CARE VALUE POLICY

POLICY: Inflammatory Conditions Care Value Policy

Tumor Necrosis Factor Inhibitors
• Cimzia® (certolizumab pegol subcutaneous injection – UCB)
• Enbrel® (etanercept subcutaneous injection – Amgen)
• Humira® (adalimumab subcutaneous injection – AbbVie)
• Simponi® (golimumab subcutaneous injection – Janssen Biotech/Johnson & Johnson)
Interleukin-6 Blockers
• Actemra® (tocilizumab subcutaneous injection – Genentech/Roche)
• Kevzara™ (sarilumab subcutaneous injection – Regeneron)
Interleukin-17 Blockers
• Cosentyx® (secukinumab subcutaneous injection – Novartis)
• Siliq™ (brodalumab subcutaneous injection – Valeant Pharmaceuticals)
• Taltz® (ixekizumab subcutaneous injection – Eli Lilly and Company)
Interleukin-23 Blockers
• Ilumya™ (tildrakizumab-asmn subcutaneous injection – Sun/Merck)
• Skyrizi™ (risankizumab-rzaa subcutaneous injection – AbbVie)
• Tremfya™ (guselkumab subcutaneous injection– Janssen Biotech/Johnson & Johnson)
Interleukin 12/23 Blocker
• Stelara® (ustekinumab subcutaneous injection – Janssen Biotech/Johnson & Johnson)
Interleukin-1 Blocker
• Kineret® (anakinra subcutaneous injection – Swedish Orphan Biovitrim)
T-Cell Costimulation Modulator
• Orencia® (abatacept subcutaneous injection – Bristol Myers Squibb)
Janus Kinases Inhibitors
• Olumiant® (baricitinib tablets – Lilly)
• Rinvoq™ (upadacitinib extended-release tablets – AbbVie)
• Xeljanz® (tofacitinib tablets – Pfizer)
• Xeljanz® XR (tofacitinib extended-release tablets – Pfizer)
Phosphodiesterase Type 4 Inhibitor
• Otezla® (apremilast tablets – Celgene Corporation)

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OVERVIEW

Several products are available for use in inflammatory conditions such as rheumatoid arthritis, ankylosing spondylitis, juvenile idiopathic arthritis, psoriatic arthritis, plaque psoriasis, Crohn's disease, and ulcerative colitis.[1-20] This policy involves the use of the products listed above.

The FDA-approved indications for each product listed in this policy are documented in Appendix A. For more information on criteria within a Prior Authorization program by specific condition refer to the respective standard *Inflammatory Conditions Prior Authorization Policy*.

Preferred and Non-Preferred Products.

	Rheumatology					Derma-tology	Gastroenterology	
	RA	**JIA**	**AS**	**nr-axSpA**	**PsA**	**Psoriasis**	**CD**	**UC**
Step 1 **Preferred**	•Enbrel •Humira •Rinvoq •Xeljanz/ XR	• Enbrel • Humira • Xeljanz	•Enbrel •Humira •Taltz	•Cimzia •Taltz	•Enbrel •Humira •Otezla •Stelara SC •Taltz •Tremfya •Xeljanz/ XR	•Enbrel •Humira •Otezla •Skyrizi •Stelara SC •Taltz •Tremfya	•Humira •Stelara SC	•Humira •Stelara SC
Step 2 **Non-Preferred** (directed to **ONE** Step 1 Product)	•Actemra SC *Directed to Humira specifically*	• Actemra SC *Directed to Humira specifically. JIA Step for Actemra SC is only for PJIA.*	--	--	--	--	•Cimzia – *Directed to Humira specifically*	•Simponi SC *Directed to Humira specifically* •Xeljanz/ XR *Directed to Humira specifically*
Step 3a **Non-Preferred** (directed to **TWO** Step 1 or 2 Products) **[documentation required]***	•Cimzia •Kevzara •Kineret •Olumiant •Orencia SC •Simponi SC	• Orencia SC	•Cimzia •Cosentyx •Simponi SC	•Cosentyx	•Cimzia •Orencia SC •Simponi SC	•Cimzia •Ilumya •Siliq	--	--
Step 3b **Non-Preferred** (directed to **THREE** Step 1 Products) **[documentation required]***	--	--	--	--	•Cosentyx *Directed to three Products from ≥ **2 different drug classes***	--	--	--
Step 3c **Non-Preferred** (directed to **FOUR** Step 1 Products) **[documentation required]***	--	--	--	--	--	• Cosentyx *Directed to four Products from ≥ **3 different drug classes***	--	--

SC – Subcutaneous; RA – Rheumatoid arthritis; AS – Ankylosing spondylitis; JIA – Juvenile idiopathic arthritis; PsA – Psoriatic arthritis; CD – Crohn's disease; UC – Ulcerative colitis; PJIA – Polyarticular juvenile idiopathic arthritis.

* The prescriber must provide written documentation supporting the trial of Preferred agents, noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to, chart notes, prescription claims records, and/or prescription receipts.

POLICY STATEMENT

For all Non-Preferred Products, this program requires the patient to meet standard *Inflammatory Conditions Prior Authorization Policy* criteria. Additionally, this program requires trial(s) of the Preferred Product(s) according to the tables above, when clinically appropriate, prior to the approval of the Non-Preferred products. There are also situations when trials of Non-Preferred agents will be considered; see criteria below. Prior Authorization is not required for agents which are Preferred for all indications. Other details of the program are as follows:

- **Continuation of Therapy:** Approval for a patient continuing therapy with a **Non-Preferred** SC or oral agent must be supported with verification, noted in the criteria as either **[verification in**

prescription claims history required] or, if not available, as **[verification by prescribing physician required]**.

- If the patient has at least 130 days of prescription claims history on file, claims history must support that the patient has received the Non-Preferred product for the specified period of time (90 or 120 days) within a 130-day look-back period; OR
- When 130 days of the patient's prescription claim history file is unavailable for verification, the prescriber must verify that the patient has been receiving the Non-Preferred product for a specified period of time (90 or 120 days), AND that the patient has been receiving the Non-Preferred product via paid claims (e.g., patient has not been receiving samples or coupons or other types of waivers in order to obtain access to the Non-Preferred product).
- For **Cosentyx**, all approvals will be forwarded to the Medical Director for evaluation.
- For patients continuing therapy, other conditions may also apply. Refer to criteria below.

- **Approval Duration:** All approvals for continuation of therapy for Non-Preferred products are provided for 1 year unless noted otherwise below. In cases where the initial approval is authorized in months, 1 month is equal to 30 days.

Documentation: When documentation is required, the prescriber must provide written documentation supporting the trials of these other agents, noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to, chart notes, prescription claims records, and/or prescription receipts.

Automation: None.

RECOMMENDED EXCEPTION CRITERIA

Non-Preferred Product	Exception Criteria
Actemra Subcutaneous	**1. Polyarticular Juvenile Idiopathic Arthritis – Initial Therapy.** **A)** Approve for 4 months if the patient meets the following (i and ii): **i.** Patient meets the standard *Inflammatory Conditions – Actemra Subcutaneous Prior Authorization Policy* criteria; AND **ii.** Patient meets ONE of the following conditions (a or b): **a)** Patient has tried Humira; OR Note: A trial of Enbrel, an infliximab product (e.g., Remicade, biosimilars), or Simponi Aria also counts. **b)** According to the prescriber, the patient has heart failure or a previously treated lymphoproliferative disorder. **B)** If the patient has met criterion 1Ai (the standard *Inflammatory Conditions – Actemra Subcutaneous Prior Authorization Policy* criteria), but criterion 1Aii is not met: offer to review for a Preferred Product (Enbrel, Humira, or Xeljanz) using the standard *Inflammatory Conditions – Prior Authorization Policy* criteria. **2. Rheumatoid Arthritis.** **A)** Approve for 3 months if the patient meets the following (i and ii): **i.** Patient meets the standard *Inflammatory Conditions – Actemra Subcutaneous Prior Authorization Policy* criteria; AND **ii.** Patient meets ONE of the following conditions (a or b): **a)** Patient has tried Humira; OR Note: A trial of Cimzia, Enbrel, an infliximab product (e.g., Remicade, biosimilars), or Simponi Aria or subcutaneous also counts.

	b) According to the prescriber, the patient has heart failure or a previously treated lymphoproliferative disorder. **B)** If the patient has met criterion 2Ai (the standard *Inflammatory Conditions – Actemra Subcutaneous Prior Authorization Policy* criteria), but criterion 2Aii is not met: offer to review for a Preferred Product (Enbrel, Humira, Rinvoq, Xeljanz, or Xeljanz XR) using the standard *Inflammatory Conditions Prior Authorization Policy* criteria. **3. Polyarticular Juvenile Idiopathic Arthritis or Rheumatoid Arthritis – Patient is Currently Receiving Actemra Subcutaneous or Intravenous.** **A)** Approve for 1 year if the patient meets BOTH of the following (i and ii): **i.** Patient meets the standard *Inflammatory Conditions – Actemra Subcutaneous Policy* criteria; AND **ii.** Patient meets ONE of the following conditions (a, b, c, d, or e): **a)** Patient has Polyarticular Juvenile Idiopathic Arthritis and has tried Humira; OR Note: A trial of Enbrel, an infliximab product (e.g., Remicade, biosimilars), or Simponi Aria also counts. **b)** Patient has Rheumatoid Arthritis and has tried Humira; OR Note: A trial of Cimzia, Enbrel, and infliximab product (e.g., Remicade, biosimilars), or Simponi Aria or subcutaneous also counts. **c)** According to the prescriber, the patient has heart failure or a previously treated lymphoproliferative disorder. **d)** According to the prescriber, the patient has been established on Actemra intravenous for at least 90 days; OR **e)** Patient has been established on Actemra subcutaneous for at least 90 days and prescription claims history indicates at least a 90-day supply of Actemra subcutaneous was dispensed within the past 130 days **[verification in prescription claims history required]** if claims history is not available, according to the prescriber **[verification by prescriber required]**. Note: In cases when 130 days of the patient's prescription claim history file is unavailable to be verified, an exception to this requirement is allowed if the prescriber has verified that the patient has been receiving Actemra subcutaneous for at least 90 days AND the patient has been receiving Actemra subcutaneous via paid claims (e.g., patient has not been receiving samples or coupons or other types of waivers in order to obtain access to Actemra subcutaneous). **B)** If the patient has met criterion 3Ai (the standard *Inflammatory Conditions – Actemra Subcutaneous Prior Authorization Policy* criteria), but criterion 3Aii is not met, offer to review for a Preferred Product using the respective standard *Inflammatory Conditions – Prior Authorization Policy* criteria: **i. Rheumatoid Arthritis:** Enbrel, Humira, Rinvoq, Xeljanz, or Xeljanz XR **ii. Polyarticular Juvenile Idiopathic Arthritis:** Enbrel, Humira, or Xeljanz **4. All Other Conditions** (including systemic juvenile idiopathic arthritis). Approve Actemra subcutaneous (initial therapy for a duration as directed or 1 year for patients continuing therapy) if the patient meets the standard *Inflammatory Conditions – Actemra Subcutaneous Prior Authorization Policy* criteria.
Cimzia	**1. Rheumatoid Arthritis – Initial Therapy.** **A)** Approve for 3 months if the patient meets the following (i and ii):

	i. Patient meets the standard *Inflammatory Conditions – Cimzia Prior Authorization Policy* criteria; AND **ii.** Patient has tried TWO of Actemra subcutaneous, Enbrel, Humira, Rinvoq, and Xeljanz/XR **[documentation required]**. Note: A trial of either or both Xeljanz products (Xeljanz and Xeljanz XR) collectively counts as **ONE** product. **B)** If the patient has met criterion 1Ai (the standard *Inflammatory Conditions – Cimzia Prior Authorization Policy* criteria), but criterion 1Aii is not met, offer to review for a Step 1 or Step 2 Product (Actemra subcutaneous, Enbrel, Humira, Rinvoq, Xeljanz, or Xeljanz XR) using the respective standard *Inflammatory Conditions Prior Authorization Policy* criteria. **2. Ankylosing Spondylitis – Initial Therapy**. **A)** Approve for 3 months if the patient meets the following (i and ii): **i.** Patient meets the standard *Inflammatory Conditions – Cimzia Prior Authorization Policy* criteria; AND **ii.** Patient has tried TWO of Enbrel, Humira, and Taltz **[documentation required]**. **B)** If the patient has met criterion 2Ai (the standard *Inflammatory Conditions – Cimzia Prior Authorization Policy* criteria), but criterion 2Aii is not met, offer to review for a Preferred Product (Enbrel, Humira, or Taltz) using the respective standard *Inflammatory Conditions Prior Authorization Policy* criteria. **3. Psoriatic Arthritis – Initial Therapy**. **A)** Approve for 3 months if the patient meets the following (i and ii): **i.** Patient meets the standard *Inflammatory Conditions – Cimzia Prior Authorization Policy* criteria; AND **ii.** Patient has tried TWO of Enbrel, Humira, Otezla, Stelara subcutaneous, Taltz, Tremfya, and Xeljanz/XR **[documentation required]**. Note: A trial of either or both Xeljanz products (Xeljanz and Xeljanz XR) collectively counts as **ONE** product. **B)** If the patient has met criterion 3Ai (the standard *Inflammatory Conditions – Cimzia Prior Authorization Policy* criteria), but criterion 3Aii is not met, offer to review for a Preferred Product (Enbrel, Humira, Otezla, Stelara subcutaneous, Taltz, Tremfya, or Xeljanz/XR) using the respective standard *Inflammatory Conditions Prior Authorization Policy* criteria). **4. Plaque Psoriasis – Initial Therapy.** **A)** Approve for 3 months if the patient meets the following (i and ii): **i.** Patient meets the standard *Inflammatory Conditions – Cimzia Prior Authorization Policy* criteria; AND **ii.** Patient has tried TWO of Enbrel, Humira, Otezla, Skyrizi, Stelara subcutaneous, Taltz, and Tremfya **[documentation required]**. **B)** If the patient has met criterion 4Ai (the standard *Inflammatory Conditions – Cimzia Prior Authorization Policy* criteria), but criterion 4Aii is not met, offer to review for a Preferred Product (Enbrel, Humira, Otezla, Skyrizi, Stelara subcutaneous, Taltz, or Tremfya) using the respective standard *Inflammatory Conditions Prior Authorization Policy* criteria). **5. Crohn's Disease – Initial Therapy.** **A)** Approve for 3 months if the patient meets the following (i and ii): **i.** Patient meets the standard *Inflammatory Conditions – Cimzia Prior Authorization Policy* criteria; AND

ii. Patient has tried Humira.

B) If the patient has met criterion 5Ai (the standard *Inflammatory Conditions – Cimzia Prior Authorization Policy* criteria), but criterion 5Aii is not met, offer to review for the Preferred Product (Humira or Stelara subcutaneous) using the standard *Inflammatory Conditions – Prior Authorization Policy* criteria.

6. Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis, Plaque Psoriasis, or Crohn's Disease – Patient is Currently Receiving Cimzia.

A) Approve for 1 year if the patient meets BOTH of the following (i and ii):

i. Patient meets the standard *Inflammatory Conditions – Cimzia Prior Authorization Policy* criteria; AND

ii. Patient meets ONE of the following conditions (a, b, c, d, e, or f):

a) Patient has Rheumatoid Arthritis and has tried TWO of Actemra subcutaneous, Enbrel, Humira, Rinvoq, and Xeljanz/XR **[documentation required]**; OR

Note: A trial of either or both Xeljanz products (Xeljanz and Xeljanz XR) collectively counts as **ONE** product.

b) Patient has Ankylosing Spondylitis and has tried TWO of Enbrel, Humira, and Taltz **[documentation required]**; OR

c) Patient has Psoriatic Arthritis and has tried TWO of Enbrel, Humira, Otezla, Stelara subcutaneous, Taltz, Tremfya, and Xeljanz/XR **[documentation required]**; OR

Note: A trial of either or both Xeljanz products (Xeljanz and Xeljanz XR) collectively counts as **ONE** product.

d) Patient has Plaque Psoriasis and has tried TWO of Enbrel, Humira, Otezla, Skyrizi, Stelara subcutaneous, Taltz, and Tremfya **[documentation required]**; OR

e) Patient has Crohn's Disease and has tried Humira; OR

f) Patient has been established on Cimzia for at least 90 days and prescription claims history indicates at least a 90-day supply of Cimzia was dispensed within the past 130 days **[verification in prescription claims history required]** if claims history is not available, according to the prescriber **[verification by prescriber required]**.

Note: In cases when 130 days of the patient's prescription claim history file is unavailable to be verified, an exception to this requirement is allowed if the prescriber has verified that the patient has been receiving Cimzia for at least 90 days AND the patient has been receiving Cimzia via paid claims (e.g., patient has not been receiving samples or coupons or other types of waivers in order to obtain access to Cimzia).

B) If the patient has met criterion 6Ai (the standard *Inflammatory Conditions – Cimzia Prior Authorization Policy* criteria), but criterion 6Aii is not met, offer to review for a one of the following Products using the respective standard *Inflammatory Conditions – Prior Authorization Policy* criteria:

i. Rheumatoid Arthritis: Actemra subcutaneous, Enbrel, Humira, Rinvoq, Xeljanz, or Xeljanz XR

ii. Ankylosing Spondylitis: Enbrel, Humira, or Taltz

iii. Psoriatic Arthritis: Enbrel, Humira, Otezla, Stelara subcutaneous, Taltz, Tremfya, Xeljanz, or Xeljanz XR

	iv. **Plaque Psoriasis:** Enbrel, Humira, Otezla, Skyrizi, Stelara subcutaneous, Taltz, or Tremfya v. **Crohn's Disease:** Humira or Stelara subcutaneous **7. Other Conditions.** Approve Cimzia (initial therapy for a duration as directed or 1 year for patients continuing therapy) if the patient meets the standard *Inflammatory Conditions – Cimzia Prior Authorization Policy* criteria.
Cosentyx	**1. Ankylosing Spondylitis – Initial Therapy.** **A)** Approve for 3 months if the patient meets the following (i and ii): **i.** Patient meets the standard *Inflammatory Conditions – Cosentyx Prior Authorization Policy* criteria; AND **ii.** Patient has tried TWO of Enbrel, Humira, and Taltz **[documentation required]**. Note: A trial of Cimzia, an infliximab Product (e.g. Remicade, biosimilars), or Simponi Aria or subcutaneous also counts **[documentation required]**. All approvals are reviewed by a Medical Director. **B)** If the patient has met criterion 1Ai (the standard *Inflammatory Conditions – Cosentyx Prior Authorization Policy* criteria), but criterion 1Aii is not met, offer to review for a Preferred Product (Humira, Enbrel, Taltz) using the respective standard *Inflammatory Conditions – Prior Authorization Policy* criteria. **2. Non-Radiographic Spondyloarthritis (nr-axSpA).** **A)** Approve for 3 months if the patient meets the following (i and ii): **i.** Patient meets the standard *Inflammatory Conditions – Cosentyx Prior Authorization Policy* criteria; AND **ii.** Patient has tried TWO of Cimzia and Taltz **[documentation required]**. Note: A trial of an Enbrel, Humira, an infliximab Product (e.g., Remicade, biosimilars), or Simponi Aria or subcutaneous also counts **[documentation required]**. All approvals are reviewed by a Medical Director. **B)** If the patient has met criterion 2Ai (the standard *Inflammatory Conditions – Cosentyx Prior Authorization Policy* criteria), but criterion 2Aii is not met, offer to review for a Preferred Product (Cimzia or Taltz) using the respective standard *Inflammatory Conditions – Prior Authorization Policy* criteria. **3. Plaque Psoriasis – Initial Therapy.** **A)** Approve for 3 months if the patient meets the following (i and ii): **i.** Patient meets the standard *Inflammatory Conditions – Cosentyx Prior Authorization Policy* criteria; AND **ii.** Patient has tried FOUR medications from at least three of the following groupings: 1) Enbrel, Humira (tumor necrosis factor inhibitor [TNFi]); 2) Skyrizi, Tremfya (interleukin [IL]-23 blocker); 3) Stelara subcutaneous (IL-12/23 blocker); 4) Taltz (IL-17 blocker); 5) Otezla (Phosphodiesterase type 4 [PDE4] blocker) **[documentation required]**. Note: A trial of Cimzia or an infliximab product (e.g., Remicade, biosimilars) also counts toward a trial of a TNFi **[documentation required]**. All approvals are reviewed by a Medical Director. **B)** If the patient has met criterion 3Ai (the standard *Inflammatory Conditions – Cosentyx Prior Authorization Policy* criteria), but criterion 3Aii is not met, offer to review for a Preferred Product (Enbrel, Humira, Otezla, Skyrizi,

Stelara subcutaneous, Taltz, or Tremfya) using the respective standard Inflammatory Conditions – *Prior Authorization* Policy criteria.

4. **Psoriatic Arthritis – Initial Therapy.**
   - **A)** Approve for 3 months if the patient meets the following (i and ii):
     - **i.** Patient meets the standard *Inflammatory Conditions – Cosentyx Prior Authorization Policy* criteria; AND
     - **ii.** Patient has tried THREE medications from at least two of the following groupings: 1) Enbrel, Humira (TNFi); 2) Tremfya (IL-23 blocker); 3) Stelara subcutaneous (IL-12/23 blocker); 4) Taltz (IL-17 blocker); 5) Xeljanz/XR (Janus kinases inhibitor) 6) Otezla (PDE4 blocker) **[documentation required]**.
       Note: A trial of Cimzia, an infliximab product (e.g., Remicade, biosimilars), or Simponi subcutaneous or Aria also counts toward a trial of a TNFi **[documentation required]**. A trial of either or both Xeljanz products (Xeljanz and Xeljanz XR) collectively counts as ONE product. All approvals are reviewed by a Medical Director.
   - **B)** If the patient has met criterion 4Ai (the standard *Inflammatory Conditions – Cosentyx Prior Authorization Policy* criteria), but criterion 4Aii is not met, offer to review for a Preferred Product (Enbrel, Humira, Otezla, Stelara subcutaneous, Taltz, Tremfya, Xeljanz, or Xeljanz XR) using the respective standard *Inflammatory Conditions – Prior Authorization Policy* criteria.
5. **Ankylosing Spondylitis, nr-axSpA, Plaque Psoriasis, or Psoriatic Arthritis – Patient is Currently Receiving Cosentyx.**
   - **A)** Approve for 1 year if the patient meets the following (i and ii):
     - **i.** Patient meets the standard *Inflammatory Conditions – Cosentyx Prior Authorization Policy* criteria; AND
     - **ii.** Patient meets ONE of the following conditions (a, b, c, d, or e):
       - **a)** Patient has Ankylosing Spondylitis and has tried TWO of Enbrel, Humira, and Taltz **[documentation required]**; OR
         Note: A trial of Cimzia, an infliximab product (e.g., Remicade, biosimilars), or Simponi (Aria or subcutaneous) also counts towards a trial of **[documentation required]**. All approvals are reviewed by a Medical Director.
       - **b)** Patient has nr-axSpA and has tried TWO of Cimzia and Taltz **[documentation required]**; OR
         Note: A trial of an Enbrel, Humira, an infliximab Product (e.g. Remicade, biosimilars), or Simponi (Aria or subcutaneous) also counts **[documentation required]**. All approvals are reviewed by a Medical Director.
       - **c)** Patient has Plaque Psoriasis and has tried FOUR medications from at least three of the following groupings: 1) Enbrel, Humira (tumor necrosis factor inhibitor [TNFi]); 2) Skyrizi, Tremfya (interleukin [IL]-23 blocker); 3) Stelara subcutaneous (IL-12/23 blocker); 4) Taltz (IL-17 blocker); 5) Otezla (Phosphodiesterase type 4 [PDE4] blocker) **[documentation required]**; OR
         Note: A trial of Cimzia or an infliximab product (e.g., Remicade, biosimilars) also counts toward a trial of a TNFi **[documentation required]**. All approvals are reviewed by a Medical Director.
       - **d)** Patient has Psoriatic Arthritis and has tried THREE medications from at least two of the following groupings: 1) Enbrel, Humira (TNFi); 2)

Tremfya (IL-23 blocker); 3) Stelara subcutaneous (IL-12/23 blocker); 4) Taltz (IL-17 blocker); 5) Xeljanz/XR (Janus kinases inhibitor) 6) Otezla (PDE4 blocker) **[documentation required]**; OR

Note: A trial of Cimzia, an infliximab product (e.g., Remicade, biosimilars), or Simponi subcutaneous or Aria also counts toward a trial of a TNFi **[documentation required]**. A trial of either or both Xeljanz products (Xeljanz and Xeljanz XR) collectively counts as ONE product. All approvals are reviewed by a Medical Director.

e) Patient has been established on Cosentyx for at least 90 days and prescription claims history indicates at least a 90-day supply of Cosentyx was dispensed within the past 130 days **[verification in prescription claims history required]** if claims history is not available, according to the prescriber **[verification by prescriber required]**, AND meets at least ONE of the following [(1), (2), (3), (4), (5), or (6)]:

Note: In cases when 130 days of the patient's prescription claim history file is unavailable to be verified, an exception to this requirement is allowed if the prescriber has verified that the patient has been receiving Cosentyx for at least 90 days AND the patient has been receiving Cosentyx via paid claims (e.g., patient has not been receiving samples or coupons or other types of waivers in order to obtain access to Cosentyx).

(1) According to the prescriber, the patient has previously experienced a sub-therapeutic response or intolerance to Taltz or Siliq **[documentation required]**; OR

(2) If the patient has Ankylosing Spondylitis or nr-axSpA: Patient has previously tried at least two biologics for the current condition, and according to the prescriber, the patient demonstrated inadequate efficacy or intolerance with both biologics **[documentation required]**; OR

(3) If the patient has Plaque Psoriasis: Patient has previously tried at least THREE medications from at least two different drug classes from the following list and, according to the prescriber, the patient demonstrated inadequate efficacy or intolerance with all three medications: 1) Interleukin (IL)-12/23 blocker; 2) IL-23 blockers; 3) Tumor necrosis factor inhibitors (TNFi) **[documentation required]**; OR

Note: Examples of medications from the drug classes: IL-12/23 blocker – Stelara; IL-23 blockers – Ilumya, Skyrizi, Tremfya; TNFis – adalimumab products (Humira, biosimilars), Cimzia, etanercept products (Enbrel, biosimilars), infliximab products (Remicade, biosimilars).

(4) If the patient has Psoriatic Arthritis: Patient has previously tried at least THREE medications from at least two different drug classes from the following list and, according to the prescriber, the patient demonstrated inadequate efficacy or intolerance with all three medications: 1) Interleukin (IL)-12/23 blocker; 2) IL-23 blocker; 3) Tumor necrosis factor inhibitors (TNFis); 4) Janus kinases inhibitor (JAKi); 5) T-cell costimulation modulator **[documentation required]**; OR

	Note: Examples of medications from the drug classes: IL-12/23 blocker – Stelara; IL-23 blocker – Tremfya; TNFis – adalimumab products (Humira, biosimilars), Cimzia, etanercept products (Enbrel, biosimilars), golimumab products (Simponi Aria or subcutaneous), infliximab products (Remicade, biosimilars); JAKi – Xeljanz/XR); T-cell costimulation modulator – Orencia intravenous or subcutaneous. **(5)** For at least 90 days, the patient has been receiving Cosentyx concomitantly with a traditional systemic agent for the condition being treated **[documentation required]**; OR Note: Examples of systemic agents taken for psoriasis include methotrexate, acitretin, and cyclosporine. Examples of systemic agents taken for rheumatic conditions include methotrexate, sulfasalazine, and leflunomide. **(6)** If the patient has plaque psoriasis: For at least 90 days, the patient has been receiving Cosentyx in combination with phototherapy **[documentation required]**. Note: Examples include narrowband ultraviolet B [NB-UVB] phototherapy. This does **not** include concomitant use with localized laser therapy for treatment of limited disease. Note: All approvals are reviewed by a Medical Director. For a patient who has not tried the Preferred Products, **Taltz** is approved for patients who meet criterion 4Aiie but do **not** meet 4Aiie [(1), (2), (3), (4), (5), or (6)]. **B)** If the patient has met criterion 4Ai (the standard *Inflammatory Conditions – Cosentyx Prior Authorization Policy* criteria), but criterion 4Aii is not met, offer to review for a Preferred Product using the respective standard *Inflammatory Conditions – Prior Authorization Policy* criteria: **i. Ankylosing Spondylitis:** Enbrel, Humira, or Taltz **ii. nr-axSpA:** Cimzia or Taltz **iii. Plaque Psoriasis:** Enbrel, Humira, Otezla, Skyrizi, Stelara subcutaneous, Taltz, or Tremfya **iv. Psoriatic Arthritis:** Enbrel, Humira, Otezla, Stelara subcutaneous, Taltz, Tremfya, or Xeljanz, or Xeljanz XR **6. Other Conditions.** Approve Cosentyx (initial therapy for a duration as directed or 1 year for patients continuing therapy) if the patient meets the standard *Inflammatory Conditions – Cosentyx Prior Authorization Policy* criteria. All approvals are reviewed by a Medical Director.
Ilumya	**1. Plaque Psoriasis – Initial Therapy.** **A)** Approve for 3 months if the patient meets the following (i and ii): **i.** Patient meets the standard *Inflammatory Conditions – Ilumya Prior Authorization Policy* criteria; AND **ii.** Patient has tried TWO of Enbrel, Humira, Otezla, Skyrizi, Stelara subcutaneous, Taltz, and Tremfya **[documentation required]**. **B)** If the patient has met criterion 1Ai (the standard *Inflammatory Conditions – Ilumya Prior Authorization Policy* criteria), but criterion 1Aii is not met, offer to review for a Preferred Product (Enbrel, Humira, Otezla, Skyrizi, Stelara subcutaneous, Taltz, and Tremfya) using the respective standard *Inflammatory Conditions – Prior Authorization Policy* criteria. **2. Plaque Psoriasis – Patient is Currently Receiving Ilumya.**

	A) Approve for 1 year if the patient meets BOTH of the following (i and ii): **i.** Patient meets the standard *Inflammatory Conditions – Ilumya Prior Authorization Policy* criteria; AND **ii.** Patient meets ONE of the following conditions (a or b): **a)** Patient has plaque psoriasis and has tried TWO of Enbrel, Humira, Otezla, Skyrizi, Stelara subcutaneous, Taltz, or Tremfya **[documentation required]**; OR **b)** Patient has been established on Ilumya for at least 90 days and prescription claims history indicates at least a 90-day supply of Ilumya was dispensed within the past 130 days **[verification in prescription claims history required]** if claims history is not available, according to the prescriber **[verification by prescriber required]**. Note: In cases when 130 days of the patient's prescription claim history file is unavailable to be verified, an exception to this requirement is allowed if the prescriber has verified that the patient has been receiving Ilumya for at least 90 days AND the patient has been receiving Ilumya via paid claims (e.g., patient has not been receiving samples or coupons or other types of waivers in order to obtain access to Ilumya). **B)** If the patient has met criterion 2Ai (the standard *Inflammatory Conditions – Ilumya Prior Authorization Policy* criteria), but criterion 2Aii is not met, offer to review for a Preferred Product (Enbrel, Humira, Otezla, Skyrizi, Stelara subcutaneous, Taltz, or Tremfya) using the respective standard *Inflammatory Conditions – Prior Authorization Policy* criteria. **3. Other Conditions.** Approve Ilumya (initial therapy for a duration as directed or 1 year for patients continuing therapy) if the patient meets the standard *Inflammatory Conditions – Ilumya Prior Authorization Policy* criteria.
Kevzara	**1. Rheumatoid Arthritis – Initial Therapy.** **A)** Approve for 3 months if the patient meets the following conditions (i and ii): **i.** Patient meets the standard *Inflammatory Conditions – Kevzara Prior Authorization Policy* criteria; AND **ii.** Patient meets ONE of the following conditions (a or b): **a)** Patient has tried TWO of Actemra subcutaneous, Enbrel, Humira, Rinvoq, and Xeljanz/XR **[documentation required]**; OR Note: A trial of either or both Xeljanz products (Xeljanz and Xeljanz XR) collectively counts as **ONE** product. A trial of Actemra intravenous, Cimzia, an infliximab product (e.g., Remicade, biosimilars), Orencia intravenous or subcutaneous, or Simponi Aria or subcutaneous also counts **[documentation required]**. **b)** According to the prescriber, the patient has heart failure OR a previously treated lymphoproliferative disorder. **B)** If the patient has met criterion 1Ai (the standard *Inflammatory Conditions – Kevzara Prior Authorization Policy* criteria), but criterion 1Aii is not met, offer to review for a Step 1 or Step 2 Product (Actemra subcutaneous, Enbrel, Humira, Rinvoq, Xeljanz, or Xeljanz XR) using the respective standard *Inflammatory Conditions Prior Authorization Policy* criteria. **2. Rheumatoid Arthritis – Patient is Currently Receiving Kevzara.** **A)** Approve for 1 year if the patient meets BOTH of the following conditions (i and ii):

	i. Patient meets the standard *Inflammatory Conditions – Kevzara Prior Authorization Policy* criteria; AND **ii.** Patient meets ONE of the following conditions (a, b, or c): **a)** Patient has tried TWO of Actemra subcutaneous, Enbrel, Humira, Rinvoq, and Xeljanz/XR **[documentation required]**; OR Note: A trial of either or both Xeljanz products (Xeljanz and Xeljanz XR) collectively counts as **ONE** product. A trial of Actemra intravenous, Cimzia, an infliximab product (e.g., Remicade, biosimilars), Orencia intravenous or subcutaneous, or Simponi Aria or subcutaneous also counts **[documentation required]**. **b)** According to the prescriber, the patient has heart failure OR a previously treated lymphoproliferative disorder; OR **c)** Patient has been established on Kevzara for at least 90 days and prescription claims history indicates at least a 90-day supply of Kevzara was dispensed within the past 130 days **[verification in prescription claims history required]** if claims history is not available, according to the prescriber **[verification by prescriber required]**. Note: In cases when 130 days of the patient's prescription claim history file is unavailable to be verified, an exception to this requirement is allowed if the prescriber has verified that the patient has been receiving Kevzara for at least 90 days AND the patient has been receiving Kevzara via paid claims (e.g., patient has not been receiving samples or coupons or other types of waivers in order to obtain access to Kevzara). **B)** If the patient has met criterion 2Ai (the standard *Inflammatory Conditions – Kevzara Prior Authorization Policy* criteria), but criterion 2Aii is not met, offer to review for a Step 1 or Step 2 Product (Actemra subcutaneous, Enbrel, Humira, Rinvoq, Xeljanz, or Xeljanz XR) using the respective standard *Inflammatory Conditions – Prior Authorization Policy* criteria. **3. Other Conditions.** Approve Kevzara (initial therapy for a duration as directed or 1 year for patients continuing therapy) if the patient meets the standard *Inflammatory Conditions – Kevzara Prior Authorization Policy* criteria.
Kineret	**1. Rheumatoid Arthritis – Initial Therapy.** **A)** Approve for 3 months if the patient meets the following (i and ii): **i.** Patient meets the standard *Inflammatory Conditions – Kineret Prior Authorization Policy* criteria; AND **ii.** Patient has tried TWO of Actemra subcutaneous, Enbrel, Humira, Rinvoq, and Xeljanz/XR **[documentation required]**. Note: A trial of either or both Xeljanz products (Xeljanz and Xeljanz XR) collectively counts as **ONE** product. A trial of Actemra intravenous, Cimzia, Orencia subcutaneous or intravenous, an infliximab product (e.g., Remicade, biosimilars), Kevzara, and Simponi Aria or subcutaneous also counts **[documentation required]**. **B)** If the patient has met criterion 1Ai (the standard *Inflammatory Conditions – Kineret Prior Authorization Policy* criteria), but criterion 1Aii is not met, offer to review for a Step 1 or Step 2 Product (Actemra subcutaneous, Enbrel, Humira, Rinvoq, Xeljanz, or Xeljanz XR) using the respective standard *Inflammatory Conditions – Prior Authorization Policy* criteria. **2. Rheumatoid Arthritis – Patient is Currently Receiving Kineret.**

	A) Approve for 1 year if the patient meets BOTH of the following conditions (i and ii): **i.** Patient meets the standard *Inflammatory Conditions – Kineret Prior Authorization Policy* criteria; AND **ii.** Patient meets ONE of the following (a or b): **a)** Patient has tried TWO of Actemra subcutaneous, Enbrel, Humira, Rinvoq, and Xeljanz/XR **[documentation required]**; OR Note: A trial of either or both Xeljanz products (Xeljanz and Xeljanz XR) collectively counts as **ONE** product. A trial of Actemra intravenous, Cimzia, Orencia subcutaneous or intravenous, an infliximab product (e.g., Remicade, biosimilars), Kevzara, or Simponi Aria or subcutaneous also counts **[documentation required]**. **b)** Patient has been established on Kineret at least 90 days and prescription claims history indicates at least a 90-day supply of Kineret was dispensed within the past 130 days **[verification in prescription claims history required]** if claims history is not available, according to the prescriber **[verification by prescriber required]**. Note: In cases when 130 days of the patient's prescription claim history file is unavailable to be verified, an exception to this requirement is allowed if the prescriber has verified that the patient has been receiving Kineret for at least 90 days AND the patient has been receiving Kineret via paid claims (e.g., patient has not been receiving samples or coupons or other types of waivers in order to obtain access to Kineret). **B)** If the patient has met criterion 2Ai (the standard *Inflammatory Conditions – Kineret Prior Authorization Policy* criteria), but criterion 2Aii is not met, offer to review for a Step 1 or Step 2 Product (Actemra subcutaneous, Enbrel, Humira, Rinvoq, Xeljanz, or Xeljanz XR) using the respective standard *Inflammatory Conditions – Prior Authorization Policy* criteria. **3. Other Conditions (e.g., Cryopyrin-Associated Periodic Syndromes [CAPS], Systemic Juvenile Idiopathic Arthritis).** Approve Kineret (initial therapy for a duration as directed or 1 year for patients continuing therapy) if the patient meets the standard *Inflammatory Conditions – Kineret Prior Authorization Policy* criteria.
Olumiant	**1. Rheumatoid Arthritis – Initial Therapy.** **A)** Approve for 3 months if the patient meets the following (i and ii): **i.** Patient meets the standard *Inflammatory Conditions – Olumiant Prior Authorization Policy* criteria; AND **ii.** Patient has tried TWO of Actemra subcutaneous, Enbrel, Humira, Rinvoq, and Xeljanz/XR **[documentation required]**. Note: A trial of either or both Xeljanz products (Xeljanz and Xeljanz XR) collectively counts as **ONE** product. A trial of Actemra intravenous, Cimzia, an infliximab product (e.g., Remicade, biosimilars), Kevzara, Orencia intravenous or subcutaneous, or Simponi Aria or subcutaneous also counts **[documentation required]**. **B)** If the patient has met criterion 1Ai (the standard *Inflammatory Conditions – Olumiant Prior Authorization Policy* criteria), but criterion 1Aii is not met, offer to review for a Step 1 or Step 2 Product (Actemra subcutaneous, Enbrel,

	Humira, Rinvoq, Xeljanz, or Xeljanz XR) using the respective standard *Inflammatory Conditions Prior Authorization Policy* criteria. **2. Rheumatoid Arthritis – Patient is Currently Receiving Olumiant.** **A)** Approve for 1 year if the patient meets BOTH of the following (i and ii): **i.** Patient meets the standard *Inflammatory Conditions – Olumiant Prior Authorization Policy* criteria; AND **ii.** Patient meets ONE of the following conditions (a or b): **a)** Patient has tried TWO of Actemra subcutaneous, Enbrel, Humira, Rinvoq, and Xeljanz/XR **[documentation required]**; OR Note: A trial of either or both Xeljanz products (Xeljanz and Xeljanz XR) collectively counts as **ONE** product. A trial of Actemra intravenous, Cimzia, an infliximab product (e.g., Remicade, biosimilars), Kevzara, Orencia intravenous or subcutaneous, or Simponi Aria or subcutaneous also counts **[documentation required]**. **b)** Patient has been established on Olumiant for at least 90 days and prescription claims history indicates at least a 90-day supply of Olumiant was dispensed within the past 130 days **[verification in prescription claims history required]** if claims history is not available, according to the prescriber **[verification by prescriber required]**. Note: In cases when 130 days of the patient's prescription claim history file is unavailable to be verified, an exception to this requirement is allowed if the prescriber has verified that the patient has been receiving Olumiant for at least 90 days AND the patient has been receiving Olumiant via paid claims (e.g., patient has not been receiving samples or coupons or other types of waivers in order to obtain access to Olumiant). **B)** If the patient has met criterion 2Ai (the standard *Inflammatory Conditions – Olumiant Prior Authorization Policy* criteria), but criterion 2Aii is not met, offer to review for a Step 1 or Step 2 Product (Actemra subcutaneous, Enbrel, Humira, Rinvoq, Xeljanz, or Xeljanz XR) using the respective standard *Inflammatory Conditions – Prior Authorization Policy* criteria. **3. Other Conditions.** Approve Olumiant (initial therapy for a duration as directed or 1 year for patients continuing therapy) if the patient meets the standard *Inflammatory Conditions – Olumiant Prior Authorization Policy* criteria.
Orencia Subcutaneous	**1. Rheumatoid Arthritis – Initial Therapy.** **A)** Approve for 3 months if the patient meets the following (i and ii): **i.** Patient meets the standard *Inflammatory Conditions – Orencia Subcutaneous Prior Authorization Policy* criteria; AND **ii.** Patient meets ONE of the following conditions (a or b): **a)** Patient has tried TWO of Actemra subcutaneous, Enbrel, Humira, Rinvoq, or Xeljanz/XR **[documentation required]**; OR Note: A trial of either or both Xeljanz products (Xeljanz and Xeljanz XR) collectively counts as **ONE** product. A trial of Actemra intravenous, Cimzia, an infliximab product (e.g., Remicade, biosimilars), Kevzara, or Simponi Aria or subcutaneous also counts **[documentation required]**. **b)** According to the prescriber, the patient has heart failure, a previously treated lymphoproliferative disorder, OR a previous serious infection.

B) If the patient has met criterion 1Ai (the standard *Inflammatory Conditions – Orencia Subcutaneous Prior Authorization Policy* criteria), but criterion 1Aii is not met, offer to review for a Step 1 or Step 2 Product (Actemra subcutaneous, Enbrel, Humira, Rinvoq, Xeljanz, or Xeljanz XR) using the respective standard *Inflammatory Conditions Prior Authorization Policy* criteria.

2. Juvenile Idiopathic Arthritis/Juvenile Rheumatoid Arthritis – Initial Therapy.

A) Approve for 3 months if the patient meets the following (i and ii):

i. Patient meets the standard *Inflammatory Conditions – Orencia Subcutaneous Prior Authorization Policy* criteria; AND

ii. Patient meets ONE of the following conditions (a or b):

a) Patient has tried TWO of Actemra subcutaneous, Enbrel, Humira, and Xeljanz; OR

Note: A trial of Actemra intravenous, Orencia intravenous, an infliximab product (e.g., Remicade, biosimilars), or Simponi Aria also counts **[documentation required]**.

b) According to the prescriber, the patient has heart failure, a previously treated lymphoproliferative disorder, OR a previous serious infection.

B) If the patient has met criterion 2Ai (the standard *Inflammatory Conditions – Orencia Subcutaneous Prior Authorization Policy* criteria), but criterion 2Aii is not met: offer to review for a Step 1 or Step 2 Product (Actemra subcutaneous, Enbrel, Humira, or Xeljanz) using the respective standard *Inflammatory Conditions – Prior Authorization Policy* criteria.

3. Psoriatic Arthritis – Initial Therapy.

A) Approve for 3 months if the patient meets the following (i and ii):

i. Patient meets the standard *Inflammatory Conditions – Orencia Subcutaneous Prior Authorization Policy* criteria; AND

ii. Patient meets ONE of the following conditions (a or b):

a) Patient has tried TWO of Enbrel, Humira, Otezla, Stelara subcutaneous, Taltz, Tremfya, or Xeljanz/XR **[documentation required]**; OR

Note: A trial of either or both Xeljanz products (Xeljanz and Xeljanz XR) collectively counts as **ONE** product. A trial of Cimzia, an infliximab product (e.g., Remicade, biosimilars), or Simponi Aria or subcutaneous also counts **[documentation required]**.

b) According to the prescriber, the patient has heart failure, a previously treated lymphoproliferative disorder, OR a previous serious infection.

B) If the patient has met criterion 3Ai (the standard *Inflammatory Conditions – Orencia Subcutaneous Prior Authorization Policy* criteria), but criterion 3Aii is not met: offer to review for a Preferred Product (Enbrel, Humira, Otezla, Stelara subcutaneous, Taltz, Tremfya, Xeljanz, or Xeljanz XR) using the respective standard *Inflammatory Conditions – Prior Authorization Policy* criteria.

4. Rheumatoid Arthritis, Juvenile Idiopathic Arthritis, or Psoriatic Arthritis – Patient is Currently Receiving Orencia (Subcutaneous or Intravenous).

A) Approve for 1 year if the patient meets BOTH of the following (i and ii):

i. Patient meets the standard *Inflammatory Conditions – Orencia Subcutaneous Policy* criteria; AND

ii. Patient meets ONE of the following (a, b, c, d, e, or f):

a) Patient has Rheumatoid Arthritis and has tried TWO of Actemra subcutaneous, Enbrel, Humira, Rinvoq, or Xeljanz/XR **[documentation required]**; OR
Note: A trial of either or both Xeljanz products (Xeljanz and Xeljanz XR) collectively counts as **ONE** product. A trial of Actemra intravenous, Cimzia, an infliximab product (e.g., Remicade, biosimilars), Kevzara, Simponi (Aria or subcutaneous) also counts **[documentation required]**.

b) Patient has Juvenile Idiopathic Arthritis and has tried TWO of Actemra subcutaneous, Enbrel, Humira, and Xeljanz; OR
Note: A trial of Actemra intravenous, Orencia intravenous, an infliximab product (e.g., Remicade, biosimilars), or Simponi Aria also counts **[documentation required]**.

c) Patient has Psoriatic Arthritis and has tried TWO of Enbrel, Humira, Otezla, Stelara subcutaneous, Taltz, Tremfya, or Xeljanz/XR **[documentation required]**; OR
Note: A trial of either or both Xeljanz products (Xeljanz and Xeljanz XR) collectively counts as **ONE** product. A trial of Cimzia, an infliximab product (e.g., Remicade, biosimilars), or Simponi Aria or subcutaneous also counts **[documentation required]**.

d) According to the prescriber, the patient has been established on Orencia intravenous for at least 90 days; OR

e) According to the prescriber, the patient has heart failure, a previously treated lymphoproliferative disorder, or a previous serious infection; OR

f) Patient has been established on Orencia subcutaneous for at least 90 days and prescription claims history indicates at least a 90-day supply of Orencia subcutaneous was dispensed within the past 130 days **[verification in prescription claims history required]** if claims history is not available, according to the prescriber **[verification by prescriber required]**.
Note: In cases when 130 days of the patient's prescription claim history file is unavailable to be verified, an exception to this requirement is allowed if the prescriber has verified that the patient has been receiving Orencia subcutaneous for at least 90 days AND the patient has been receiving Orencia subcutaneous via paid claims (e.g., patient has not been receiving samples or coupons or other types of waivers in order to obtain access to Orencia subcutaneous).

B) If the patient has met criterion 4Ai (the standard *Inflammatory Conditions – Orencia Subcutaneous Prior Authorization Policy* criteria), but criterion 4Aii is not met, offer to review for one of the following Products using the respective standard *Inflammatory Conditions Prior Authorization Policy* criteria.

i. Rheumatoid Arthritis: Actemra subcutaneous, Enbrel, Humira, Rinvoq, Xeljanz, or Xeljanz XR

ii. Juvenile Idiopathic Arthritis: Actemra subcutaneous, Enbrel, Humira, and Xeljanz

iii. Psoriatic Arthritis: Enbrel, Humira, Otezla, Stelara subcutaneous, Taltz, Tremfya, Xeljanz, or Xeljanz XR

	5. <u>Other Conditions</u>. Approve <u>Orencia subcutaneous</u> (initial therapy for a duration as directed or <u>1 year</u> for patients continuing therapy) if the patient meets the standard *Inflammatory Conditions – Orencia Subcutaneous Prior Authorization Policy* criteria.
Siliq	**1. <u>Plaque Psoriasis – Initial Therapy</u>.** **A)** Approve for 3 months if the patient meets the following (i <u>and</u> ii): **i.** Patient meets the standard *Inflammatory Conditions – Siliq Prior Authorization Policy* criteria for plaque psoriasis; AND **ii.** Patient has tried TWO of Enbrel, Humira, Otezla, Skyrizi, Stelara subcutaneous, Taltz, and Tremfya **[documentation required]**. **B)** If the patient has met criterion 1Ai (the standard *Inflammatory Conditions – Siliq Prior Authorization Policy* criteria), but criterion 1Aii is not met, offer to review for a Preferred Product (<u>Enbrel, Humira, Otezla, Skyrizi, Stelara subcutaneous, Taltz, or Tremfya</u>) using the respective standard *Inflammatory Conditions – Prior Authorization Policy* criteria. **2. <u>Plaque Psoriasis – Patient is Currently Receiving Siliq</u>.** **A)** Approve for 1 year if the patient meets the following (i <u>and</u> ii): **i.** Patient meets the standard *Inflammatory Conditions – Siliq Prior Authorization Policy* criteria; AND **ii.** Patient meets ONE of the following conditions (a <u>or</u> b): **a)** Patient has tried TWO of Enbrel, Humira, Otezla, Skyrizi, Stelara subcutaneous, Taltz, or Tremfya **[documentation required]**; OR **b)** Patient has been established on Siliq for at least 90 days <u>and</u> prescription claims history indicates <u>at least a 90-day supply of Siliq was dispensed within the past 130 days</u> **[verification in prescription claims history required]** if claims history is not available, according to the prescriber **[verification by prescriber required]**, AND meets at least ONE of the following [(1), (2), (3), <u>or</u> (4)]: <u>Note</u>: In cases when 130 days of the patient's prescription claim history file is unavailable to be verified, an exception to this requirement is allowed if the prescriber has verified that the patient has been receiving Siliq for at least 90 days AND the patient has been receiving Siliq via paid claims (e.g., patient has <u>not</u> been receiving samples or coupons or other types of waivers in order to obtain access to Siliq). **(1)** According to the prescriber, the patient has previously experienced a sub-therapeutic response or intolerance to Cosentyx or Taltz **[documentation required]**; OR **(2)** Patient has previously tried at least THREE medications from at least <u>two</u> different drug classes from the following list and, according to the prescriber, the patient demonstrated inadequate efficacy or intolerance with all three medications: 1) Interleukin (IL)-12/23 blocker; 2) IL-23 blockers; 3) Tumor necrosis factor inhibitors (TNFis) **[documentation required]**; OR <u>Note</u>: Examples of medications from the drug classes: IL-12/23 blocker – Stelara; IL-23 blockers – Ilumya, Skyrizi, Tremfya; TNFis – adalimumab products (Humira, biosimilars), Cimzia, etanercept products (Enbrel, biosimilars), infliximab products (Remicade, biosimilars).

	(3) For at least 90 days, the patient has been receiving Siliq concomitantly with a traditional systemic agent for the condition being treated **[documentation required]**; OR Note: Examples of systemic agents taken for psoriasis include methotrexate, acitretin, and cyclosporine. **(4)** For at least 90 days, the patient has been receiving Siliq in combination with phototherapy **[documentation required]**. Note: Examples include narrowband ultraviolet B (NB-UVB) phototherapy. This does **not** include concomitant use with localized laser therapy for treatment of limited disease. Note: For patients who have not tried the Preferred Products, Taltz is approved for patients who meet criterion 2Aiib but do not meet 2Aiib[(1), (2), (3), or (4)]. **B)** If the patient has met criterion 2Ai (the standard *Inflammatory Conditions – Siliq Prior Authorization Policy* criteria), but criterion 2Aii is not met, offer to review for a Preferred Product (Enbrel, Humira, Otezla, Skyrizi, Stelara subcutaneous, Taltz, or Tremfya) using the respective standard *Inflammatory Conditions – Prior Authorization Policy* criteria. **3. Other Conditions.** Approve Siliq (initial therapy for a duration as directed or 1 year for patients continuing therapy) if the patient meets the standard *Inflammatory Conditions – Siliq Prior Authorization Policy* criteria.
Simponi Subcutaneous	**1. Rheumatoid Arthritis – Initial Therapy.** **A)** Approve for 3 months if the patient meets the following (i and ii): **i.** Patient meets the standard *Inflammatory Conditions – Simponi Subcutaneous Prior Authorization Policy* criteria; AND **ii.** Patient has tried TWO of Actemra subcutaneous, Enbrel, Humira, Rinvoq, and Xeljanz/XR **[documentation required]**; OR Note: A trial of either or both Xeljanz products (Xeljanz and Xeljanz XR) collectively counts as **ONE** product. **B)** If the patient has met criterion 1Ai (the standard *Inflammatory Conditions – Simponi Subcutaneous Prior Authorization Policy* criteria), but criterion 1Aii is not met, offer to review for a Step 1 or Step 2 Product (Actemra subcutaneous, Enbrel, Humira, Rinvoq, Xeljanz, or Xeljanz XR) using the respective standard *Inflammatory Conditions – Prior Authorization Policy* criteria. **2. Ankylosing Spondylitis – Initial Therapy.** **A)** Approve for 3 months if the patient meets the following (i and ii): **i.** Patient meets the standard *Inflammatory Conditions – Simponi Subcutaneous Prior Authorization Policy* criteria; AND **ii.** Patient has tried TWO of Enbrel, Humira, and Taltz **[documentation required]**. **B)** If the patient has met criterion 2Ai (the standard *Inflammatory Conditions – Simponi Subcutaneous Prior Authorization Policy* criteria), but criterion 2Aii is not met, offer to review for a Preferred Product (Enbrel, Humira, or Taltz) using the respective standard *Inflammatory Conditions – Prior Authorization Policy* criteria. **3. Psoriatic Arthritis – Initial Therapy.** **A)** Approve for 3 months if the patient meets the following (i and ii): **i.** Patient meets the standard *Inflammatory Conditions – Simponi Subcutaneous Prior Authorization Policy* criteria; AND

ii. Patient has tried TWO of Enbrel, Humira, Otezla, Stelara subcutaneous, Taltz, Tremfya, and Xeljanz/XR **[documentation required]**.
Note: A trial of either or both Xeljanz products (Xeljanz and Xeljanz XR) collectively counts as **ONE** product.

B) If the patient has met criterion 3Ai (the standard *Inflammatory Conditions – Simponi Subcutaneous Prior Authorization Policy* criteria), but criterion 3Aii is not met, offer to review for a Preferred Product (Enbrel, Humira, Otezla, Stelara subcutaneous, Taltz, Tremfya, Xeljanz, or Xeljanz XR) using the respective standard *Inflammatory Conditions – Prior Authorization Policy* criteria.

4. Ulcerative Colitis – Initial Therapy.

A) Approve for 3 months if the patient meets the following (i and ii):

i. Patient meets the standard *Inflammatory Conditions – Simponi Subcutaneous Prior Authorization Policy* criteria; AND

ii. Patient has tried Humira.

B) If the patient has met criterion 4Ai (the standard *Inflammatory Conditions – Simponi Subcutaneous Prior Authorization Policy* criteria), but criterion 4Aii is not met, offer to review for a Preferred Product (Humira or Stelara subcutaneous) using the standard *Inflammatory Conditions Prior Authorization Policy* criteria.

5. Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis, or Ulcerative Colitis – Patient is Currently Receiving Simponi Subcutaneous or Aria.

A) Approve for 1 year if the patient meets BOTH of the following (i and ii):

i. Patient meets the standard *Inflammatory Conditions – Simponi Subcutaneous Prior Authorization Policy* criteria; AND

ii. Patient meets ONE of the following conditions (a, b, c, d, e, or f):

a) Patient has Rheumatoid Arthritis and has tried TWO of Actemra subcutaneous, Enbrel, Humira, Rinvoq, and Xeljanz/XR **[documentation required]**; OR
Note: A trial of either or both Xeljanz products (Xeljanz and Xeljanz XR) collectively counts as **ONE** product.

b) Patient has Ankylosing Spondylitis and has tried TWO of Enbrel, Humira, and Taltz **[documentation required]**; OR

c) Patient has Psoriatic Arthritis and has tried TWO of Enbrel, Humira, Otezla, Stelara subcutaneous, Taltz, Tremfya, and Xeljanz/XR **[documentation required]**; OR
Note: A trial of either or both Xeljanz products (Xeljanz and Xeljanz XR) collectively counts as **ONE** product.

d) Patient has Ulcerative Colitis and has tried Humira; OR

e) According to the prescriber, the patient has been established on Simponi Aria for at least 90 days; OR

f) Patient has been established on Simponi subcutaneous for at least 90 days and prescription claims history indicates at least a 90-day supply of Simponi subcutaneous was dispensed within the past 130 days **[verification in prescription claims history required]** if claims history is not available, according to the prescriber **[verification by prescriber required]**.
Note: In cases when 130 days of the patient's prescription claim history file is unavailable to be verified, an exception to this

	requirement is allowed if the prescriber has verified that the patient has been receiving Simponi subcutaneous for at least 90 days AND the patient has been receiving Simponi subcutaneous via paid claims (e.g., patient has not been receiving samples or coupons or other types of waivers in order to obtain access to Simponi subcutaneous). **B)** If the patient has met criterion 5Ai (the standard *Inflammatory Conditions – Simponi subcutaneous Prior Authorization Policy* criteria), but criterion 5Aii is not met, offer to review for a one of the following Products using the respective standard *Inflammatory Conditions – Prior Authorization Policy* criteria: **i. Rheumatoid Arthritis:** Actemra subcutaneous, Enbrel, Humira, Rinvoq, Xeljanz, or Xeljanz XR **ii. Ankylosing Spondylitis:** Enbrel, Humira, or Taltz **iii. Psoriatic Arthritis:** Enbrel, Humira, Otezla, Stelara subcutaneous, Taltz, Tremfya, Xeljanz, or Xeljanz XR **iv. Ulcerative Colitis:** Humira or Stelara subcutaneous **6. Other Conditions**. Approve Simponi subcutaneous (initial therapy for a duration as directed or 1 year for patients continuing therapy) if the patient meets the standard *Inflammatory Conditions – Simponi Subcutaneous Prior Authorization Policy* criteria.
Xeljanz **Xeljanz XR**	**1. Ulcerative Colitis – Initial Therapy.** **A)** Approve for 4 months if the patient meets the following (i and ii): **i.** Patient meets the standard *Inflammatory Conditions – Xeljanz/Xeljanz XR Prior Authorization Policy* criteria; AND **ii.** Patient has tried Humira. Note: A trial of an infliximab product (e.g., Remicade, biosimilars) or Simponi subcutaneous also counts. **B)** If the patient has met criterion 1Ai (the standard *Inflammatory Conditions – Xeljanz/Xeljanz XR Prior Authorization Policy* criteria), but criterion 1Aii is not met, offer to review for the Preferred Product (Humira or Stelara subcutaneous) using the standard *Inflammatory Conditions Prior Authorization Policy* criteria. **2. Ulcerative Colitis – Patient is Currently Receiving Xeljanz/Xeljanz XR.** **A)** Approve for 1 year if the patient meets the following (i and ii): **i.** Patient meets the standard *Inflammatory Conditions – Xeljanz/Xeljanz XR Prior Authorization Policy* criteria; AND **ii.** Patient meets ONE of the following conditions (a or b): **a)** Patient has tried Humira; OR Note: A trial of an infliximab product (e.g., Remicade, biosimilars) or Simponi subcutaneous also counts. **b)** Patient has been established on Xeljanz/Xeljanz XR for at least 90 days and prescription claims history indicates at least a 90-day supply of Xeljanz/Xeljanz XR was dispensed within the past 130 days **[verification in prescription claims history required]** if claims history is not available, according to the prescriber **[verification by prescriber required]**; OR Note: In cases when 130 days of the patient's prescription claim history file is unavailable to be verified, an exception to this requirement is allowed if the prescriber has verified that the patient has been receiving Xeljanz/Xeljanz XR for at least 90 days AND the

	patient has been receiving Xeljanz/Xeljanz XR via paid claims (e.g., patient has <u>not</u> been receiving samples or coupons or other types of waivers in order to obtain access to Xeljanz/Xeljanz XR). **B)** If the patient has met criterion 2Ai (the standard *Inflammatory Conditions – Xeljanz/Xeljanz XR Prior Authorization Policy* criteria but criterion 2Aii is not met, offer to review for a Preferred product (<u>Humira or Stelara subcutaneous</u>) using the respective standard *Inflammatory Conditions Prior Authorization Policy* criteria. **3. <u>Other Conditions</u>.** Approve the requested agent (initial therapy for a duration as directed or <u>1 year</u> for patients continuing therapy) if the patient meets the standard *Inflammatory Conditions – Xeljanz/Xeljanz XR Prior Authorization Policy* criteria.

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APPENDIX A

Table 1. Approved TNFis for Targeted Indications.*

	Rheumatology					Dermatology	Gastroenterology	
	RA	**JIA**	**AS**	**nr-axSpA**	**PsA**	**PsO**	**CD**	**UC**
Tumor Necrosis Factor Inhibitors								
Cimzia	√	--	√	√	√	√	√	--
Enbrel	√	√	√	--	√	√	--	--
Humira	√	√	√	--	√	√	√	√
Infliximab Products#	√	--	√	--	√	√	√	√
Simponi Subcutaneous	√	--	√	--	√	--	--	√
Simponi Aria	√	√	√	--	√	--	--	--

TNFis – Tumor necrosis factor inhibitors; * Refer to the selected standard *Inflammatory Conditions Prior Authorization Policies* for the specific patient population approved for each indication; RA – Rheumatoid arthritis; JIA – Juvenile idiopathic arthritis; AS – Ankylosing spondylitis; nr-axSpA – Non-radiographic spondyloarthritis; PsA – Psoriatic arthritis; PsO – Plaque psoriasis; CD – Crohn's disease; UC – Ulcerative colitis; # Remicade, biosimilars.

Table 2. Approved IL-17, IL-23, and IL-12/23 Blockers for Targeted Indications.[*]

	Rheumatology			Dermatology	Gastroenterology	
	Ankylosing Spondylitis	nr-axSpA	Psoriatic Arthritis	Plaque Psoriasis	Crohn's Disease	Ulcerative Colitis
Interleukin-17 Blockers						
Cosentyx	√	√	√	√	--	--
Siliq	--	--	--	√	--	--
Taltz	√	√	√	√	--	--
Interleukin-23 Blockers						
Ilumya	--	--	--	√	--	--
Skyrizi	--	--	--	√	--	--
Tremfya	--	--	√	√	--	--
Interleukin-12/23 Blockers						
Stelara Subcutaneous	--	--	√	√	√[^]	√[^]
Stelara Intravenous	--	--	--	--	√[#]	√[#]

IL – Interleukin; [*] Refer to the selected standard *Prior Authorization Policies* for the specific patient population approved for each indication; nr-axSpA – Non-radiographic spondyloarthritis; [^] Maintenance dosing only; [#] Induction dosing only.

Table 3. Approved Oral tsDMARDs for Targeted Indications.[*]

	Rheumatology			Dermatology	Gastroenterology
	Rheumatoid Arthritis	Juvenile Idiopathic Arthritis	Psoriatic Arthritis	Plaque Psoriasis	Ulcerative Colitis
Janus Kinases Inhibitors					
Olumiant	√	--	--	--	--
Rinvoq	√	--	--	--	--
Xeljanz	√	√[#]	√	--	√
Xeljanz XR	√	--	√	--	√
Phosphodiesterase Type 4 Inhibitor					
Otezla	--	--	√	√	--

tsDMARDs – Targeted synthetic disease-modifying antirheumatic drugs; [*] Refer to the selected standard *Prior Authorization Policies* for the specific patient population approved for each indication; [#] Indicated in polyarticular JIA.

Table 4. Other Approved Biologics for Targeted Indications.[*]

	Rheumatology		
	Rheumatoid Arthritis	Juvenile Idiopathic Arthritis	Psoriatic Arthritis
Interleukin-6 Blockers			
Actemra Intravenous	√	√[^]	--
Actemra Subcutaneous	√	√[^]	--
Kevzara	√	--	--
Interleukin-1 Blocker			
Kineret	√	--	--
T-Cell Costimulation Modulator			
Orencia Intravenous	√	√[#]	√
Orencia Subcutaneous	√	√[#]	√
CD20-Directed Cytolytic Antibody			
Rituxan Intravenous	√	--	--

[*] Refer to the selected standard *Prior Authorization Policies* for the specific patient population approved for each indication; [^] Indicated in polyarticular and systemic JIA; [#] Indicated in polyarticular JIA.