (GCA)**

| Diagnosis of GCA requires the presence of at least 3 of 5 criteria below: |
|---|
| 1. Patient is 50 years of age or older.<br>2. New onset of localized headache.<br>3. Temporal artery tenderness or decreased temporal artery pulse.<br>4. Erythrocyte sedimentation rate of 50 mm per hour or greater.<br>5. Abnormal temporal artery biopsy. |

**Appendix 6: Example Contraindications to Self-Administered Therapy**

| |
|---|
| The member is 13 years of age or younger. |
| Inability to self-inject due to significant behavioral issues and/or cognitive impairment including, but not limited to, those associated with developmental delay, down syndrome, dementia, or excessive anxiety such as needle phobia. |
| Preferred self-administered therapy/therapies are relatively contraindicated. |

| Cross References |
|---|
| Immune Globulin Replacement Therapy (IVIG, SCIG), Medication Policy Manual. Policy No. dru020 |
| Site of Care Review, Medication Policy Manual, Policy No. dru408 |
| Monoclonal antibodies for Skin and Other Inflammatory Conditions, Medication Policy Manual, Policy No. dru493 |
| Chimeric Antigen Receptor (CAR) T-cell Therapies, Medication Policy Manual, Policy No. dru523 |
| Products with Therapeutically Equivalent Biosimilars/Reference Products, Medication Policy Manual, Policy No. dru620 |
| Interleukin-1 Antagonists, Medication Policy Manual, Policy No. dru677 |
| Medications for Multiple Sclerosis, Medication Policy Manual, Policy No. dru753 |
| Imdelltra, tarlatamab, Medication Policy Manual, Policy No. dru792 |
| Blincyto, blinatumomab, Medication Policy Manual, Policy No. dru388 |
| Medications for Multiple Myeloma, other cancers, and other hematologic disorders, Medication Policy Manual, Policy No. dru672 |
| Bispecific T-Cell Engager (BiTE) Therapies for B-Cell Lymphoma, Medication Policy Manual, Policy No. dru761 |

| Codes | Number | Description |
|---|---|---|
| HCPCS | J3262 | Injection, tocilizumab (Actemra IV), 1 mg |
| HCPCS | J0717 | Injection, certolizumab pegol (Cimzia lyophilized powder vials), 1 mg |
| HCPCS | J3247 | Injection, secukinumab (Cosentyx), intravenous, 1 mg |
| HCPCS | J3380 | Injection, vedolizumab (Entyvio), 1 mg |
| HCPCS | J3245 | Injection, tildrakizumab (Ilumya), 1 mg |
| HCPCS | J2267 | Injection, mirikizumab-mrkz (Omvoh), 1 mg |
| HCPCS | J0129 | Injection, abatacept (Orencia), 10 mg |
| HCPCS | Q9999 | Injection, ustekinumab-aauz (Otulfi), 1 mg |
| HCPCS | Q9997 | Injection, ustekinumab-ttwe (Pyzchiva), intravenous, 1 mg |
| HCPCS | Q9996 | Injection, ustekinumab-ttwe (Pyzchiva), subcutaneous, 1 mg |
| HCPCS | Q9998 | Injection, ustekinumab-aekn (Selarsdi), 1 mg |
| HCPCS | J1602 | Injection, golimumab (Simponi Aria), 1 mg, for intravenous use |
| HCPCS | J2327 | Injection, risankizumab-rzaa (Skyrizi), intravenous, 1 mg |
| HCPCS | J1747 | Injection, spesolimab-sbzo (Spevigo), 1 mg |

| Codes | Number | Description |
|---|---|---|
| HCPCS | J3358 | Ustekinumab (Stelara), for intravenous injection, 1 mg |
| HCPCS | J3357 | Ustekinumab (Stelara), for subcutaneous injection, 1 mg |
| HCPCS | Q5133 | Injection, tocilizumab-bavi (Tofidence), 1 mg |
| HCPCS | J1628 | Injection, guselkumab (Tremfya), 1 mg |
| HCPCS | Q5135 | Injection, tocilizumab-aazg (Tyenne), biosimilar, 1 mg |
| HCPCS | Q5137 | Injection, ustekinumab-auub (Wezlana), biosimilar, subcutaneous, 1 mg |
| HCPCS | Q5138 | Injection, ustekinumab-auub (Wezlana), biosimilar, intravenous, 1 mg |

**References**


1. Reich K, Papp KA, Blauvelt A, et al. Tildrakizumab versus placebo or etanercept for chronic plaque psoriasis (reSURFACE 1 and reSURFACE 2): results from two randomised controlled, phase 3 trials. *Lancet.* 2017;390(10091):276-88. PMID: 28596043
2. Leonardi CL, Kimball AB, Papp KA, et al. Efficacy and safety of ustekinumab, a human interleukin-12/23 monoclonal antibody, in patients with psoriasis: 76-week results from a randomised, double-blind, placebo-controlled trial (PHOENIX 1). *Lancet.* 2008;371:1665-74. PMID: 18486739
3. Papp KA, Langley RG, Lebwohl M, et al. Efficacy and safety of ustekinumab, a human interleukin-12/23 monoclonal antibody, in patients with psoriasis: 52-week results from a randomised, double-blind, placebo-controlled trial (PHOENIX 2). *Lancet.* 2008;371:1675-84. PMID: 18486740
4. Inman RD. Treatment of arthritis associated with inflammatory bowel disease. Last updated January 2022. In: Sieper J, ed. Waltham, MA: UpToDate, 2022.
5. Couriel DR, Saliba R, de Lima M, et al. A phase III study of infliximab and corticosteroids for the initial treatment of acute graft-versus-host disease. *Biology of blood and marrow transplantation : journal of the American Society for Blood and Marrow Transplantation.* 2009;15(12):1555-62. PMID: 19896079
6. R. B. Granuloma annulare: Management. Last updated September 2021. In: Stratman E, ed. Waltham, MA: UpToDate, 2021.
7. Korhonen T, Karppinen J, Paimela L, et al. The treatment of disc-herniation-induced sciatica with infliximab: one-year follow-up results of FIRST II, a randomized controlled trial. *Spine.* 2006;31(24):2759-66. PMID: 17108825
8. Korhonen T, Karppinen J, Paimela L, et al. The treatment of disc herniation-induced sciatica with infliximab: results of a randomized, controlled, 3-month follow-up study. *Spine.* 2005;30(24):2724-8. PMID: 16371894
9. Genevay S, Viatte S, Finckh A, et al. Adalimumab in severe and acute sciatica: a multicenter, randomized, double-blind, placebo-controlled trial. *Arthritis and rheumatism.* 2010;62(8):2339-46. PMID: 20506391

10. Genevay S, Finckh A, Zufferey P, et al. Adalimumab in acute sciatica reduces the long-term need for surgery: a 3-year follow-up of a randomised double-blind placebo-controlled trial. *Annals of the rheumatic diseases.* 2012;71(4):560-2. PMID: 21998121

11. Khanna D, Denton CP, Jahreis A, et al. Safety and efficacy of subcutaneous tocilizumab in adults with systemic sclerosis (faSScinate): a phase 2, randomised, controlled trial. *Lancet.* 2016;387(10038):2630-40. PMID: 27156934

12. Moutsopoulos NM, Katsifis GE, Angelov N, et al. Lack of efficacy of etanercept in Sjogren syndrome correlates with failed suppression of tumour necrosis factor alpha and systemic immune activation. *Annals of the rheumatic diseases.* 2008;67(10):1437-43. PMID: 18198195

13. Norheim KB, Harboe E, Goransson LG, et al. Interleukin-1 inhibition and fatigue in primary Sjogren's syndrome--a double blind, randomised clinical trial. *PloS one.* 2012;7(1):e30123. PMID: 22253903

14. Uppal SS, Hayat SJ,Raghupathy R. Efficacy and safety of infliximab in active SLE: a pilot study. *Lupus.* 2009;18(8):690-7. PMID: 19502264

15. Illei GG, Shirota Y, Yarboro CH, et al. Tocilizumab in systemic lupus erythematosus: data on safety, preliminary efficacy, and impact on circulating plasma cells from an open-label phase I dosage-escalation study. *Arthritis and rheumatism.* 2010;62(2):542-52. PMID: 20112381

16. Merrill JT, Burgos-Vargas R, Westhovens R, et al. The efficacy and safety of abatacept in patients with non-life-threatening manifestations of systemic lupus erythematosus: results of a twelve-month, multicenter, exploratory, phase IIb, randomized, double-blind, placebo-controlled trial. *Arthritis and rheumatism.* 2010;62(10):3077-87. PMID: 20533545

17. Wallace DJ, Furie RA, Tanaka Y, et al. Baricitinib for systemic lupus erythematosus: a double-blind, randomised, placebo-controlled, phase 2 trial. *Lancet.* 2018;392(10143):222-31. PMID: 30043749

18. de Menthon M, Cohen P, Pagnoux C, et al. Infliximab or rituximab for refractory Wegener's granulomatosis: long-term follow up. A prospective randomised multicentre study on 17 patients. *Clinical and experimental rheumatology.* 2011;29(1 Suppl 64):S63-71. PMID: 21586199

19. 2010 update of the ASAS/EULAR recommendations for the management of ankylosing spondylitis. Secondary 2010 update of the ASAS/EULAR recommendations for the management of ankylosing spondylitis [cited 10/30/2013]. 'Available from:' http://ard.bmj.com/content/70/6/896.full.

20. 2011 American College of Rheumatology Recommendations for the Treatment of Juvenile Idiopathic Arthritis: Initiation and Safety Monitoring of Therapeutic Agents for the Treatment of Arthritis and Systemic Features. Secondary 2011 American College of Rheumatology Recommendations for the Treatment of Juvenile Idiopathic Arthritis: Initiation and Safety Monitoring of Therapeutic Agents for the Treatment of Arthritis and Systemic Features [cited 09/13/2013]. 'Available from:' http://www.rheumatology.org/Practice/Clinical/Guidelines/Clinical_Practice_Guidelines/.

21. European League Against Rheumatism recommendations for the management of psoriatic arthritis with pharmacological therapies. Secondary European League Against Rheumatism recommendations for the management of psoriatic arthritis with pharmacological therapies [cited 09/13/2013]. 'Available from:' http://ard.bmj.com/content/71/1/4.abstract.

22. 2012 Update of the 2008 American College of Rheumatology Recommendations for the Use of Disease-Modifying Antirheumatic Drugs and Biologic Agents in the Treatment of Rheumatoid Arthritis. Secondary 2012 Update of the 2008 American College of Rheumatology Recommendations for the Use of Disease-Modifying Antirheumatic Drugs and Biologic Agents in the Treatment of Rheumatoid Arthritis [cited 09/13/2013]. 'Available from:' http://www.rheumatology.org/Practice/Clinical/Guidelines/Clinical_Practice_Guidelines/.

23. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs. Secondary EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs [cited 09/13/2013]. 'Available from:' http://ard.bmj.com/content/early/2010/05/04/ard.2009.126532.abstract.

24. Angeles-Han ST, Ringold S, Beukelman T, et al. 2019 American College of Rheumatology/Arthritis Foundation Guideline for the Screening, Monitoring, and Treatment of Juvenile Idiopathic Arthritis-Associated Uveitis. *Arthritis care & research.* 2019;71(6):703-16. PMID: 31021540

25. Ringold S, Angeles-Han ST, Beukelman T, et al. 2019 American College of Rheumatology/Arthritis Foundation Guideline for the Treatment of Juvenile Idiopathic Arthritis: Therapeutic Approaches for Non-Systemic Polyarthritis, Sacroiliitis, and Enthesitis. *Arthritis Rheumatol.* 2019;71(6):846-63. PMID: 31021537

26. Cosentyx (secukinumab) [Prescribing Information]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; December 2021.

27. Ward MM, Deodhar A, Gensler LS, et al. 2019 Update of the American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network Recommendations for the Treatment of Ankylosing Spondylitis and Nonradiographic Axial Spondyloarthritis. *Arthritis Rheumatol.* 2019;71(10):1599-613. PMID: 31436036

28. Singh JA, Guyatt G, Ogdie A, et al. Special Article: 2018 American College of Rheumatology/National Psoriasis Foundation Guideline for the Treatment of Psoriatic Arthritis. *Arthritis Rheumatol.* 2019;71(1):5-32. PMID: 30499246

29. Fraenkel L, Bathon JM, England BR, et al. 2021 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis care & research.* 2021;73(7):924-39. PMID: 34101387

30. FDA requires warnings about increased risk of serious heart-related events, cancer, blood clots, and death for JAK inhibitors that treat certain chronic inflammatory conditions. Secondary FDA requires warnings about increased risk of serious heart-related events, cancer, blood clots, and death for JAK inhibitors that treat certain chronic inflammatory conditions [cited 9/9/2021]. 'Available from:' https://www.fda.gov/drugs/drug-safety-and-availability/fda-requires-warnings-about-increased-risk-serious-heart-related-events-cancer-blood-clots-and-death?utm_medium=email&utm_source=govdelivery.

31. Stone JH, Tuckwell K, Dimonaco S, et al. Trial of Tocilizumab in Giant-Cell Arteritis. *The New England journal of medicine.* 2017;377(4):317-28. PMID: 28745999

32. Actemra [Prescribing Information]. South San Francisco, CA: Genentech, Inc; February 2022.

33. Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. *Journal of the American Academy of Dermatology*. 2019;80(4):1029-72. PMID: 30772098

34. American Academy of Dermatology Association. Pustular Psoriasis: Treatment Options. Accessed 9/30/2022. Available at: https://www.aad.org/public/diseases/psoriasis/treatment/genitals/pustular.

35. Kalb, R.E. (2022). Pustular psoriasis: pathogenesis, clinical manifestations, and diagnosis (literature review current through August 2022). UpToDate. Waltham, MA, UpToDate.

36. Choon SE, Navarini AA,Pinter A. Clinical Course and Characteristics of Generalized Pustular Psoriasis. Am J Clin Dermatol. 2022;23(Suppl 1):21-29. PMID: 35061227.

37. Ingram JR, Woo PN, Chua SL, et al. Interventions for hidradenitis suppurativa: a Cochrane systematic review incorporating GRADE assessment of evidence quality. *The British journal of dermatology*. 2016. PMID: 26801356

38. Jemec GBE, Okun MM, Forman SB, et al. Adalimumab medium-term dosing strategy in moderate-to-severe hidradenitis suppurativa: integrated results from the phase III randomized placebo-controlled PIONEER trials. Br J Dermatol. 2019 Nov;181(5):967-975. doi: 10.1111/bjd.17919. Epub 2019 Aug 14. PMID: 30916379.

39. 39Humira® [Prescribing Information]. North Chicago, IL: Abbvie, Inc.; January 2019

40. Kimball AB, Jemec GBE, Sayed CJ, et al. Efficacy and safety of bimekizumab in patients with moderate-to-severe hidradenitis suppurativa (BE HEARD I and BE HEARD II): two 48-week, randomised, double-blind, placebo-controlled, multicentre phase 3 trials. *Lancet*. 2024;403(10443):2504-19. PMID: 38795716

41. Lichtenstein GR, Loftus EV, Isaacs KL, et al. ACG Clinical Guideline: Management of Crohn's Disease in Adults. *Am J Gastroenterol*. 2018;113:481-517. PMID: 29610508

42. Feuerstein JD, Isaacs KL, Schneider Y, et al. AGA Clinical Practice Guidelines on the Management of Moderate to Severe Ulcerative Colitis. *Gastroenterology*. 2020;158(5):1450-61. PMID: 31945371

43. Travis S, Silverberg MS, Danese S, et al. Vedolizumab for the Treatment of Chronic Pouchitis. *The New England journal of medicine*. 2023;388(13):1191-200. PMID: 36988594

44. 44Xeljanz [Prescribing Information]. New York, NY: Pfizer; December 2019

45. Rubin DT, Ananthakrishnan AN, Siegel CA, et al. ACG Clinical Guideline: Ulcerative Colitis in Adults. *Am J Gastroenterol*. 2019;114:384-413. PMID: 30840605

46. NCCN Clinical Practice Guidelines in Oncology: Management of Immunotherapy-Related Toxicities v.1.2025. Secondary NCCN Clinical Practice Guidelines in Oncology: Management of Immunotherapy-Related Toxicities v.1.2025. [cited 03/17/2025]. 'Available from:' https://www.nccn.org/professionals/physician_gls/pdf/immunotherapy.pdf.

47. Bergqvist V, Hertervig E, Gedeon P, et al. Vedolizumab treatment for immune checkpoint inhibitor-induced enterocolitis. *Cancer Immunol Immunother*. 2017;66(5):581-92. PMID: 28204866

48. Abu-Sbeih H, Ali FS, Alsaadi D, et al. Outcomes of vedolizumab therapy in patients with immune checkpoint inhibitor-induced colitis: a multi-center study. *J Immunother Cancer*. 2018;6(1):142. PMID: 30518410

49. Gravina AG, Pellegrino R, Esposito A, et al. The JAK-STAT Pathway as a Therapeutic Strategy in Cancer Patients with Immune Checkpoint Inhibitor-Induced Colitis: A Narrative Review. *Cancers (Basel).* 2024;16(3). PMID: 38339367

50. Shirwaikar Thomas A, Lee SE, Shatila M, et al. IL12/23 Blockade for Refractory Immune-Mediated Colitis: 2-Center Experience. *Am J Gastroenterol.* 2023;118(9):1679-83. PMID: 37216614

51. Miehlke S, Guagnozzi D, Zabana Y, et al. European guidelines on microscopic colitis: United European Gastroenterology and European Microscopic Colitis Group statements and recommendations. *United European Gastroenterol J.* 2021;9(1):13-37. PMID: 33619914

52. Chao, NJ and Zeiser, R. Prevention of acute graft-versus-host disease. Last updated November 2021. Waltham, MA: UpToDate, 2021.

53. Watkins B, Qayed M, McCracken C, et al. Phase II Trial of Costimulation Blockade With Abatacept for Prevention of Acute GVHD. *J Clin Oncol.* 2021;39(17):1865-77. PMID: 33449816

54. Kasiske BL, Zeier MG, Chapman JR, et al. KDIGO clinical practice guideline for the care of kidney transplant recipients: a summary. *Kidney Int.* 2010;77(4):299-311. PMID: 19847156

55. Velidedeoglu E, Cavaille-Coll MW, Bala S, et al. Summary of 2017 FDA Public Workshop: Antibody-mediated Rejection in Kidney Transplantation. *Transplantation.* 2018;102(6):e257-e64. PMID: 29470345

56. Vo AA, Choi J, Kim I, et al. A Phase I/II Trial of the Interleukin-6 Receptor-Specific Humanized Monoclonal (Tocilizumab) + Intravenous Immunoglobulin in Difficult to Desensitize Patients. *Transplantation.* 2015;99(11):2356-63. PMID: 26018350

57. Teagle A,Hargest R. Management of pyoderma gangrenosum. *J R Soc Med.* 2014;107:228-36. PMID: 24912791

58. Regueiro M, Valentine J, Plevy S, et al. Infliximab for treatment of pyoderma gangrenosum associated with inflammatory bowel disease. *Am J Gastroenterol.* 2003;98:1821-6. PMID: 12907338

59. Soto-Gomez N, Peters JI,Nambiar AM. Diagnosis and Management of Sarcoidosis. *Am Fam Physician.* 2016;93:840-8. PMID: 27175719

60. Thillai M, Atkins CP, Crawshaw A, et al. BTS Clinical Statement on pulmonary sarcoidosis. *Thorax.* 2021;76:4-20. PMID: 33268456

61. Hellmich B, Agueda A, Monti S, et al. 2018 Update of the EULAR recommendations for the management of large vessel vasculitis. *Annals of the rheumatic diseases.* 2020;79:19-30. PMID: 31270110

62. Mekinian A, Saadoun D, Vicaut E, et al. Tocilizumab in treatment-naive patients with Takayasu arteritis: TOCITAKA French prospective multicenter open-labeled trial. *Arthritis Res Ther.* 2020;22:218. PMID: 32943098

63. Nakaoka Y, Higuchi K, Arita Y, et al. Tocilizumab for the treatment of patients with refractory Takayasu arteritis. *Int Heart J.* 2013;54:405-11. PMID: 24309452

64. Nakaoka Y, Isobe M, Takei S, et al. Efficacy and safety of tocilizumab in patients with refractory Takayasu arteritis: results from a randomised, double-blind, placebo-controlled, phase 3 trial in Japan (the TAKT study). *Annals of the rheumatic diseases.* 2018;77:348-54. PMID: 29191819

65. Nigrovic PA. Cryopyrin-associated periodic syndromes and related disorders. . In: UpToDate, ed. Basow DS ed. Waltham, MA: UpToDate, 2013.

66. Sanclemente G, Murphy R, Contreras J, et al. Anti-TNF agents for paediatric psoriasis. *The Cochrane database of systematic reviews.* 2015(11):CD010017. PMID: 26598969

67. European biotech gets boost as Genmab market value hits $7 billion. Secondary European biotech gets boost as Genmab market value hits $7 billion [cited 11/20/2015]. 'Available from:' http://www.reuters.com/article/2015/11/17/us-genmab-europe-biotech-idUSKCN0T61RU20151117#7OexUWlSTIozpu79.97.

68. Abe K, Itoyama Y, Sobue G, et al. Confirmatory double-blind, parallel-group, placebo-controlled study of efficacy and safety of edaravone (MCI-186) in amyotrophic lateral sclerosis patients. *Amyotrophic lateral sclerosis & frontotemporal degeneration.* 2014;15(7-8):610-7. PMID: 25286015

69. Sibley CH, Plass N, Snow J, et al. Sustained response and prevention of damage progression in patients with neonatal-onset multisystem inflammatory disease treated with anakinra: a cohort study to determine three- and five-year outcomes. *Arthritis and rheumatism.* 2012;64(7):2375-86. PMID: 22294344

70. Porter, DL and Maloney, DG. Cytokine release syndrome (CRS). (literature review current through January 2025). Waltham, MA: UpToDate, 2024.

71. Ludwig H, Terpos E, van de Donk N, et al. Prevention and management of adverse events during treatment with bispecific antibodies and CAR T cells in multiple myeloma: a consensus report of the European Myeloma Network. *Lancet Oncol.* 2023;24(6):e255-e69. PMID: 37269857

72. Smolen JS, Landewe R, Bijlsma J, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2016 update. *Annals of the rheumatic diseases.* 2017;76:960-77. PMID: 28264816

73. Institute for Clinical and Economic Review, Targeted Immunomodulators for the Treatment of Moderate-to-Severe Plaque Psoriasis: Effectiveness and Value: November 4, 2016. https://icer-review.org/wp-content/uploads/2016/08/NE_CEPAC_Psoriasis_Evidence_Report_110416.pdf. Accessed: 11/15/2016

74. Institute for Clinical and Economic Review, Targeted Immune Modulators for Rheumatoid Arthritis: Effectiveness & Value: April 7, 2017. https://icer-review.org/wp-content/uploads/2016/08/NE_CEPAC_RA_Evidence_Report_FINAL_040717.pdf. Accessed: 6/21/17

75. Safety trial finds risk of blood clots in the lungs and death with higher dose of tofacitinib (Xeljanz, Xeljanz XR) in rheumatoid arthritis patients; FDA to investigate. Secondary Safety trial finds risk of blood clots in the lungs and death with higher dose of tofacitinib (Xeljanz, Xeljanz XR) in rheumatoid arthritis patients; FDA to investigate [cited 03/01/2019]. 'Available from:' https://www.fda.gov/Drugs/DrugSafety/ucm631871.htm.

76. FDA approves Boxed Warning about increased risk of blood clots and death with higher dose of arthritis and ulcerative colitis medicine tofacitinib (Xeljanz, Xeljanz XR). Secondary FDA approves Boxed Warning about increased risk of blood clots and death with higher dose of arthritis and ulcerative colitis medicine tofacitinib (Xeljanz, Xeljanz XR) [cited 7/26/2019]. 'Available from:'

77. Pfizer Shares Co-Primary Endpoint Results From Post-Marketing Required Safety Study of XELJANZ® (TOFACITINIB) In Subjects with Rheumatoid Arthritis (RA). Secondary Pfizer Shares Co-Primary Endpoint Results From Post-Marketing Required Safety Study of XELJANZ® (TOFACITINIB) In Subjects with Rheumatoid Arthritis (RA) [cited 3/3/2021]. 'Available from:' https://www.pfizer.com/news/press-release/press-release-detail/pfizer-shares-co-primary-endpoint-results-post-marketing.

78. Greenup AJ, Rosenfeld G,Bressler B. Ustekinumab use in Crohn's disease: a Canadian tertiary care centre experience. *Scandinavian journal of gastroenterology*. 2017;52(12):1354-59. PMID: 28885058

79. Ma C, Fedorak RN, Kaplan GG, et al. Long-term Maintenance of Clinical, Endoscopic, and Radiographic Response to Ustekinumab in Moderate-to-Severe Crohn's Disease: Real-world Experience from a Multicenter Cohort Study. *Inflammatory bowel diseases*. 2017;23(5):833-39. PMID: 28328624

80. Feuerstein JD, Nguyen GC, Kupfer SS, et al. American Gastroenterological Association Institute Guideline on Therapeutic Drug Monitoring in Inflammatory Bowel Disease. *Gastroenterology*. 2017;153(3):827-34. PMID: 28780013

81. Vande Casteele N, Herfarth H, Katz J, et al. American Gastroenterological Association Institute Technical Review on the Role of Therapeutic Drug Monitoring in the Management of Inflammatory Bowel Diseases. *Gastroenterology*. 2017;153(3):835-57 e6. PMID: 28774547

82. Institute for Clinical and Economic Review, Targeted Immune Modulators for Rheumatoid Arthritis: Effectiveness & Value: April 7, 2017. https://icer-review.org/wp-content/uploads/2016/08/NE_CEPAC_RA_Evidence_Report_FINAL_040717.pdf. Accessed: 6/21/17.

83. Safety trial finds risk of blood clots in the lungs and death with higher dose of tofacitinib (Xeljanz, Xeljanz XR) in rheumatoid arthritis patients; FDA to investigate. Secondary Safety trial finds risk of blood clots in the lungs and death with higher dose of tofacitinib (Xeljanz, Xeljanz XR) in rheumatoid arthritis patients; FDA to investigate [cited 03/01/2019]. 'Available from:' https://www.fda.gov/Drugs/DrugSafety/ucm631871.htm.

84. Reich K, Korber A, Mrowietz U, et al. Secukinumab 2-weekly vs. 4-weekly dosing in patients with plaque-type psoriasis: results from the randomized GAIN study. *The British journal of dermatology*. 2021;184(5):849-56. PMID: 32652528

85. Lee JB, Broadwell A, Fan Y, et al. Population Pharmacokinetic and Exposure-Response Model Simulations: Predicted Exposure and Efficacy for Maintenance Doses of Intravenous Golimumab Every 6 or 8 Weeks in Patients With Moderately to Severely Active Rheumatoid Arthritis. *Clin Ther*. 2022;44(3):457-64 e2. PMID: 35183373

86. Biosimilar and Interchangeable Products. Secondary Biosimilar and Interchangeable Products. [cited March 20, 2025]. 'Available from:' https://www.fda.gov/drugs/biosimilars/biosimilar-products-information.

87. DrugDex. Micromedex Healthcare Series [Internet database]. Greenwood Village, CO: Truven Health Analytics. Updated periodically.

*Revision History*

| Revision Date | Revision Summary |
|---|---|
| 4/2/2026 | Effective 7/1/26<br>• Changed Selarsdi (ustekinumab-aekn) from preferred to non-preferred.<br>• Clarified Cimzia (certolizumab pegol) doses of 200 mg or greater in patients ≥40 kg with PJIA as not medically necessary. No change to intent. |
| 1/22/2026 | Effective 4/1/26<br>• Added Ustekinumab-srlf (unbranded) as non-preferred. |
| 12/4/2025 | Effective 1/1/26<br>• Added new Skyrizi (risankizumab) 180 mg/1.2 ml prefilled syringes to quantity limitation chart. |
| 7/10/2025 | Effective 11/1/25<br>• Changed Stelara (ustekinumab) from preferred to non-preferred. |
| 7/10/2025 | Effective 9/1/25<br>• Changed Selarsdi (ustekinumab-aekn), Steqeyma (ustekinumab-stba), and Yesintek (ustekinumab-kfce) from non-preferred to preferred.<br>• Added Ustekinumab (unbranded Janssen product) and biosimilars Starjemza (ustekinumab-hmny) and Ustekinumab-stba (unbranded) as non-preferred.<br>• Added new Spevigo (spesolimab-sbzo) 300 mg prefilled syringe to Authorization Limits table. |
| 04/03/2025 | Effective 6/1/2025<br>• Added new indications:<br>o Omvoh (mirikizumab) IV as non-preferred for Crohn's disease (CD).<br>o Tremfya (guselkumab) IV as preferred for CD.<br>• Added new biosimilars as non-preferred:<br>o Actemra (tocilizumab) biosimilar Avtozma IV<br>o Stelara (ustekinumab) biosimilars Steqeyma and Yesintek |
| 12/12/2024 | Effective 3/1/2025<br>• Added Cimzia (certolizumab) as a level 3 treatment option for its new indication in polyarticular juvenile idiopathic arthritis (PJIA) for doses less than 200 mg which require administration by a health care professional using the vial kit.<br>• Added new Stelara (ustekinumab) biosimilars Imuldosa and Otulfi to policy as non-preferred options. |
| 12/16/2024 | Effective 1/15/2025<br>• Policy updated to reflect the name change of Washington State Rx Services to ArrayRx. |
| 9/19/2024 | Effective 01/01/2025<br>• Moved Actemra (tocilizumab) IV to non-preferred for all applicable indications.<br>• Added new Stelara (ustekinumab) biosimilars Pyzchiva, Selarsdi, and Wezlana to policy as non-preferred options. |

| Revision Date | Revision Summary |
|---|---|
| 9/19/2024 | Effective 12/1/2024<br>• Added Tremfya (guselkumab) IV induction as a preferred provider-administered option for ulcerative colitis ahead of anticipated FDA approval.<br>• Added Skyrizi (risankizumab) IV induction as a preferred provider-administered option for ulcerative colitis. |
| 6/20/2024 | • Updated authorization limit wording for Simponi Aria in *Table* 2 for clarity. No change to intent.<br>• Added new Spevigo (spesolimab) SC formulation to policy criteria and quantity limit for a loading dose in GPP maintenance.<br>• Added Tofidence IV (tocilizumab-bavi) to policy as non-preferred.<br>• Added Tyenne IV (tocilizumab-aazg) to policy as preferred.<br>• Added investigational dose escalation language for Cosentyx (secukinumab). |
| 3/21/2024 | Effective 4/1/2024<br>• Updated Avsola (infliximab) and Stelara (ustekinumab) as preferred products.<br>• Added Omvoh (mirikizumab) as a non-preferred product for ulcerative colitis (UC).<br>• Updated background to include pouchitis and collagenous colitis.<br>• Updated reference to Washington State Rx Services. Product list available at: https://www.hca.wa.gov/assets/pebb/ump-preferred-drug-list-2024.pdf |
| 12/7/2023 | • Updated new Cosentyx (secukinumab) IV formulation to policy criteria and QL for AS, nrSpA, and PsA.<br>• Removed discontinued Cosentyx (secukinumab) lyophilized powder vials for subcutaneous administration. |
| 09/14/2023 | Updated Actemra (tocilizumab) criteria for use in cytokine release syndrome (CRS). Requirement changed to diagnosis only. CRS no longer need be chimeric antigen receptor (CAR) T-cell induced for coverage approval. |
| 3/16/2023 | Updated reference to Washington State Rx Services. Product list available at: https://www.hca.wa.gov/assets/pebb/ump-preferred-drug-list-2023.pdf |

| Revision Date | Revision Summary |
|---|---|
| 12/9/2022 | Effective 1/19/2023:<br>• Updated diagnostic requirements for systemic juvenile idiopathic arthritis (SJIA). Now requires disease activity for at least 6 weeks instead of 6 months.<br>• Skyrizi (risankizumab) quantity limit updated to include new 180 mg maintenance dose for Crohn's Disease (CD).<br>• Updated preferred self-administered products to include Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib), Skyrizi (risankizumab) in their respective indications.<br>• Added Spevigo (spesolimab) to the policy for generalized pustular psoriasis (GPP) as a provider-administered option. |
| 8/29/2022 | Effective 10/1/2022:<br>• Added Skyrizi (risankizumab) to policy as a preferred provider administered option for Crohn's disease.<br>• Updated references to Products with Therapeutically Equivalent Biosimilars/Reference Products dru620 (dru905 archived effective 7/15/2022).<br>• Updated cross references and HCPCS codes. |
| 5/23/2022 | Effective 7/1/2022:<br>• Updated policy to allow dosing escalation of Simponi Aria (golimumab) to every 6 weeks.<br>• Added Actemra (tocilizumab) IV to policy for Giant Cell Arteritis (GCA).<br>• Updated Entyvio (vedolizumab) for Crohn's Disease (CD) and Ulcerative Colitis (UC) as a preferred provider-administered option.<br>• Added HCPCS codes for provider-administered products. |
| 2/22/2022 | Effective 3/13/2022:<br>• Added coverage criteria for intravenous Actemra (tocilizumab) for solid organ transplant, antibody mediated rejection (AMR).<br>• Added criteria to allow coverage of intravenous Orencia (abatacept) for *prophylaxis* of graft versus host disease (GVHD).<br>• Added coverage criteria for Cosentyx (secukinumab) for enthesitis-related arthritis (ERA).<br>• Wording for intravenous Actemra (tocilizumab) criteria for cytokine release syndrome (CRS) was modified to allow for coverage as part of CAR-T treatment plan.<br>• Updated position statement to clarify that non-TNFs may be an option for New York Heart Association (NYHA) class III/IV heart failure (HF) based on guidelines and post-market reports of new or worsening HF with TNF inhibitors. |
| 10/15/2021 | • Revised preferred infliximab products and clarified that they are reviewed under Medication Policy Manual, Products with Therapeutically Equivalent Biosimilars/Reference Products, dru905.<br>• Added unbranded Janssen infliximab product to policy as non-preferred. |

| Revision Date | Revision Summary |
|---|---|
| 7/16/2021 | Updated appendix numbers in criteria. No other changes. |
| 4/21/2021 | • Added coverage criteria for sarcoidosis and Takayasu Arteritis.<br>• Updated investigational uses. |
| 2/22/2021 | Removed requirement for step therapy with two prior self-administered products prior to approval of infliximab products (Remicade and biosimilars). |
| 10/28/2020 | • Added Simponi Aria as a provider-administered option for polyarticular juvenile idiopathic arthritis (PJIA), a newly approved FDA indication.<br>• Increased authorization limit for infliximab in immune-mediated colitis to two infusions.<br>• Clarified that Cosentyx (secukinumab) vials are a provider-administered option for non-radiographic axial spondyloarthritis. |
| 8/25/2020 | Effective 10/1/2020:<br>• Revised clinical documentation requirements.<br>• Updated quantity limits for Cimzia (certolizumab) based on newly FDA approved indication.<br>• Removed references to appendix 2 in policy criteria and listed requirements for prior conventional therapies directly in criteria.<br>• **Non-Radiographic Axial Spondyloarthritis:** New diagnosis category in policy.<br>• **Chronic Plaque Psorasis:**<br>- Non-biologic-step-therapy requirements changed from "BSA ≥ 10% AND phototherapy AND conventional DMARD" to "BSA ≥ 10% OR phototherapy OR conventional agent."<br>- Conventional agent list expanded from just DMARDs to also include treatments such as topical corticosteroids.<br>• **Hidradenitis Suppurativa:**<br>- Removed requirement for disease severity.<br>- Removed requirement for functional impairment.<br>- Expanded list of acceptable step therapies from only antibiotics to also include corticosteroids, hormonal therapies, metformin, and retinoids.<br>• **Systemic juvenile idiopathic arthritis:** Expanded list of acceptable step therapies from only conventional DMARDs to also include NSAIDs.<br>• **Uveitits:** Expanded list of acceptable step therapies from only systemic corticosteroids to also include periocular intravitreal corticosteroids. |

| Revision Date | Revision Summary |
|---|---|
| 4/22/2020 | • Updated quantity limits for Cosentyx (secukinumab) in axial Spondyloarthritis/ankylosing spondylitis.<br>• Clarified that quantity limits for Cosentyx (secukinumab) in this policy apply to vials. Cosentyx (secukinumab) syringes are considered self-administered.<br>• Updated biosimilar list to include Abrilada (adalimumab-afzb) and Avsola (infliximab-axxq).<br>• Updated dosing for Stelara (ustekinumab) in ulcerative colitis.<br>• Added COT language. |
| 10/23/2019 | New UMP-specific policy replacing dru444 for those members. Effective 1/1/2020. |

*Drug names identified in this policy are the trademarks of their respective owners.*