

## Louisiana Medicaid Pain Management – Cytokine and CAM Antagonists

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for cytokine or CAM antagonists.

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available [HERE](#).

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*When currently posted criteria are not met, a clinical reviewer will consider the most current FDA-approved prescribing information for the requested agent when evaluating the request.*

### **General approval criteria for initiation of therapy for both preferred and non-preferred cytokine and CAM antagonists (ALL criteria must be met):**

- An appropriate diagnosis is required, and the agent must be prescribed according to U.S. Food and Drug Administration approved indications, dosing, safety and monitoring regulations; **AND**
- The requested dose does not exceed the quantity limit (if applicable) listed in Table 1; **AND**
- If the request is for a non-preferred agent, there is no preferred alternative that is:
  - The exact same chemical entity, formulation, strength, etc.; **OR**
  - An FDA-approved biosimilar to the requested medication that is indicated for the condition being treated; **AND**
- If the request is for Selarsdi™ syringe, Steqeyma™ or Pyszchiva™, the recipient has had an inadequate response or intolerance to one or more TNF antagonists; **OR**
- If the request is for Stelara®, **ONE** of the following is required:
  - The recipient has a documented treatment failure with an adequate trial (26 weeks) of an FDA-approved biosimilar to Stelara®; **OR**
  - The provider **states on the request** clinical justification why **EACH** biosimilar for Stelara® cannot be used; **AND**
- For those agents identified as non-preferred on the PDL, the following conditions apply:
  - **ONE** of the following is true and is **stated on the request**
    - The recipient had documented *intolerable side effects* or a documented *treatment failure* with an adequate trial (6-12 weeks) of **TWO** preferred agents, if the preferred agents are indicated for the specified diagnosis; **OR**
    - The recipient has a *contraindication* to the preferred agents indicated for the specified diagnosis.

### **Approval criteria for initiation of therapy for specific diagnoses:**

#### **Acute Graft versus Host Disease, Prophylaxis (Orencia®)**

- The recipient is 2 years of age or older; **AND**
- The recipient is undergoing hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated donor; **AND**

- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a hematologist or oncologist; **AND**
- The prescriber **states on the request** that Orenzia® will be used in combination with a calcineurin inhibitor (e.g., tacrolimus) and methotrexate.

### **Alopecia Areata (Leqselvi™, Litfulo™, Olumiant®)**

- For Litfulo™, the recipient is 12 years of age or older; **OR**
- For Leqselvi™ or Olumiant®, the recipient is 18 years of age or older; **AND**
- The following is true and is **stated on the request**:
  - The recipient has at least 50% scalp hair loss as measured by the Severity of Alopecia Tool (SALT) for more than 6 months; **AND**
  - The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a rheumatologist or dermatologist; **AND**
  - The agent is not being given in combination with other JAK inhibitors (e.g., tofacitinib), biologic DMARDs, or with potent immunosuppressants such as azathioprine and cyclosporine; **AND**
- For Litfulo™, the recipient has an ALC (absolute lymphocyte count) > 500/mm<sup>3</sup> and a platelet count of > 100,000/mm<sup>3</sup>; **OR**
- For Leqselvi™ or Olumiant®, the recipient has an ANC (absolute neutrophil count) ≥ 1000/mm<sup>3</sup>, an ALC (absolute lymphocyte count) ≥ 500/mm<sup>3</sup>, and hemoglobin ≥ 8 g/dL.

### **Ankylosing Spondylitis [for Bimzelx®, Cimzia®, Cosentyx®, Rinvoq®, and Taltz®, this includes Non-Radiographic Axial Spondyloarthritis] (Abrilada™, Amjevita™, Avsola®, Bimzelx®, Cimzia®, Cosentyx®, Cyltezo®, Enbrel®, Hadlima®, Hulio®, Humira®, Hyrimoz®, Idacio®, Inflectra®, Remicade®, Renflexis®, Simlandi®, Simponi®, Simponi Aria®, Taltz®, Xeljanz® tablet, Xeljanz® XR, Yuflyma®, Yusimry™)**

- The recipient is 18 years of age or older; **AND**
- The following is true and is **stated on the request**:
  - The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a rheumatologist; **AND**
  - The recipient had documented intolerable side effects or a documented treatment failure with a non-steroidal anti-inflammatory agent (NSAID) during a single 3-month period; **OR**
  - The recipient has a contraindication to NSAIDs; **AND**
  - For Abrilada™, Amjevita™, Cyltezo®, Hadlima®, Hulio®, Hyrimoz®, Idacio®, Simlandi®, Yuflyma®, or Yusimry™, the quantity does not exceed 2 syringes every 28 days; **OR**
  - For Cosentyx®, the loading dose does not exceed 150mg at Weeks 0, 1, 2, 3, and 4, and the maintenance dose does not exceed 300mg every 28 days; **OR**
  - For Xeljanz® and Xeljanz® XR:
    - The agent is not being given in combination with biologic DMARDs or potent immunosuppressants such as azathioprine and cyclosporine; **AND**
    - The recipient has an absolute lymphocyte count (ALC) ≥ 500 cells/mm<sup>3</sup>, an ANC ≥ 1,000 cells/mm<sup>3</sup>, and hemoglobin level ≥ 9 g/dL; **AND**
    - The recipient has had an inadequate response or intolerance to one or more TNF antagonists; **OR**

- For Taltz®, the recipient has had an inadequate response or intolerance to one or more TNF antagonists; **OR**
- For Rinvoq®:
  - The agent is not being given in combination with JAK inhibitors, biologic DMARDs or potent immunosuppressants such as azathioprine and cyclosporine; **AND**
  - The recipient has an ALC  $\geq 500$  cells/mm<sup>3</sup>, an ANC  $\geq 1,000$  cells/mm<sup>3</sup>, and hemoglobin level  $\geq 8$  g/dL; **AND**
  - The recipient has had an inadequate response or intolerance to one or more TNF antagonists.

### **Atopic Dermatitis (Cibinqo™, Rinvoq®)**

- The recipient is 12 years of age or older on the date of the request; **AND**
- The following is true and is **stated on the request**:
  - The disease is refractory and moderate to severe; **AND**
  - The recipient has a contraindication to, documented intolerance or treatment failure with an adequate trial (6-12 weeks) of **ONE** conventional systemic treatment, including biologics; **AND**
  - There has been a treatment failure or intolerable side effect with or contraindication to a preferred topical corticosteroid agent (see Dermatology – Steroids, Topical – Low, Medium, High and Very High Potency); **AND**
  - The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a dermatologist, immunologist or allergist; **AND**
  - The agent is not being given in combination with other JAK inhibitors, biologic immunomodulators, or with other immunosuppressants; **AND**
  - For Cibinqo™:
    - The dose does not exceed 200mg per day; **AND**
    - The recipient has a platelet count  $\geq 150,000$ /mm<sup>3</sup>, an ALC  $\geq 500$  cells/mm<sup>3</sup>, an ANC  $\geq 1,000$  cells/mm<sup>3</sup>, and hemoglobin level  $\geq 8$  g/dL; **OR**
  - For Rinvoq®:
    - The dose does not exceed 30mg per day; **AND**
    - The recipient has an ALC  $\geq 500$  cells/mm<sup>3</sup>, an ANC  $\geq 1,000$  cells/mm<sup>3</sup>, and hemoglobin level  $\geq 8$  g/dL.

### **Coronavirus Disease 2019 (COVID-19)**

- Olumiant®, Actemra®, Tofidence™ and Tyenne® are indicated for the treatment of coronavirus disease 2019 (COVID-19) in **hospitalized patients** and will not be approved for outpatient treatment of COVID-19.

### **Crohn's Disease (Abrilada™, Amjevita™, Avsola®, Cimzia®, Cyltezo®, Entyvio®, Hadlima®, Hulio®, Humira®, Hyrimoz®, Idacio®, Imuldosa™, Inflectra®, Omvoh™, Otulfi™, Pyzchiva®, Renflexis®, Remicade®, Rinvoq®, Selarsdi™, Simlandi®, Skyrizi®, Stelara®, Steqeyma®, Tremfya®, Yesintek™, Yuflyma®, Yusimry™, Zymfentra™)**

- For Abrilada™, Amjevita™, Avsola®, Cyltezo®, Hadlima®, Hulio®, Humira®, Hyrimoz®, Idacio®, Inflectra®, Renflexis®, Remicade®, Simlandi®, Yuflyma®, or Yusimry™, the recipient is 6 years of age or older; **OR**

- For Cimzia®, Entyvio®, Imuldosa™, Omvoh™, Otulfi™, Pyzchiva®, Rinvoq®, Selarsdi™, Skyrizi®, Stelara®, Steqeyma®, Tremfya®, Yesintek™, or Zymfentra™ the recipient is 18 years of age or older; **AND**
- The following is true and is **stated on the request**:
  - The disease is moderate to severe; **AND**
  - The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a gastroenterologist; **AND**
  - For Abrilada™, Cyltezo®, Hadlima®, Hulio®, Idacio®, or Yusimry™, the quantity does not exceed 6 syringes in the first 28 days of therapy, and 2 syringes every 28 days thereafter; **OR**
  - For Amjevita™, Hyrimoz®, Simlandi® or Yuflyma®, the quantity does not exceed 3 syringes in the first 28 days of therapy, and 2 syringes every 28 days thereafter; **OR**
  - For Entyvio®, the recipient:
    - Had an inadequate response with, lost response to, or was intolerant to a tumor necrosis factor (TNF) blocker or immunomodulator; **OR**
    - Had an inadequate response with, was intolerant to, or demonstrated dependence on corticosteroids; **OR**
  - For Rinvoq®:
    - The agent is not being given in combination with JAK inhibitors, biologic DMARDs or potent immunosuppressants such as azathioprine and cyclosporine; **AND**
    - The recipient has an ALC  $\geq 500$  cells/mm<sup>3</sup>, an ANC  $\geq 1,000$  cells/mm<sup>3</sup>, and hemoglobin level  $\geq 8$  g/dL; **AND**
    - The recipient has had an inadequate response or intolerance to one or more TNF antagonists; **AND**
    - The following doses are not exceeded:
      - Induction dose of 45mg/day for 12 weeks; **AND**
      - Maintenance dose of 30mg/day; **OR**
  - For Skyrizi®, the following doses are not exceeded:
    - Induction dose of 600mg IV at Week 0, Week 4, and Week 8; **AND**
    - Maintenance dose of 360mg subcutaneous at Week 12, and every 8 weeks thereafter; **OR**
  - For Zymfentra™, the recipient has completed an intravenous induction regimen with an infliximab product.

#### **Cytokine release syndrome (CRS), severe or life-threatening (Actemra®, Tyenne®)**

- The recipient is 2 years of age or older; **AND**
- The following is true and is **stated on the request**:
  - The recipient has severe or life-threatening chimeric antigen receptor (CAR) T cell-induced CRS; **AND**
  - The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a rheumatologist or an oncologist or specialist in the area of chimeric antigen receptor (CAR) T cell-induced cytokine release syndrome; **AND**
  - Prior to the initiation of treatment, lab testing was performed consisting of a complete blood count (CBC) and liver function test; **AND**

- Actemra® and Tyenne® are prescribed according to U.S. Food and Drug Administration labeled dosing for CRS:
  - 12mg/kg for recipients weighing < 30kg
  - 8mg/kg for recipients weighing ≥ 30kg;
  - Up to a maximum of 800mg per infusion and a maximum of 4 doses up to at least 8 hours apart.

**Deficiency of Interleukin-1 Receptor Antagonist (DIRA) (Arcalyst®, Kineret®)**

- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a specialist in the treatment of DIRA; **AND**
- For Arcalyst®:
  - The recipient weighs at least 10kg (current weight is stated on the request); **AND**
  - The maximum weekly dose does not exceed 320mg; **OR**
- For Kineret®, the maximum daily dose does not exceed 8mg/kg.

**Enthesitis-Related Arthritis (Cosentyx®)**

- The recipient is 4 years of age or older; **AND**
- The following is true and is **stated on the request**:
  - The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a rheumatologist; **AND**
  - The recipient has a contraindication to or documented intolerance or failure with an adequate trial (6-12 weeks) of **AT LEAST ONE** disease modifying antirheumatic drug (DMARD) (such as methotrexate, corticosteroids, or azathioprine); **AND**
  - The dose does not exceed 150mg at Weeks 0, 1, 2, 3, and 4, and every 28 days thereafter.

**Generalized Myasthenia Gravis (Uplizna®)**

- The recipient is 18 years of age or older; **AND**
- The recipient has a diagnosis of generalized myasthenia gravis (gMG); **AND**
- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a neurologist; **AND**
- The following is true and is **stated on the request**:
  - The recipient has a positive serologic test for **ONE** of the following:
    - anti-acetylcholine receptor (AChR) antibodies; **OR**
    - anti-muscle specific tyrosine kinase (MuSK) antibodies; **AND**
  - The recipient has a Myasthenia Gravis Foundation of America (MGFA) clinical classification of Class II to IV; **AND**
  - The recipient has a Myasthenia Gravis-Activities of Daily Living (MG-ADL) baseline score of **ONE** of the following:
    - between 6 and 10 with > 50% of this score attributed to non-ocular items; **OR**
    - ≥ 11; **AND**
  - The recipient has had failure of at least **TWO** immunosuppressive therapy agents, unless clinically significant adverse effects are experienced or all are contraindicated.

**Generalized Pustular Psoriasis (GPP) Flare (Spevigo®- intravenous dosage form only)**

- The recipient is 12 years of age or older and weighs at least 40 kg (recipient weight must be **stated on the request**); **AND**
- The following is true and is **stated on the request**:
  - The recipient has a diagnosis of generalized pustular psoriasis (GPP); **AND**
  - The recipient has had a flare of GPP of moderate-to-severe intensity, as defined by all of the following:
    - A Generalized Pustular Psoriasis Physician Global Assessment (GPPPGA) total score of at least 3 (moderate) [the total GPPPGA score ranges from 0 (clear) to 4 (severe)]; **AND**
    - The presence of fresh pustules (new appearance or worsening of pustules); **AND**
    - GPPPGA pustulation sub-score of at least 2 (mild); **AND**
    - At least 5% of body surface area covered with erythema and the presence of pustules; **AND**
  - The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a dermatologist, immunologist or rheumatologist; **AND**
  - The dose does not exceed 900mg per dose.

**Generalized Pustular Psoriasis (GPP) -When Not Experiencing a Flare (Spevigo® - subcutaneous dosage form only)**

- The recipient is 12 years of age or older and weighs at least 40 kg (recipient weight must be **stated on the request**); **AND**
- The following is true and is **stated on the request**:
  - The recipient has a diagnosis of generalized pustular psoriasis (GPP); **AND**
  - The recipient has a documented history of at least 2 presentations of moderate to severe GPP flares with fresh pustulation (new appearance or worsening) in the previous 12 months; **AND**
  - The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a dermatologist, immunologist or rheumatologist; **AND**
  - The dose does not exceed 600mg per dose.

**Giant Cell Arteritis (Actemra®, Rinvoq®, Tofidence™, Tyenne®)**

- The recipient is 18 years of age or older; **AND**
- The following is true and is **stated on the request**:
  - The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a rheumatologist; **AND**
  - For Actemra®/Tofidence™/Tyenne®:
    - Prior to the initiation of treatment, lab testing was performed consisting of an ANC, platelet count, and liver function tests (ALT/AST); **AND**
    - The recipient has an ANC  $\geq 2,000/\text{mm}^3$ , a platelet count  $\geq 100,000/\text{mm}^3$ , and the ALT/AST levels do not exceed 1.5 times the upper limit of normal (ULN); **OR**
  - For Rinvoq®:
    - The dose does not exceed 15mg per day; **AND**
    - The agent is not being given in combination with biologic DMARDs or potent immunosuppressants such as azathioprine and cyclosporine; **AND**

- The recipient has an ALC  $\geq 500$  cells/mm<sup>3</sup>, an ANC  $\geq 1,000$  cells/mm<sup>3</sup>, and hemoglobin level  $\geq 8$  g/dL.

### **Gout Flares (Ilaris®)**

- The recipient is 18 years of age or older; **AND**
- The following is true and is **stated on the request**:
  - The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a rheumatologist; **AND**
  - The recipient has experienced at least three gout flares in the previous year; **AND**
  - The recipient has a contraindication to, documented intolerance or treatment failure with **ALL** of the following: colchicine, corticosteroids, and NSAID's; **AND**
  - The recipient is currently being treated with urate-lowering therapy (ULT) (e.g. allopurinol, febuxostat, probenecid) or has a contraindication to all ULT agents; **AND**
  - The maximum dose is 150mg administered subcutaneously as a single dose.

### **Hidradenitis Suppurativa (Abrilada™, Amjevita™, Bimzelx®, Cosentyx®, Cyltezo®, Hadlima®, Hulio®, Humira®, Hyrimoz®, Idacio®, Simlandi®, Yuflyma®, Yusimry™)**

- For Abrilada™, Bimzelx®, Cosentyx®, Hadlima®, Hulio®, Idacio®, or Yusimry™, the recipient is 18 years of age or older; **AND**
- For Amjevita™, Cyltezo®, Humira®, Hyrimoz®, Simlandi®, or Yuflyma®, the recipient is 12 years of age or older; **AND**
- The following is true and is **stated on the request**:
  - The recipient has a diagnosis of moderate to severe hidradenitis suppurativa (i.e., Hurley Stage II or III); **AND**
  - The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a dermatologist; **AND**
  - For Bimzelx®, the dose does not exceed 640mg every 28 days for the first 4 months of therapy, and 320mg every 28 days thereafter; **OR**
  - For Cosentyx®, the loading dose does not exceed 300mg at Weeks 0, 1, 2, 3, and 4, and the maintenance dose does not exceed 300mg every 14 days; **OR**
  - For Abrilada™, Cyltezo®, Hadlima®, Hulio®, Idacio®, or Yusimry™, the quantity does not exceed 6 syringes in the first 28 days of therapy, and 4 syringes every 28 days thereafter; **OR**
  - For Amjevita™, Hyrimoz®, Simlandi® or Yuflyma®, the quantity does not exceed 3 syringes in the first 28 days of therapy, and 4 syringes every 28 days thereafter.

### **Immunoglobulin G4-Related Disease (IgG4-RD) (Uplizna®)**

- The recipient is 18 years of age or older; **AND**
- The following is true and is **stated on the request**:
  - The recipient has a confirmed diagnosis of IgG4-RD; **AND**
  - The recipient has experienced an IgG4-RD flare that required corticosteroid treatment; **AND**
  - The recipient has a confirmed history of IgG4-RD affecting  $\geq 2$  organs/sites.

### **Neuromyelitis Optica Spectrum Disorder (NMOSD) (Enspryng®, Uplizna®)**

- The recipient is 18 years of age or older; **AND**
- The following is true and is **stated on the request**:

- The recipient has a diagnosis of neuromyelitis optica spectrum disorder; **AND**
- The recipient is anti-aquaporin-4 (AQP4) antibody positive; **AND**
- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a neurologist, ophthalmologist or rheumatologist.

**Oral Ulcers Associated with Behçet’s Disease (Otezla®/Otezla XR™)**

- The recipient is 18 years of age or older; **AND**
- The recipient has a diagnosis of Behçet’s Disease; **AND**
- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a rheumatologist; **AND**
- The request states that the recipient has active oral ulcers.

**Periodic Fever Syndromes:**

- **Cryopyrin-Associated Periodic Syndromes (CAPS) (Arcalyst®, Kineret®, and Ilaris®)** - The following is true and is **stated on the request**:
  - For Kineret®:
    - The medication is being prescribed for the treatment of Neonatal-Onset Multisystem Inflammatory Disease (NOMID), which has been confirmed by one of the following:
      - NLRP-3 [nucleotide-binding domain, leucine rich family (NLR), pyrin domain containing 3] gene (also known as Cold-Induced Auto-inflammatory Syndrome-1 [CIAS1]) mutation; **OR**
      - Evidence of active inflammation which includes both clinical symptoms (e.g., rash, fever, arthralgia) and elevated acute phase reactants (e.g., ESR, CRP); **AND**
    - The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a rheumatologist or a specialist in the treatment of NOMID; **AND**
    - The maximum daily dose does not exceed 8mg/kg; **OR**
  - For Arcalyst® and Ilaris®:
    - The medication is being prescribed for the treatment of either Familial Cold Autoinflammatory Syndrome (FCAS) or Muckle-Wells Syndrome (MWS); **AND**
    - The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a rheumatologist or a specialist in the treatment of FCAS and MWS; **AND**
  - For Arcalyst®:
    - The recipient is 12 years of age or older; **OR**
  - For Ilaris®:
    - The recipient is 4 years of age or older; **AND**
    - The maximum dose is 150mg every 8 weeks.
- **Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS); OR Hyperimmunoglobulin D Syndrome (HIDS); OR Mevalonate Kinase Deficiency (MKD); OR Familial Mediterranean Fever (FMF) (Ilaris®)**
  - The recipient is 2 years of age or older; **AND**

- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a rheumatologist or a specialist in the treatment of TRAPS, HIDS, MKD and FMF; **AND**
- The maximum dose is 300mg every 4 weeks.

**Plaque Psoriasis (Abrilada™, Amjevita™, Avsola®, Bimzelx®, Cimzia®, Cosentyx®, Cyltezo®, Enbrel®, Hadlima®, Hulio®, Humira®, Hyrimoz®, Idacio®, Ilumya®, Imuldosa™, Inflectra®, Otezla®/Otezla XR™, Otulfi™, Pyzchiva®, Remicade®, Renflexis®, Selarsdi™, Simlandi®, Skyrizi®, Sotyktu™, Stelara®, Steqeyma®, Taltz®, Tremfya®, Yesintek™, Yuflyma®, Yusimry™)**

- For Abrilada™, Amjevita™, Avsola®, Bimzelx®, Cimzia®, Cyltezo®, Hadlima®, Hulio®, Humira®, Hyrimoz®, Idacio®, Ilumya®, Inflectra®, Remicade®, Renflexis®, Simlandi®, Skyrizi®, Sotyktu™, Yuflyma®, or Yusimry™, the recipient is 18 years of age or older; **OR**
- For Cosentyx®, Imuldosa™, Otulfi™, Pyzchiva®, Selarsdi™, Stelara®, Steqeyma®, Taltz®, or Yesintek™, the recipient is 6 years of age or older; **OR**
- For Enbrel®, the recipient is 4 years of age or older; **OR**
- For Otezla®, the recipient is 6 years of age or older and weighs at least 20 kg (recipient weight must be **stated on the request**); **OR**
- For Otezla XR™, the recipient is 6 years of age or older and weighs at least 50 kg (recipient weight must be **stated on the request**); **OR**
- For Tremfya®, the recipient is 6 years of age or older and weighs at least 40 kg (recipient weight must be **stated on the request**); **AND**
- The following is true and is **stated on the request**:
  - The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a rheumatologist or dermatologist; **AND**
  - The recipient has a contraindication to, documented intolerance or treatment failure with an adequate trial (6-12 weeks) of **AT LEAST ONE** of the following therapies: phototherapy, methotrexate, and/or cyclosporine; **AND**
  - For all agents except Otezla® when used in recipients 18 years of age or older, the recipient has Body Surface Area (BSA) involvement of at least 3% or involvement of the palms, soles, head and neck or genitalia, causing disruption in normal activities and/or employment; **AND**
  - For Abrilada™, Cyltezo®, Hadlima®, Hulio®, Idacio®, or Yusimry™, the quantity does not exceed 4 syringes in the first 28 days of therapy, and 2 syringes every 28 days thereafter; **OR**
  - For Cosentyx®, the loading dose does not exceed 300mg at Weeks 0, 1, 2, 3, and 4, and the maintenance dose does not exceed 300mg every 28 days; **OR**
  - For Skyrizi®, the dose does not exceed 150mg at Week 0, Week 4 and every 12 weeks thereafter; **OR**
  - For Amjevita™, Hyrimoz®, Simlandi® or Yuflyma®, the quantity does not exceed 3 syringes in the first 28 days of therapy, and 2 syringes every 28 days thereafter; **OR**
  - For Sotyktu™:
    - The dose does not exceed 6mg per day; **AND**

- The agent is not being given in combination with potent immunosuppressants such as azathioprine and cyclosporine; **OR**
- For Taltz<sup>®</sup>, the recipient has had an inadequate response or intolerance to one or more TNF antagonists; **OR**
- For Abrilada<sup>™</sup>, Amjevita<sup>™</sup>, Cimzia<sup>®</sup>, Cosentyx<sup>®</sup>, Cyltezo<sup>®</sup>, Enbrel<sup>®</sup>, Hadlima<sup>®</sup>, Hulio<sup>®</sup>, Humira<sup>®</sup>, Hyrimoz<sup>®</sup>, Idacio<sup>®</sup>, Imuldosa<sup>™</sup>, Otulfi<sup>™</sup>, Pyzchiva<sup>®</sup>, Selarsdi<sup>™</sup>, Simlandi<sup>®</sup>, Stelara<sup>®</sup>, Steqeyma<sup>®</sup>, Taltz<sup>®</sup>, Tremfya<sup>®</sup>, Yesintek<sup>™</sup>, Yuflyma<sup>®</sup>, or Yusimry<sup>™</sup>, the disease is chronic moderate to severe plaque psoriasis; **OR**
- For Bimzelx<sup>®</sup>, Ilumya<sup>®</sup>, Skyrizi<sup>®</sup> or Sotyktu<sup>™</sup>, the recipient has a diagnosis of moderate-to-severe plaque psoriasis; **OR**
- For Avsola<sup>®</sup>, Inflectra<sup>®</sup>, Remicade<sup>®</sup> or Renflexis<sup>®</sup>, the disease is chronic severe plaque psoriasis; **OR**
- For Otezla<sup>®</sup>/Otezla XR<sup>™</sup> when used in recipients 6-17 years of age, the disease is moderate-to-severe plaque psoriasis.

**Polyarticular Juvenile Idiopathic Arthritis (Abrilada<sup>™</sup>, Actemra<sup>®</sup>, Amjevita<sup>™</sup>, Cimzia<sup>®</sup>, Cyltezo<sup>®</sup>, Enbrel<sup>®</sup>, Hadlima<sup>®</sup>, Hulio<sup>®</sup>, Humira<sup>®</sup>, Hyrimoz<sup>®</sup>, Idacio<sup>®</sup>, Kevzara<sup>®</sup>, Orencia<sup>®</sup>, Rinvoq<sup>®</sup>/Rinvoq<sup>®</sup> LQ, Simlandi<sup>®</sup>, Simponi Aria<sup>®</sup>, Tofidence<sup>™</sup>, Tyenne<sup>®</sup>, Xeljanz<sup>®</sup> tablet, Xeljanz<sup>®</sup> oral solution, Yuflyma<sup>®</sup>, Yusimry<sup>™</sup>)**

- The recipient is 2 years of age or older; **AND**
- The following is true and is **stated on the request**:
  - The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a rheumatologist; **AND**
  - The recipient has a contraindication to, documented intolerance or treatment failure with an adequate trial (6-12 weeks) of methotrexate or corticosteroids; **AND**
  - For Abrilada<sup>™</sup>, Amjevita<sup>™</sup>, Cyltezo<sup>®</sup>, Hadlima<sup>®</sup>, Hulio<sup>®</sup>, Hyrimoz<sup>®</sup>, Idacio<sup>®</sup>, Simlandi<sup>®</sup>, Yuflyma<sup>®</sup>, or Yusimry<sup>™</sup>, the quantity does not exceed 2 syringes every 28 days; **OR**
  - For Kevzara<sup>®</sup>:
    - The recipient weighs 63kg or greater; **AND**
    - The recipient has an ANC  $\geq 2000/\text{mm}^3$ , a platelet count  $\geq 150,000/\text{mm}^3$  and liver transaminases do not exceed 1.5 times the upper limit of normal (ULN); **OR**
  - For Rinvoq<sup>®</sup>/Rinvoq<sup>®</sup> LQ:
    - The dose does not exceed 15mg per day; **AND**
    - The agent is not being given in combination with biologic DMARDs or potent immunosuppressants such as azathioprine and cyclosporine; **AND**
    - The recipient has an ALC  $\geq 500 \text{ cells}/\text{mm}^3$ , an ANC  $\geq 1,000 \text{ cells}/\text{mm}^3$ , and hemoglobin level  $\geq 8 \text{ g}/\text{dL}$ ; **AND**
    - The recipient has had an inadequate response or intolerance to one or more TNF antagonists; **OR**
  - For Xeljanz<sup>®</sup> tablet and Xeljanz<sup>®</sup> oral solution:
    - The agent is not being given in combination with biologic DMARDs or potent immunosuppressants such as azathioprine and cyclosporine; **AND**
    - The recipient has an absolute lymphocyte count (ALC)  $\geq 500 \text{ cells}/\text{mm}^3$ , an ANC  $\geq 1,000 \text{ cells}/\text{mm}^3$ , and hemoglobin level  $\geq 9 \text{ g}/\text{dL}$ ; **AND**

- The recipient has had an inadequate response or intolerance to one or more TNF antagonists.

### **Polymyalgia Rheumatica (PMR) (Kevzara®)**

- The recipient is 18 years of age or older; **AND**
- The following is true and is **stated on the request**:
  - The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a rheumatologist; **AND**
  - The recipient has an ANC  $\geq 2000/\text{mm}^3$ , a platelet count  $\geq 150,000/\text{mm}^3$  and liver transaminases do not exceed 1.5 times the upper limit of normal (ULN); **AND**
  - The recipient has a contraindication to, documented intolerance or treatment failure with a trial of corticosteroids **OR** is established on corticosteroid therapy and cannot tolerate corticosteroid taper.

### **Psoriatic Arthritis (Abrilada™, Amjevita™, Avsola®, Bimzelx®, Cimzia®, Cosentyx®, Cyltezo®, Enbrel®, Hadlima®, Hulio®, Humira®, Hyrimoz®, Idacio®, Imuldosa™, Inflectra®, Orencia®, Otezla®/Otezla XR®, Otulfi™, Pyzchiva®, Remicade®, Renflexis®, Rinvoq®/Rinvoq® LQ, Selarsdi™, Simlandi®, Simponi®, Simponi Aria®, Skyrizi®, Stelara®, Steqeyma®, Taltz®, Tremfya®, Xeljanz® tablet, Xeljanz® oral solution, Xeljanz® XR, Yesintek™, Yuflyma®, Yusimry™)**

- For Abrilada™, Amjevita™, Avsola®, Bimzelx®, Cimzia®, Cyltezo®, Hadlima®, Hulio®, Humira®, Hyrimoz®, Idacio®, Inflectra®, Remicade®, Renflexis®, Simlandi®, Simponi®, Skyrizi®, Taltz®, Xeljanz® XR, Yuflyma®, or Yusimry™, the recipient is 18 years of age or older; **OR**
- For Imuldosa™, Otulfi™, Pyzchiva®, Selarsdi™, Stelara®, Steqeyma® or Yesintek™, the recipient is 6 years of age or older; **OR**
- For Cosentyx®, Enbrel®, Orencia®, Rinvoq®/Rinvoq® LQ, Simponi Aria®, Xeljanz® tablet or Xeljanz® oral solution, the recipient is 2 years of age or older; **OR**
- For Otezla®, the recipient is 6 years of age or older and weighs at least 20 kg (recipient weight must be **stated on the request**); **OR**
- For Otezla XR™, the recipient is 6 years of age or older and weighs at least 50 kg (recipient weight must be **stated on the request**); **OR**
- For Tremfya®, the recipient is 6 years of age or older and weighs at least 40 kg (recipient weight must be **stated on the request**); **AND**
- The following is true and is **stated on the request**:
  - The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a dermatologist or rheumatologist; **AND**
  - For Abrilada™, Amjevita™, Cyltezo®, Hadlima®, Hulio®, Hyrimoz®, Idacio®, Simlandi®, Yuflyma®, or Yusimry™, the quantity does not exceed 2 syringes every 28 days; **OR**
  - For Cosentyx®, the loading dose does not exceed 150mg at Weeks 0, 1, 2, 3, and 4, and the maintenance dose does not exceed 300mg every 28 days; **OR**
  - For Rinvoq®/Rinvoq® LQ:
    - The dose does not exceed 15mg per day; **AND**
    - The agent is not being given in combination with biologic DMARDs or potent immunosuppressants such as azathioprine and cyclosporine; **AND**

- The recipient has an ALC  $\geq 500$  cells/mm<sup>3</sup>, an ANC  $\geq 1,000$  cells/mm<sup>3</sup>, and hemoglobin level  $\geq 8$  g/dL; **AND**
- The recipient has had an inadequate response or intolerance to one or more TNF antagonists; **OR**
- For Skyrizi®, the dose does not exceed 150mg at Week 0, Week 4 and every 12 weeks thereafter; **OR**
- For Taltz®, the recipient has had an inadequate response or intolerance to one or more TNF antagonists; **OR**
- For Xeljanz® and Xeljanz® XR:
  - The agent is not being given in combination with biologic DMARDs or potent immunosuppressants such as azathioprine and cyclosporine; **AND**
  - The recipient has an absolute lymphocyte count (ALC)  $\geq 500$  cells/mm<sup>3</sup>, an ANC  $\geq 1,000$  cells/mm<sup>3</sup>, and hemoglobin level  $\geq 9$  g/dL; **AND**
  - The recipient has had an inadequate response or intolerance to one or more TNF antagonists.

### **Recurrent Pericarditis (Arcalyst®)**

- The recipient is 12 years of age or older; **AND**
- The following is true and is **stated on the request**:
  - The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a cardiologist; **AND**
  - The recipient has a contraindication to, documented intolerance or treatment failure with an adequate trial of at least one standard of care therapy (such as NSAIDs and colchicine).

### **Rheumatoid Arthritis (Abrilada™, Actemra®, Amjevita™, Avsola®, Cimzia®, Cyltezo®, Enbrel®, Hadlima®, Hulio®, Humira®, Hyrimoz®, Idacio®, Inflectra®, Kevzara®, Kineret®, Olumiant®, Orenzia®, Remicade®, Renflexis®, Rinvoq®, Simlandi®, Simponi®, Simponi Aria®, Tofidence™, Tyenne®, Xeljanz® tablet, Xeljanz® XR, Yuflyma®, Yusimry™)**

- The recipient is 18 years of age or older; **AND**
- The following is true and is **stated on the request**:
  - The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a rheumatologist; **AND**
  - The recipient has a contraindication to, documented intolerance or treatment failure with an adequate trial (6-12 weeks) of at least one non-biologic DMARD (such as methotrexate, leflunomide, or azathioprine); **AND**
  - The agent is being used to treat moderately to severely active rheumatoid arthritis; **AND**
  - For Abrilada™, Amjevita™, Cyltezo®, Hadlima®, Hulio®, Hyrimoz®, Idacio®, Simlandi®, Yuflyma®, or Yusimry™, the quantity does not exceed 4 syringes every 28 days; **OR**
  - For Actemra®, the dose does not exceed 800mg per infusion; **OR**
  - For Rinvoq®:
    - The dose does not exceed 15mg per day; **AND**
    - The agent is not being given in combination with biologic DMARDs or potent immunosuppressants such as azathioprine and cyclosporine; **AND**

- The recipient has an ALC  $\geq 500$  cells/mm<sup>3</sup>, an ANC  $\geq 1,000$  cells/mm<sup>3</sup>, and hemoglobin level  $\geq 8$  g/dL; **AND**
- The recipient has had an inadequate response or intolerance to one or more TNF antagonists; **OR**
- For Xeljanz® tablet and Xeljanz® XR:
  - The agent is not being given in combination with biologic DMARDs or potent immunosuppressants such as azathioprine and cyclosporine; **AND**
  - The recipient has an ALC  $\geq 500$  cells/mm<sup>3</sup>, an ANC  $\geq 1,000$  cells/mm<sup>3</sup>, and hemoglobin level  $\geq 9$  g/dL; **AND**
  - The recipient has had an inadequate response or intolerance to one or more TNF antagonists; **OR**
- For Avsola®, Inflectra®, Remicade®, Renflexis®, Simponi®, or Simponi® Aria, the medication is being used in combination with methotrexate; **OR**
- For Kevzara®, the recipient has an ANC  $\geq 2000$ /mm<sup>3</sup>, a platelet count  $\geq 150,000$ /mm<sup>3</sup> and liver transaminases do not exceed 1.5 times the upper limit of normal (ULN); **OR**
- For Olumiant®:
  - The recipient has had an inadequate response to one or more TNF antagonists; **AND**
  - The agent is not being given in combination with other JAK inhibitors (e.g., tofacitinib), biologic DMARDs, or with potent immunosuppressants such as azathioprine and cyclosporine; **AND**
  - The recipient has an ANC  $\geq 1000$ /mm<sup>3</sup>, an ALC  $\geq 500$ /mm<sup>3</sup>, and hemoglobin  $\geq 8$  g/dL.

#### **Still's Disease (Ilaris®) [Including Adult-Onset Still's Disease]**

- The recipient is 2 years of age or older; **AND**
- The following is true and is **stated on the request**:
  - The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a pulmonologist or rheumatologist; **AND**
  - The maximum dose is 300mg every 4 weeks administered subcutaneously; **AND**
  - The recipient has a contraindication to or documented intolerance or failure with an adequate trial (6-12 weeks) of **AT LEAST ONE** disease modifying antirheumatic drug (DMARD) (such as methotrexate, corticosteroids, or azathioprine).

#### **Systemic Juvenile Idiopathic Arthritis (Actemra®, Ilaris®, Tofidence™, Tyenne®)**

- The recipient is 2 years of age or older; **AND**
- The following is true and is **stated on the request**:
  - The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a rheumatologist; **AND**
  - For Ilaris®, the maximum dose is 300mg every 4 weeks administered subcutaneously; **AND**
  - The recipient has a contraindication to or documented intolerance or failure with an adequate trial (6-12 weeks) of **AT LEAST ONE** disease modifying antirheumatic drug (DMARD) (such as methotrexate, corticosteroids, or azathioprine).

#### **Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD) (Actemra®)**

- The recipient is 18 years of age or older; **AND**

- The following is true and is **stated on the request**:
  - The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a pulmonologist; **AND**
  - The maximum dose is 162mg given subcutaneously once a week.

**Ulcerative Colitis (Abrilada™, Amjevita™, Avsola®, Cyltezo®, Entyvio®, Hadlima®, Hulio®, Humira®, Hyrimoz®, Idacio®, Imuldosa™, Inflectra®, Omvoh™, Otulfi™, Pyzchiva®, Remicade®, Renflexis®, Rinvoq®, Selarsdi™, Simlandi®, Simponi®, Skyrizi®, Stelara®, Steqeyma®, Tremfya®, Velsipity™, Xeljanz® Tablet, Xeljanz® XR, Yesintek™, Yuflyma®, Yusimry™, Zymfentra™)**

- For Abrilada™, Amjevita™, Cyltezo®, Entyvio®, Hadlima®, Hulio®, Hyrimoz®, Idacio®, Imuldosa™, Omvoh™, Otulfi™, Pyzchiva®, Rinvoq®, Selarsdi™, Simlandi®, Skyrizi®, Stelara®, Steqeyma®, Tremfya®, Velsipity™, Xeljanz® tablet, Xeljanz® XR, Yesintek™, Yuflyma®, Yusimry™, or Zymfentra™, the recipient is 18 years of age or older; **OR**
- For Avsola®, Inflectra®, Remicade® or Renflexis®, the recipient is 6 years of age or older; **OR**
- For Humira®, the recipient is 5 years of age or older; **OR**
- For Simponi®, the recipient weighs at least 15 kg (recipient weight must be **stated on the request**); **AND**
- The following is true and is **stated on the request**:
  - The disease is moderate to severe; **AND**
  - The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a gastroenterologist; **AND**
  - For Entyvio®, the recipient had an inadequate response with, lost response to, or was intolerant to a TNF blocker or immunomodulator; or had an inadequate response with, was intolerant to, or demonstrated dependence on corticosteroids; **OR**
  - For Abrilada™, Cyltezo®, Hadlima®, Hulio®, Idacio®, or Yusimry™, the quantity does not exceed 6 syringes in the first 28 days of therapy, and 2 syringes every 28 days thereafter; **OR**
  - For Amjevita™, Hyrimoz®, Simlandi® or Yuflyma®, the quantity does not exceed 3 syringes in the first 28 days of therapy, and 2 syringes every 28 days thereafter; **OR**
  - For Rinvoq®:
    - The agent is not being given in combination with JAK inhibitors, biologic DMARDs or potent immunosuppressants such as azathioprine and cyclosporine; **AND**
    - The recipient has an ALC  $\geq 500$  cells/mm<sup>3</sup>, an ANC  $\geq 1,000$  cells/mm<sup>3</sup>, and hemoglobin level  $\geq 8$  g/dL; **AND**
    - The recipient has had an inadequate response or intolerance to one or more TNF antagonists; **OR**
  - For Simponi®, the following doses are not exceeded:
    - Induction dose of 200mg at Week 0 followed by 100mg at Week 2; **AND**
    - Maintenance dose of 100mg every 4 weeks; **OR**
  - For Skyrizi®, the following doses are not exceeded:
    - Induction dose of 1200mg IV at Week 0, Week 4, and Week 8; **AND**

- Maintenance dose of 360mg subcutaneous at Week 12, and every 8 weeks thereafter; **OR**
- For Xeljanz® tablet and Xeljanz® XR:
  - The agent is not being given in combination with biologic DMARDs or potent immunosuppressants such as azathioprine and cyclosporine; **AND**
  - The recipient has an ALC  $\geq$  500 cells/mm<sup>3</sup>, an ANC  $\geq$  1,000 cells/mm<sup>3</sup>, and hemoglobin level  $\geq$  9 g/dL; **AND**
  - The recipient has had an inadequate response or intolerance to one or more TNF antagonists; **OR**
- For Zymfentra™, the recipient has completed an intravenous induction regimen with an infliximab product.

**Uveitis (Abrilada™, Amjevita™, Cyltezo®, Hadlima®, Hulio®, Humira®, Hyrimoz®, Idacio®, Simlandi®, Yuflyma®, Yusimry™)**

- The recipient has a diagnosis of non-infectious intermediate, posterior, and panuveitis; **AND**
- For Abrilada™, Hadlima®, Hulio®, Idacio®, or Yusimry™, the recipient is 18 years of age or older; **OR**
- For Amjevita™, Cyltezo®, Humira®, Hyrimoz®, Simlandi®, or Yuflyma®, the recipient is 2 years of age or older; **AND**
- The following is true and is **stated on the request**:
  - The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, an ophthalmologist or a rheumatologist; **AND**
  - The recipient had an inadequate response to conventional treatment for uveitis, which may include corticosteroids; **AND**
  - For Abrilada™, Cyltezo®, Hadlima®, Hulio®, Idacio®, or Yusimry™, the quantity does not exceed 4 syringes in the first 28 days of therapy, and 2 syringes every 28 days thereafter; **OR**
  - For Amjevita™, Hyrimoz®, Simlandi® or Yuflyma®, the quantity does not exceed 3 syringes in the first 28 days of therapy, and 2 syringes every 28 days thereafter.

**Approval criteria for continuation of therapy for both preferred and non-preferred cytokine or CAM antagonists (Except for Orencia® when used for prophylaxis of acute graft vs host disease AND Spevigo®):**

- The prescriber **states on the request** that there is evidence of a positive response to treatment as indicated by improvement in signs and symptoms compared to baseline, or by halting of disease progression (no progression of disease signs and symptoms as compared to baseline); **AND**
- The requested dose does not exceed the quantity limit (if applicable) listed in Table 1; **AND**
- For Abrilada™, Amjevita™, Cyltezo®, Hadlima®, Hulio®, Humira®, Hyrimoz®, Idacio®, Simlandi®, Yuflyma®, or Yusimry™, if diagnosis is ulcerative colitis, the prescriber **states on the request** that there is evidence of clinical remission.

**Duration of approval for initiation of therapy:**

- Abrilada™, Amjevita™, Cyltezo®, Hadlima®, Hulio®, Humira®, Hyrimoz®, Idacio®, Simlandi®, Yuflyma®, or Yusimry™ for ulcerative colitis: 8 weeks

- Ilaris® for gout flares: 3 days (to allow for 1 dose) – Subsequent authorization of Ilaris® for additional gout flares will require meeting the initial approval criteria **AND** a minimum of 12 weeks since last dose of Ilaris®.
- Orencia® for prophylaxis of acute graft vs host disease: 28 days per transplantation
- Spevigo® (intravenous dosage form only) duration of approval: 10 days (to allow for up to 2 doses) – Subsequent authorization of Spevigo® (intravenous dosage form only) for additional GPP flares will require meeting the initial approval criteria **AND** documented resolution of the previous GPP flare.
- Duration of approval for initiation of all other agents / conditions: 6 months

**Duration of approval for continuation of therapy: 12 months**

<b>Table 1. Quantity Limits for Selected Cytokine/CAM Antagonists</b>	
<b>Generic (Brand Example)</b>	<b>Quantity Limit</b>
Abatacept Clickject, Syringe (Orencia®)	4 injections per 28 days
Abrocitinib Tablet (Cibinqo™)	30 tablets per 30 days; Maximum 1 tablet per day
Adalimumab Pen Kit, Syringe Kit (Humira®) 10mg, 20mg, 40mg	4 injections per 28 days
Adalimumab Pen Kit (Humira®) 80mg	2 injections per 28 days
Adalimumab Biosimilars	See diagnosis-specific criteria
Anakinra Syringe (Kineret®)	30 injections per 30 days
Apremilast Tablet (Otezla®/Otezla XR™)	IR tablet: 60 tablets per 30 days; Maximum 2 tablets per day
	XR tablet: 30 tablets per 30 days; Maximum 1 tablet per day
	Starter Pack - 1 fill per 365 days
Baricitinib Tablet (Olumiant®)	30 tablets per 30 days; Maximum 1 tablet per day
Bimekizumab-bkzx Pen, Syringe (Bimzelx®)	1 injection per 28 days (see diagnosis-specific criteria for HS loading dose)
Canakinumab/PF Vial (Ilaris®)	2 vials per 28 days
Certolizumab Pegol Syringe Kit (Cimzia®)	Syringes – 2 injections per 28 days
	Starter Kit - 1 fill per 365 days
Deucravacitinib Tablet (Sotyktu®)	30 tablets per 30 days; Maximum 1 tablet per day
Etanercept Cartridge, Pen, Syringe, Vial (Enbrel®)	Starting Dose – 8 injections per 28 days for 3 months (if applicable)
	Maintenance Dose – 4 injections per 28 days
Etrasimod Tablet (Velsipity™)	30 tablets per 30 days; Maximum 1 tablet per day
Golimumab Pen, Syringe (Simponi®)	1 injection per 28 days (see diagnosis specific criteria for UC loading dose)
Guselkumab Autoinjector, Pen, Syringe (Tremfya®)	100mg/ml (starting dose) – 1 injection per 28 days for 2 months
	100mg/ml (maintenance dose) – 1 injection per 56 days

	200mg/2ml Starter Kit – 1 fill per 365 days
	200mg/2ml – 1 injection per 28 days
Infliximab-dyyb Pen, Syringe (Zymfentra™)	2 injections per 28 days
Ixezumab Autoinjector, Syringe (Taltz®)	3-pack – 1 fill per 365 days
	2-pack – 2 fills per 365 days
	1 injection per 28 days
Mirkizumab-mrkz Pen, Syringe (Omvoh™)	2 injections per 28 days
Rilonacept Vial (Arcalyst®)	Starting Dose – 5 vials per 28 days for 1 month
	Maintenance Dose – 4 vials per 28 days
Risankizumab-rzaa On-Body Cartridge, Pen, Syringe, Vial (Skyrizi®)	Cartridge – 1 cartridge per 56 days
	Syringe/Pen (starting dose) – 1 injection per 28 days for 2 months
	Syringe/Pen (maintenance dose) – 1 injection per 84 days
	Vial – see diagnosis-specific criteria
Ritlecitinib Tablet (Litfulo™)	30 tablets per 30 days; Maximum 1 tablet per day
Sarilumab Pen, Syringe (Kevzara®)	2 injections per 28 days
Satralizumab-mwge Syringe (Enspryng™)	Starting Dose – 2 injections per 28 days for one month
	Maintenance Dose – 1 injection per 28 days
Secukinumab Pen, Syringe (Cosentyx®)	See diagnosis-specific criteria
Tildrakizumab-asmn Syringe (Ilumya®)	Starting Dose – 1 injection per 28 days for 2 months
	Maintenance Dose – 1 injection per 84 days
Tocilizumab Pen, Syringe (Actemra®) Tocilizumab-aazg Pen, Syringe (Tyenne®) Tocilizumab-bavi Pen, Syringe (Tofidence™)	4 injections per 28 days
Tofacitinib Citrate Tablet, Solution (Xeljanz®) Tofacitinib Citrate ER Tablet (Xeljanz® XR)	Tablet – 60 tablets per 30 days; Maximum 2 tablets per day
	XR Tablet – 30 tablets per 30 days; Maximum 1 tablet per day
	Solution – 300mls per 30 days; Maximum 10mls per day
Upadacitinib ER Tablet (Rinvoq™) Upadacitinib Solution (Rinvoq™ LQ)	Tablet – 30 tablets per 30 days; Maximum 1 tablet per day
	Solution – 360mls per 30 days; Maximum 12mls per day
Ustekinumab Syringe, Vial (Stelara®) Ustekinumab-aaaz Syringe, Vial (Otulfi™) Ustekinumab-aeqn Syringe, Vial (Selarsdi™) Ustekinumab-kfce Syringe, Vial (Yesintek™) Ustekinumab-stba Syringe, Vial (Steqeyma™) Ustekinumab-srlf Syringe, Vial (Imuldosa™) Ustekinumab-ttwe Syringe, Vial (Pyzchiva™)	Syringe (starting dose) – 1 injection per 28 days for 2 months
	Syringe (maintenance dose) – 1 injection per 56 days
	Vial – 4 vials (as 56-day supply) per 365 days
Vedolizumab Pen, Vial (Entyvio®)	Pen – 2 injections per 28 days
	Vial (starting dose) – 2 vials per 28 days for one month
	Vial (maintenance dose) – 1 vial per 56 days

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<b>Revision / Date</b>	<b>Implementation Date</b>
Removed diagnosis requirement at POS, add non-radiographic axial spondyloarthritis for Cimzia®, add max dose for Actemra® for RA, add severity to RA criteria / May 2019	August 2019
Incorporated Otezla® new indication for oral ulcers associated with Behçet’s Disease, modify age for ulcerative colitis for Inflectra® and Renflexis® / August 2019	November 2019
Added Stelara® to ulcerative colitis (new indication) and Taltz® to Ankylosing Spondylitis (new indication), added specialists to giant cell arteritis, oral ulcers with Bechet’s disease and TRAPS, HIDS, MKD and FMF / January 2020	May 2020
Combined Skyrizi® criteria with Cytokine and CAM Antagonists criteria, formatting changes / July 2020	July 2020
Modified age for Taltz® for plaque psoriasis, added diagnosis of non-radiographic axial spondyloarthritis to Cosentyx® and Taltz®, added diagnosis of Still’s Disease for Ilaris®, clarified diagnosis for Actemra®, updated references, formatting changes / June 2020	October 2020
Modified age for Stelara® for plaque psoriasis, added indication of active psoriatic arthritis to Tremfya®; updated references; incorporated Skyrizi® into the document / September 2020	January 2021
Modified age to Simponi Aria® for active psoriatic arthritis, added indication of polyarticular juvenile idiopathic arthritis; updated reference / September 2020	April 2021
Incorporated new formulation of Xeljanz® oral solution, added indication of polyarticular juvenile idiopathic arthritis; modified age for Simponi Aria®; formatting changes, updated references / November 2020	April 2021
Added Deficiency of Interleukin-1 Receptor Antagonist (DIRA) to Kineret® and Arcalyst®, updated references / January 2021	July 2021
Added Avsola®, Enspryng® and Uplizna®; updated age for Humira®, updated references / February 2021	July 2021
Added Recurrent Pericarditis to Arcalyst®, updated references / March 2021	July 2021
Added Systemic Sclerosis-Associated Interstitial Lung Disease for Actemra®, updated reference / March 2021	July 2021
Updated Cosentyx® age for plaque psoriasis, updated references / June 2021	January 2022
Updated criteria for Rinvoq® and all Xeljanz® formulations to include treatment failure with one or more TNF antagonist, added Rinvoq® to psoriatic arthritis (new indication) and Xeljanz® to	April 2022

ankylosing spondylitis (new indication), updated references / December 2021	
Added indication of prophylaxis for acute graft vs host disease for Orencia®, updated references / December 2021	April 2022
Added indication of atopic dermatitis for Rinvoq®, modified wording for Otezla® to include all adults with plaque psoriasis, added indication of psoriatic arthritis for Skyrizi®, updated age indication of psoriatic arthritis for Cosentyx®, added indication of enthesitis-related arthritis for Cosentyx®, added quantity limits for Humira® and Enbrel®, added COVID-19 statement about Olumiant®, updated references/ February 2022	July 2022
Moved Olumiant COVID-19 statement to criteria, added indication of ulcerative colitis and ankylosing spondylitis for Rinvoq®, added indication of Crohn’s disease for Skyrizi®, removed prescriber attestations regarding Hepatitis B and TB testing, updated references / April 2022	October 2022
Added indication of alopecia areata for Olumiant®, updated psoriatic arthritis age indication for Stelara®, combined Cibinqo™ criteria with Cytokine and CAM Antagonists criteria, updated references / November 2022	January 2023
Added indication of Non-Radiographic Axial Spondyloarthritis for Rinvoq®, updated references / October 2022	April 2023
Combined Amjevita™, Sotyktu™, and Spevigo® with Cytokine and CAM Antagonists criteria, added indication of polymyalgia rheumatica (PMR) for Kevzara®, added ‘preferred alternative’ statement, updated references / December 2022	July 2023
Added indication of Crohn’s disease for Rinvoq®, updated references / May 2023	October 2023
Added indication of uveitis for Amjevita™, removed previous use of a conventional treatment or oral DMARD for Crohn’s disease, Hidradenitis Suppurativa, Psoriatic Arthritis, and Ulcerative Colitis, added Actemra® to COVID-19 statement, combined Cyltezo®, Hadlima®, Hulio®, Hyrimoz®, Idacio®, Yuflyma® and Yusimry™, formatting changes, updated references / July 2023	January 2024
Added indications of hidradenitis suppurativa and uveitis for Idacio®, expanded age indication of psoriatic arthritis for Enbrel® and Orencia®, added indication of gout flares for Ilaris®, added indication of hidradenitis suppurativa for Cosentyx®, updated references / November 2023	April 2024
Added indication of uveitis for Yuflyma® and Yusimry™, removed BSA requirement from Otezla®, modified quantity limit criteria for select adalimumab products to reflect new dosage forms, combined Abrilada™, Bimzelx®, Omvoh™ and Velsipity™ with Cytokine and CAM Antagonists criteria, removed QL for Enbrel® and Humira® from criteria, expanded prescriber specialties for select agents, updated references, formatting changes / February 2024	July 2024

Expanded age indication of GPP for Spevigo®, differentiated the use of dosage forms of Spevigo® for GPP, expanded age indication of plaque psoriasis for Otezla®, updated references / April 2024	October 2024
Expanded age indication of psoriatic arthritis for Rinvoq®, added indication of polyarticular juvenile idiopathic arthritis for Kevzara® and Rinvoq®, added Rinvoq® LQ dosage form, added indication of ulcerative colitis for Skyrizi®, added Litfulo™, Simlandi®, Tofidence™, Tyenne®, and Zymfentra™, updated references / August 2024	January 2025
Added indication of polyarticular juvenile idiopathic arthritis for Cimzia®, added indication of ulcerative colitis for Tremfya®, added indications of psoriatic arthritis and ankylosing spondylitis (including non-radiographic axial spondyloarthritis) and Hidradenitis Suppurativa for Bimzelx®, updated references / November 2024	March 2025
Added indication of Crohn's disease for Omvoh™, updated references / January 2025	June 2025
Combined Yesintek™ with criteria document / May 2025	July 2025
Added indication of CRS and COVID-19 for Tyenne®, added indication of Crohn's disease for Tremfya®, added Otulfi™, Pyzchiva®, Selarsdi™, Steqeyma®, updated references / March 2025	August 2025
Removed Siliq® / September 2025	October 2025
Added indication of IgG4-RD for Uplizna®, removed the previous use of MTX when Rinvoq® is being used to treat RA, added indication of giant cell arteritis for Rinvoq®, removed previous use of corticosteroids for giant cell arteritis, added criterion requiring the use of Stelara® biosimilars, added quantity limits for selected agents, added Leqselvi™ and Imuldosa™, updated references / June 2025	January 2026
Added criterion requiring previous use of a TNF antagonist for Taltz® and preferred Stelara® biosimilars / December 2025	February 2026
Changed COVID-19 criterion wording to hospitalized patients to reflect Actemra expanded age indication, added Otezla XR™ formulation, expanded age indication of Tremfya® for plaque psoriasis and psoriatic arthritis, expanded age indication of Simponi® for ulcerative colitis, expanded age indication of Xeljanz® for psoriatic arthritis, expanded age indication of Amjevita™, Cytelzo®, Hyrimoz®, Simlandi®, and Yuflyma® for uveitis and HS, updated references / September 2025	April 2026
<u>Added indication of gMG for Uplizna®, updated references / February 2026</u>	<u>July 2026</u>