

Clinical Policy: Biologic DMARDs

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[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

The following are biologic disease-modifying anti-rheumatic drugs (DMARDs) requiring prior authorization: tocilizumab (Actemra®), certolizumab pegol (Cimzia®), secukinumab (Cosentyx®), etanercept (Enbrel®), vedolizumab (Entyvio®), adalimumab (Humira®), tildrakizumab-asmn (Ilumya™), infliximab-dyyb (Inflectra®), sarilumab (Kevzara®), anakinra (Kineret®), baricitinib (Olumiant®), abatacept (Orencia®), apremilast (Otezla®), infliximab (Remicade®), infliximab-abda (Renflexis™), upadacitinib (Rinvoq™), brodalumab (Siliq™), golimumab (Simponi®, Simponi Aria®), risankizumab-rzaa (Skyrizi™), ustekinumab (Stelara®), ixekizumab (Taltz®), guselkumab (Tremfya®), natalizumab (Tysabri®), tofacitinib (Xeljanz®, Xeljanz® XR).

FDA Approved Indication(s)

	AS	nr-axSpA	CD	UC	GCA	NOMID	PJJA	SJJA	PsO	PsA	RA	HS	MS	UV	CRS	BD
Actemra					x		x [#]	x [#]			x [#]				x [*]	
Cimzia	x	x	x						x	x	x					
Cosentyx	x								x	x						
Enbrel	x						x		x	x	x					
Entyvio			x	x												
Humira	x		x	x			x		x	x	x	x		x		
Ilumya									x							
Inflectra	x		x	x					x	x	x					
Kevzara											x					
Kineret						x					x					
Olumiant											x					
Orencia							x			x	x					
Otezla									x	x						x
Remicade	x		x	x					x	x	x					
Renflexis	x		x	x					x	x	x					
Rinvoq											x					
Siliq									x							
Simponi	x			x						x	x					
Simponi Aria	x									x	x					
Skyrizi									x							
Stelara			x [#]						x	x						
Taltz									x	x						
Tremfya									x							
Tysabri			x										x			
Xeljanz/ XR				x [±]						x	x					

	AS	nr-axSpA	CD	UC	GCA	NOMID	PJIA	SJIA	PsO	PsA	RA	HS	MS	UV	CRS	BD
Xeljanz XR																

*=IV only; #=IV/SC; ^ = SC only; †=IR only

AS=ankylosing spondylitis; nr-axSpA=non-radiographic axial spondyloarthritis; CD=Crohn’s disease; UC=ulcerative colitis; GCA = giant cell arteritis; NOMID=neonatal-onset multisystem inflammatory disease; PJIA=polyarticular juvenile idiopathic arthritis; SJIA=systemic juvenile idiopathic arthritis; PsO=plaque psoriasis; PsA=psoriatic arthritis; RA=rheumatoid arthritis; HS=hidradenitis suppurativa, MS=multiple sclerosis, UV=uveitis; CRS=cytokine release syndrome; BD=Behçet’s disease

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Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Actemra, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Rinvoq, Siliq, Simponi, Simponi Aria, Skyrizi, Stelara, Taltz, Tremfya, Tysabri, Xeljanz, and Xeljanz XR are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Axial Spondylitis (must meet all):

1. Diagnosis of AS or nr-axSpA;
2. Request is for one of the following: Humira, Cimzia, Cosentyx, Enbrel, Inflectra, Remicade, Renflexis, Simponi, or Simponi Aria;
3. Prescribed by or in consultation with a rheumatologist;
4. Age \geq 18 years;
5. Failure of at least TWO non-steroidal anti-inflammatory drugs (NSAIDs) at up to maximally indicated doses, each used for at \geq 4 weeks unless contraindicated or clinically significant adverse effects are experienced;
6. For Cimzia: Failure of TWO of the following, **Humira, Enbrel, Cosentyx**, each used for \geq 3 consecutive months, unless (a or b):
 - a. Evidence supports member has nr-axSpA;
 - b. Member is contraindicated or clinically significant adverse effects are experienced to **Humira, Enbrel, Cosentyx**;
7. For AS:
 - a. For Simponi: Failure of TWO of the following, each used for \geq 3 consecutive months, unless contraindicated or clinically significant adverse effects are experienced: **Humira, Enbrel, Cosentyx**;
 - b. For Inflectra, or Renflexis: Failure of a trial of \geq 3 consecutive months of **Remicade** or **Simponi Aria**, unless contraindicated or clinically significant adverse effects are experienced;
8. Dose does not exceed maximum dose indicated in Section V.

Approval duration: 6 months or to member's renewal date, whichever is longer

B. Behçet's Disease (must meet all):

1. Diagnosis of oral ulcers in members with BD;
2. Request is for Otezla;
3. Prescribed by or in consultation with a dermatologist or rheumatologist;
4. Age \geq 18 years;
5. Failure of a topical corticosteroid (e.g., triamcinolone acetonide cream) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
6. Failure of an oral corticosteroid (e.g., prednisone) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
7. Failure of colchicine at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
8. Dose does not exceed 60 mg per day.

Approval duration: 6 months or to member's renewal date, whichever is longer

C. Crohn's Disease (must meet all):

1. Diagnosis of CD;
2. Request is for one of the following: Humira, Cimzia, Entyvio, Inflectra, Remicade, Renflexis, Stelara, Tysabri;
3. Prescribed by or in consultation with a gastroenterologist;
4. Member meets one of the following (a or b):

- a. Failure of a ≥ 3 consecutive month trial of at least ONE immunomodulator (e.g., azathioprine, 6-mercaptopurine [6-MP], methotrexate [MTX]) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
 - b. Medical justification supports inability to use immunomodulators (*see Appendix D*);
5. Member meets one of the following (a or b):
 - a. For Humira, Inflectra, Remicade, Renflexis: age ≥ 6 years;
 - b. For Cimzia, Entyvio, Stelara, Tysabri: age ≥ 18 years;
 6. For Cimzia or Stelara: Failure of a trial of ≥ 3 consecutive months of **Humira** unless contraindicated or clinically significant adverse effects are experienced;
 7. For Entyvio, Inflectra, Renflexis, or Tysabri: Failure of a trial of ≥ 3 consecutive months of **Remicade** unless contraindicated or clinically significant adverse effects are experienced;
 8. Dose does not exceed maximum dose indicated in Section V.

Approval duration: 6 months or to member's renewal date, whichever is longer

D. Cytokine Release Syndrome (must meet all):

1. Member has a scheduled chimeric antigen receptor (CAR) T-cell therapy (e.g., Kymriah™, Yescarta™);
2. Request is for an intravenous formulation of Actemra;
3. Dose does not exceed 800 mg per infusion for up to 4 total doses.

Approval duration: Up to 4 total doses

E. Giant Cell Arteritis (must meet all):

1. Diagnosis of GCA;
2. Request is for subcutaneous formulation of Actemra;
3. Prescribed by or in consultation with a rheumatologist;
4. Age ≥ 18 years;
5. Failure of a trial of ≥ 3 consecutive months of a systemic corticosteroid at up to maximally tolerated doses in conjunction with MTX or azathioprine, unless contraindicated or clinically significant adverse effects are experienced;
6. Dose does not exceed 162 mg SC every week.

Approval duration: 6 months or to member's renewal date, whichever is longer

F. Hidradenitis Suppurativa (must meet all):

1. Diagnosis of HS;
2. Request is for Humira;
3. Prescribed by or in consultation with a dermatologist, rheumatologist, or gastroenterologist;
4. Age ≥ 12 years;
5. Documentation of Hurley stage II or stage III (*see Appendix D*);
6. Failure of a trial of ≥ 3 consecutive months of systemic antibiotic therapy (e.g., clindamycin, minocycline, doxycycline, rifampin) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
7. Dose does not exceed maximum dose indicated in Section V.

Approval duration: 6 months or to member's renewal date, whichever is longer

G. Neonatal-Onset Multisystem Inflammatory Disease (must meet all):

1. Diagnosis of NOMID or chronic infantile neurological, cutaneous and articular syndrome (CINCA);
2. Request is for Kineret;
3. Prescribed by or in consultation with a rheumatologist;
4. Dose does not exceed maximum dose indicated in Section V.

Approval duration: 6 months or to member's renewal date, whichever is longer

H. Plaque Psoriasis (must meet all):

1. Diagnosis of PsO;
2. Request is for one of the following: Humira, Cimzia, Cosentyx, Enbrel, Ilumya, Inflectra, Otezla, Remicade, Renflexis, Siliq, Skyrizi, Stelara, Taltz or Tremfya;
3. Prescribed by or in consultation with a dermatologist or rheumatologist;
4. Member meets one of the following (a, b, or c):
 - a. For Humira, Cimzia, Cosentyx, Ilumya, Inflectra, Otezla, Remicade, Renflexis, Siliq, Skyrizi, Taltz, Tremfya: age \geq 18 years;
 - b. For Enbrel: age \geq 4 years;
 - c. For Stelara: age \geq 12 years;
5. Member meets one of the following (a or b):
 - a. Failure of a trial of \geq 3 consecutive months of MTX at up to maximally indicated doses;
 - b. Member has intolerance or contraindication to MTX (*see Appendix D*), and failure of a trial of \geq 3 consecutive months of cyclosporine or acitretin at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
6. For Ilumya: Failure of a trial of **Humira** and **Enbrel** and either **Otezla** or **Cosentyx**, each used for \geq 3 consecutive months, unless contraindicated or clinically significant adverse effects are experienced;
7. For Cimzia, Siliq, Stelara, Taltz, or Tremfya and age \geq 18 years: Failure of **Humira** and **Cosentyx**, each used for \geq 3 consecutive months, unless contraindicated or clinically significant adverse effects are experienced;
8. For Inflectra, or Renflexis: Failure of a trial of \geq 3 consecutive months of **Remicade** or **Simponi Aria** unless contraindicated or clinically significant adverse effects are experienced;
9. Dose does not exceed maximum dose indicated in Section V.

Approval duration: 6 months or to member's renewal date, whichever is longer

I. Polyarticular Juvenile Idiopathic Arthritis (must meet all):

1. Diagnosis of PJIA;
2. Request is for one of the following: Humira, Enbrel, Orencia, or Actemra;
3. Prescribed by or in consultation with a rheumatologist;
4. Age \geq 2 years;
5. Failure of a trial of \geq 3 consecutive months of MTX at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;

6. For SC Ocrencia or SC Actemra: Failure of **Humira** and **Enbrel**, each used for ≥ 3 consecutive months, unless contraindicated or clinically significant adverse effects are experienced;
7. Dose does not exceed maximum dose indicated in Section V.

Approval duration: 6 months or to member's renewal date, whichever is longer

J. Psoriatic Arthritis (must meet all):

1. Diagnosis of PsA;
2. Request is for one of the following: Humira, Cimzia, Cosentyx, Enbrel, Inflectra, Ocrencia, Otezla, Remicade, Renflexis, Simponi, Simponi Aria, Stelara, Taltz, Xeljanz, or Xeljanz XR;
3. Prescribed by or in consultation with a dermatologist or rheumatologist;
4. Age ≥ 18 years;
5. For Cimzia, SC Ocrencia, Simponi, Stelara, Taltz, Xeljanz, or Xeljanz XR: Failure of a trial of **Humira** and **Enbrel** and either **Otezla** or **Cosentyx**, each used for ≥ 3 consecutive months, unless contraindicated or clinically significant adverse effects are experienced;
6. For Inflectra, Renflexis, or IV Ocrencia: Failure of a trial of ≥ 3 consecutive months of **Remicade** or **Simponi Aria** unless contraindicated or clinically significant adverse effects are experienced;
7. Dose does not exceed maximum dose indicated in Section V.

Approval duration: 6 months or to member's renewal date, whichever is longer

K. Rheumatoid Arthritis (must meet all):

1. Diagnosis of RA;
2. Request is for one of the following: Humira, Actemra, Cimzia, Enbrel, Inflectra, Kevzara, Kineret, Olumiant, Ocrencia, Remicade, Renflexis, Rinvoq, Simponi, Simponi Aria, Xeljanz, Xeljanz XR;
3. Prescribed by or in consultation with a rheumatologist;
4. Age ≥ 18 years;
5. Member meets one of the following (a or b):
 - a. Failure of a ≥ 3 consecutive month trial of MTX at up to maximally indicated doses;
 - b. Member has intolerance or contraindication to MTX (*see Appendix D*), and failure of a ≥ 3 consecutive month trial of at least ONE conventional DMARD (e.g., sulfasalazine, leflunomide, hydroxychloroquine) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effect are experienced;
6. For Xeljanz or Xeljanz XR: Failure of **Humira** and **Enbrel**, each used for ≥ 3 consecutive months, unless contraindicated or clinically significant adverse effects are experienced;
7. For Cimzia, Kevzara, Kineret, Olumiant, Ocrencia, or Simponi: Failure of a trial of ≥ 3 consecutive months of **Humira** and **Enbrel**, followed by **Xeljanz** or **Xeljanz XR**, unless contraindicated or clinically significant adverse effects are experienced;

8. For SC Actemra: Failure of a trial of ≥ 3 consecutive months of **Humira** and **Enbrel**, followed by **Xeljanz** or **Xeljanz XR**, and then followed by **Kevzara**, unless contraindicated or clinically significant adverse effects are experienced;
9. For Inflectra, Renflexis, IV Actemra, or IV Orencia: Failure of a trial of ≥ 3 consecutive months of **Remicade** or **Simponi Aria** unless contraindicated or clinically significant adverse effects are experienced;
10. Dose does not exceed maximum dose indicated in Section V.

Approval duration: 6 months or to member's renewal date, whichever is longer

L. Systemic Juvenile Idiopathic Arthritis (must meet all):

1. Diagnosis of SJA;
2. Request is for Actemra;
3. Prescribed by or in consultation with a dermatologist, rheumatologist, or gastroenterologist;
4. Age ≥ 2 years;
5. Member meets one of the following (a or b):
 - a. Failure of a trial of ≥ 3 consecutive months of MTX or leflunomide at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
 - b. Failure of a ≥ 2 week trial of a systemic corticosteroid at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
6. Dose does not exceed maximum dose indicated in Section V.

Approval duration: 6 months or to member's renewal date, whichever is longer

M. Ulcerative Colitis (must meet all):

1. Diagnosis of UC;
2. Request is for one of the following: Humira, Entyvio, Inflectra, Remicade, Renflexis, Simponi, or Xeljanz immediate-release;
3. Prescribed by or in consultation with a gastroenterologist;
4. Member meets one of the following (a or b):
 - a. For Humira, Entyvio, Simponi, Xeljanz immediate-release: age ≥ 18 years;
 - b. For Remicade, Inflectra, Renflexis: age ≥ 6 years;
5. Failure of a trial of ≥ 3 consecutive months of azathioprine, 6-mercaptopurine, or aminosalicylate (e.g., sulfasalazine), at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
6. For Simponi or Xeljanz immediate-release: Failure of a trial of ≥ 3 consecutive months of **Humira** unless contraindicated or clinically significant adverse effects are experienced;
7. For Entyvio, Inflectra or Renflexis: Failure of a trial of ≥ 3 consecutive months of **Remicade** unless contraindicated or clinically significant adverse effects are experienced;
8. Dose does not exceed maximum dose indicated in Section V.

Approval duration: 6 months or to member's renewal date, whichever is longer

N. Uveitis (must meet all):

1. Diagnosis of non-infectious intermediate, posterior, or panuveitis;
2. Request is for Humira;
3. Age \geq 2 years;
4. Prescribed by or in consultation with an ophthalmologist or rheumatologist;
5. Failure of a \geq 2 week trial of a systemic corticosteroid (e.g., prednisone) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
6. Failure of a trial of non-biologic immunosuppressive therapy (e.g., azathioprine, methotrexate, mycophenolate mofetil, cyclosporine, tacrolimus, cyclophosphamide, chlorambucil) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
7. Dose does not exceed maximum dose indicated in Section V.

Approval duration: 6 months or to member's renewal date, whichever is longer

O. Relapsing-Remitting Multiple Sclerosis (must meet all):

1. Refer to Tysabri MS criteria.

P. Other diagnoses/indications

1. Refer to CP.CPA.09 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. All Indications in Section I (must meet all):

1. Member meets one of the following (a or b):
 - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
 - b. Documentation supports that member is currently receiving IV Actemra for CAR T cell-induced CRS and member has not yet received 4 total doses;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed maximum dose indicated in Section V.

Approval duration:

For CRS: Up to 4 doses total

For all other indications: 6 months or to member's renewal date, whichever is longer

B. Other diagnoses/indications (must meet 1 or 2):

1. Currently receiving medication via a health plan affiliated with Centene Corporation and documentation supports positive response to therapy.

Approval duration: Duration of request or 12 months (whichever is less); or

2. Refer to CP.CPA.09 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off-label use policy – CP.CPA.09 or evidence of coverage documents;
- B. Combination use with Rinvoq, Xeljanz or biological DMARDs such as TNF antagonists [Cimzia, Enbrel, Simponi, Remicade, Inflectra, Renflexis], interleukin-1 receptor (IL-1R) antagonists [Kineret], interleukin-6 receptor (IL-6R) antagonists [Actemra, Kevzara], interleukin-17 receptor (IL-17R) antagonists [Siliq], interleukin-23 (IL-23) inhibitor [Tremfya], anti-CD20 monoclonal antibodies [Rituxan] and selective co-stimulation modulators [Orencia] because of the possibility of increased immunosuppression, neutropenia and increased risk of infection;
- C. For Siliq: treatment of patients with Crohn’s disease.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

- | | |
|---|--|
| AS: ankylosing spondylitis | nr-axSpA: non-radiographic axial spondyloarthritis |
| BD: Behçet’s disease | NSAIDs: non-steroidal anti-inflammatory drugs |
| CAR: chimeric antigen receptor | PJIA: polyarticular juvenile idiopathic arthritis |
| CD: Crohn’s disease | PsO: plaque psoriasis |
| CINCA: chronic infantile neurological, cutaneous and articular syndrome | PsA: psoriatic arthritis |
| CRS: cytokine release syndrome | RA: rheumatoid arthritis |
| DMARDs: disease-modifying antirheumatic drugs | SJIA: systemic juvenile idiopathic arthritis |
| GCA: giant cell arteritis | TNF: tumor necrosis factor |
| HS: hidradenitis suppurativa, | UC: ulcerative colitis |
| MS: multiple sclerosis | UV: uveitis |
| MTX: methotrexate | |
| NOMID: neonatal-onset multisystem inflammatory disease | |

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
acitretin (Soriatane®)	PsO 25 or 50 mg PO QD	50 mg/day
azathioprine (Azasan®, Imuran®)	RA 1 mg/kg/day PO QD or divided BID CD*, GCA*, UC*, UV* 1.5 – 2 mg/kg/day PO	2.5 mg/kg/day
chlorambucil (Leukeran®)	UV*	0.2 mg/kg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	0.2 mg/kg PO QD, then taper to 0.1 mg/kg PO QD or less	
clindamycin (Cleocin®) + rifampin (Rifadin®)	HS* clindamycin 300 mg PO BID and rifampin 300 mg PO BID	clindamycin: 1,800 mg/day rifampin: 600 mg/day
corticosteroids	<p>CD* prednisone 40 mg PO QD for 2 weeks or IV 50 – 100 mg Q6H for 1 week</p> <p>budesonide (Entocort EC®) 6 – 9 mg PO QD</p> <p>GCA* Various</p> <p>SJIA* < 0.5 mg/kg/day PO of prednisone or equivalent</p> <p>UV* prednisone 5 – 60 mg/day PO in 1 – 4 divided doses</p> <p>BD* triamcinolone acetonide cream (Orabase® 0.1%) Apply topically to the isolated oral ulcer 3 to 4 times daily as needed for pain.</p> <p>prednisone <u>Initial dose:</u> Week 1: 15 mg PO daily Week 2 onwards: 10 mg PO daily tapered over 2-3 weeks <u>Maintenance dose (if recurrent):</u> 5 mg PO daily</p>	Various
Cuprimine® (d-penicillamine)	RA* <u>Initial dose:</u> 125 or 250 mg PO QD <u>Maintenance dose:</u> 500 – 750 mg/day PO QD	1,500 mg/day
cyclophosphamide (Cytoxan®)	UV* 1 – 2 mg/kg/day PO	N/A

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
cyclosporine (Sandimmune [®] , Neoral [®])	PsO 2.5 – 4 mg/kg/day PO divided BID RA 2.5 – 4 mg/kg/day PO divided BID UV* 2.5 – 5 mg/kg/day PO in divided doses	PsO, RA: 4 mg/kg/day UV: 5 mg/kg/day
doxycycline (Acticlate [®])	HS* 50 – 100 mg PO BID	300 mg/day
hydroxychloroquine (Plaquenil [®])	RA* <u>Initial dose:</u> 400 – 600 mg/day PO QD <u>Maintenance dose:</u> 200 – 400 mg/day PO QD	600 mg/day
leflunomide (Arava [®])	PJIA* Weight < 20 kg: 10 mg every other day Weight 20 - 40 kg: 10 mg/day Weight > 40 kg: 20 mg/day RA 100 mg PO QD for 3 days, then 20 mg PO QD SJIA* 100 mg PO every other day for 2 days, then 10 mg every other day	PJIA, RA: 20 mg/day SJIA: 10 mg every other day
6-mercaptopurine (Purixan [®])	CD*, UC* 50 mg PO QD or 1 – 2 mg/kg/day PO	2 mg/kg/day
methotrexate (Rheumatrex [®])	CD*, UC* 15 – 25 mg/week IM or SC GCA* 20 – 25 mg/week PO PsO 10 – 25 mg/week PO or 2.5 mg PO Q12 hr for 3 doses/week PJIA* 10 – 20 mg/m ² /week PO, SC, or IM	30 mg/week

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	<p>RA 7.5 mg/week PO, SC, or IM or 2.5 mg PO Q12 hr for 3 doses/week</p> <p>SJIA* 0.5 – 1 mg/kg/week PO</p> <p>UV* 7.5 – 20 mg/week PO</p>	
minocycline (Minocin®)	<p>HS* 50 – 100 mg PO BID</p>	200 mg/day
mycophenolate mofetil (Cellcept®)	<p>UV* 500 – 1,000 mg PO BID</p>	3 g/day
NSAIDs (e.g., indomethacin, ibuprofen, naproxen, celecoxib)	<p>AS, nr-axSpA Varies</p>	Varies
Pentasa® (mesalamine)	<p>CD, UC 1,000 mg PO QID</p>	4 g/day
Ridaura® (auranofin)	<p>RA 6 mg PO QD or 3 mg PO BID</p>	9 mg/day (3 mg TID)
sulfasalazine (Azulfidine®)	<p>PJIA* 30-50 mg/kg/day PO divided BID</p> <p>RA 2 g/day PO in divided doses</p> <p>UC <u>Initial dose:</u> <i>Adults:</i> 3 – 4 g/day PO in divided doses (not to exceed Q8 hrs) <i>Pediatrics:</i> 40 – 60 mg/kg/day PO in 3 – 6 divided doses</p> <p><u>Maintenance dose:</u> <i>Adults:</i> 2 g PO QD <i>Pediatrics:</i> 30 mg/kg/day PO in 4 divided doses</p>	<p>PJIA: 2 g/day</p> <p>RA: 3 g/day</p> <p>UC: 4 g/day</p>
tacrolimus (Prograf®)	<p>CD* 0.27 mg/kg/day PO in divided doses or 0.15 – 0.29 mg/kg/day PO</p> <p>UV* 0.1-0.15 mg/kg/day PO</p>	N/A

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Biologics DMARDs (e.g., Humira, Enbrel, Cosentyx, Remicade, Simponi Aria, Otezla, Xeljanz/Xeljanz XR, Kevzara)	See Section V. Dosing and Administration	See Section V. Dosing and Administration
colchicine (Colcrys [®])	BD* 1.2 to 1.8 mg PO daily	1.8 mg/day

Therapeutic alternatives are listed as Brand name[®] (generic) when the drug is available by brand name only and generic (Brand name[®]) when the drug is available by both brand and generic.

**Off-label*

Appendix C: Contraindications/Boxed Warnings

Drug Name	Contraindication(s)	Boxed Warning(s)
Actemra	Known hypersensitivity to Actemra	Risk of serious infections
Cimzia	None reported	<ul style="list-style-type: none"> • There is an increased risk of serious infections leading to hospitalization or death including tuberculosis (TB), bacterial sepsis, invasive fungal infections (such as histoplasmosis), and infections due to other opportunistic pathogens. • Lymphoma and other malignancies have been observed. • Epstein Barr Virus-associated post-transplant lymphoproliferative disorder has been observed.
Cosentyx	Serious hypersensitivity reaction to secukinumab or to any of the excipients	None reported
Enbrel	Patients with sepsis	<ul style="list-style-type: none"> • Serious infections • Malignancies
Entyvio	Patients who have had a known serious or severe hypersensitivity reaction to Entyvio or any of its excipients	None reported
Humira	None reported	<ul style="list-style-type: none"> • Serious infections • Malignancies
Ilumya	Serious hypersensitivity reaction to tildrakizumab or to any of the excipients	None reported

Drug Name	Contraindication(s)	Boxed Warning(s)
Inflectra, Remicade, Renflexis	<ul style="list-style-type: none"> • Doses > 5 mg/kg in patients with moderate-to-severe heart failure • Re-administration to patients who have experienced a severe hypersensitivity reaction to infliximab products • Known hypersensitivity to inactive components of the product or to any murine proteins 	<ul style="list-style-type: none"> • Serious infections • Malignancy
Kevzara	Known hypersensitivity to sarilumab or any of the inactive ingredients	Risk of serious infections
Kineret	Known hypersensitivity to <i>E. coli</i> -derived proteins, Kineret, or any components of the product	None reported
Olumiant	None reported	<ul style="list-style-type: none"> • Serious infections • Malignancies • Thrombosis
Orencia	None reported	None reported
Otezla	Known hypersensitivity to apremilast or to any of the excipients in the formulation	None reported
Rinvoq	None reported	<ul style="list-style-type: none"> • Serious infections • Malignancies • Thrombosis
Siliq	Patients with Crohn's disease	Suicidal ideation and behavior
Simponi, Simponi Aria	None reported	<ul style="list-style-type: none"> • Serious infections • Malignancies
Skyrizi	None reported	None reported
Stelara	Clinically significant hypersensitivity to ustekinumab or any of its excipients	None reported
Taltz	Previous serious hypersensitivity reaction, such as anaphylaxis, to ixekizumab or to any of the excipients	None reported
Tremfya	None reported	None reported
Tysabri	<ul style="list-style-type: none"> • Patients who have or have had progressive multifocal leukoencephalopathy • Patients who have had a hypersensitivity reaction to Tysabri 	<ul style="list-style-type: none"> • Progressive multifocal leukoencephalopathy

Drug Name	Contraindication(s)	Boxed Warning(s)
Xeljanz/ Xeljanz XR	None reported	<ul style="list-style-type: none"> • There is an increased risk of serious infections leading to hospitalization or death including tuberculosis (TB), bacterial sepsis, invasive fungal infections (such as histoplasmosis), and infections due to other opportunistic pathogens. • Lymphoma and other malignancies have been observed. • Epstein Barr Virus-associated post-transplant lymphoproliferative disorder has been observed. • Rheumatoid arthritis patients with at least one cardiovascular risk factor had a higher rate of all-cause mortality and thrombosis with Xeljanz 10 mg twice daily vs. 5 mg twice daily or TNF blockers.

Appendix D: General Information

- Safety:
 - These agents are immunosuppressive and have the potential to increase the risk of infection and reactivate latent, chronic infections. They should not be administered to patients with a clinically important infection. Caution should be used in patients with chronic infections or history of recurrent infection. If patient develops a serious infection these agents should be discontinued.
 - Serious infections were seen in clinical studies with concurrent use of Kineret and another TNF-blocking agent, Enbrel, with no added benefit compared to Enbrel alone. Because of the nature of the adverse reactions with this combination therapy, similar toxicities may also result from combination of anakinra and other TNF blocking agents.
- Rheumatoid Arthritis:
 - In RA, failure of MTX or DMARD is defined as a contraindication or $\leq 50\%$ decrease in swollen joint count, $\leq 50\%$ decrease in tender joint count, and $\leq 50\%$ decrease in ESR, or $\leq 50\%$ decrease in CRP, or contraindication to at least 3 months of therapy with MTX at doses up to 25 mg per week or maximum tolerated dose.
- Ankylosing Spondylitis:
 - Several AS treatment guidelines call for a trial of 2 or 3 NSAIDs prior to use of an anti-TNF agent. A two year trial showed that continuous NSAID use reduced radiographic progression of AS versus on demand use of NSAID.
- Ulcerative Colitis:
 - For Ulcerative Colitis maintenance therapy, failure is defined as having two or more exacerbations requiring steroid therapy.
- Polyarticular Juvenile Idiopathic Arthritis:
 - Failure of MTX in PJIA is defined as disease activity remaining moderate to high despite treatment with MTX.

- In PJI, response to treatment is reflected by improvement of disease activity level and poor prognostic features including: reduction in the number of active joints, ESR or CRP, Physician global assessment, patient/parent global assessment, arthritis of the hip or cervical spine, positive RF or ACPA, radiographic damage.
- Xeljanz:
 - Per prescribing information, Xeljanz should not be used in combination with biologic DMARDs [such as Kineret] or potent immunosuppressants such as azathioprine and cyclosporine. As stated in the black box warning, patients treated with Xeljanz are at increased risk for developing serious infections that may lead to hospitalization or death. Most patients who developed these infections were taking concomitant immunosuppressants such as MTX or corticosteroids.
- Stelara:
 - Stelara is for subcutaneous administration and is intended for use under the guidance and supervision of a physician. After proper training in subcutaneous injection technique, a patient may self-inject with Stelara if a physician determines that it is appropriate. Patients should be instructed to follow the directions provided in the Medication Guide.
 - In the PHOENIX 2 trial, dosing intensification of Stelara to every 8 weeks did not result in greater efficacy compared with continuing treatment every 12 weeks.
- Neonatal-Onset Multisystem Inflammatory Disease:
 - Other names used for NOMID are as follows: chronic infantile neurological, CINCA, chronic neurologic, cutaneous, and articular syndrome, infantile onset multisystem inflammatory disease, IOMID syndrome, and Prieur-Griscelli syndrome.
- Enbrel:
 - Off-label indications:
 - Graft vs. Host disease is listed in Micromedex as Class IIa for pediatric patients and Enbrel is recommended in most cases.
 - Severe, refractory hidradenitis suppurativa is listed in Micromedex with an evidence rating of Class IIa for adult patients.
- Hidradenitis suppurativa:
 - HS is sometimes referred to as: "acne inversa, acne conglobata, apocrine acne, apocrinitis, Fox-den disease, hidradenitis axillaris, HS, pyoderma sinifica fistulans, Velpeau's disease, and Verneuil's disease."
 - In HS, Hurley stages are used to determine severity of disease. Hurley stage II indicates moderate disease, and is characterized by recurrent abscesses, with sinus tracts and scarring, presenting as single or multiple widely separated lesions. Hurley stage III indicates severe disease, and is characterized by diffuse or near-diffuse involvement presenting as multiple interconnected tracts and abscesses across an entire area.
 - Enbrel has off-label use supported by some efficacy data in severe, refractory HS through retrospective cohort studies and case reports. This off-label indication for Enbrel is recommended by Micromedex with a Class IIa recommendation.
- Taltz:
 - Taltz is currently being studied for the treatment of rheumatoid arthritis, radiographic axial spondyloarthritis, ankylosing spondylitis, and psoriatic arthritis.
- Definition of failure of MTX or DMARDs

- Failure of a trial of conventional DMARDs:
 - Child-bearing age is not considered a contraindication for use of MTX. Each drug has risks in pregnancy. An educated patient and family planning would allow use of MTX in patients who have no intention of immediate pregnancy.
 - Social use of alcohol is not considered a contraindication for use of MTX. MTX may only be contraindicated if patients choose to drink over 14 units of alcohol per week. However, excessive alcohol drinking can lead to worsening of the condition, so patients who are serious about clinical response to therapy should refrain from excessive alcohol consumption.
- Examples of positive response to therapy may include, but are not limited to:
 - Reduction in joint pain/swelling/tenderness
 - Improvement in ESR/CRP levels
 - Improvements in activities of daily living
- Ulcerative colitis: there is insufficient evidence to support the off-label weekly dosing of Humira for the treatment of moderate-to-severe UC. It is the position of Centene Corporation® that the off-label weekly dosing of Humira for the treatment of moderate-to-severe UC is investigational and not medically necessary at this time.
 - The evidence from the *post hoc* study of the Humira pivotal trial suggests further studies are needed to confirm the benefit of weekly Humira dosing for the treatment of UC in patients with inadequate or loss of therapeutic response to treatment with Humira every other week. No large, randomized or prospective studies have been published to support the efficacy of the higher frequency of dosing, while national and international treatment guidelines also do not strongly support dose escalation of Humira for UC. The current market consensus is that weekly dosing of Humira is not medically necessary due to lack of evidence to support its benefit.
- The following may be considered for medical justification supporting inability to use an immunomodulator for Crohn's disease:
 - Inability to induce short-term symptomatic remission with a 3-month trial of systemic glucocorticoids
 - High-risk factors for intestinal complications may include:
 - Initial extensive ileal, ileocolonic, or proximal GI involvement
 - Initial extensive perianal/severe rectal disease
 - Fistulizing disease (e.g., perianal, enterocutaneous, and rectovaginal fistulas)
 - Deep ulcerations
 - Penetrating, stricturing or stenosis disease and/or phenotype
 - Intestinal obstruction or abscess
 - For TNF-inhibitors, high risk factors for postoperative recurrence may include:
 - Less than 10 years duration between time of diagnosis and surgery
 - Disease location in the ileum and colon
 - Perianal fistula
 - Prior history of surgical resection
 - Use of corticosteroids prior to surgery
- Cimzia:
 - According to the CRADLE, a prospective, postmarketing, multicenter, pharmacokinetic study (n = 17), there were no or minimal certolizumab pegol transfer

from the maternal plasma to breast milk, with a relative infant dose of 0.15% of the maternal dose.

- PsA: According to the 2018 American College of Rheumatology and National Psoriasis Foundation guidelines, TNF inhibitors or oral small molecules (e.g., methotrexate, sulfasalazine, cyclosporine, leflunomide, apremilast) are preferred over other biologics (e.g., interleukin-17 inhibitors or interleukin-12/23 inhibitors) for treatment-naïve disease. TNF inhibitors are also generally recommended over oral small molecules as first-line therapy unless disease is not severe, member prefers oral agents, or TNF inhibitor therapy is contraindicated.
- Otezla is the first and only FDA-approved treatment for oral ulcers associated with Behçet's disease. However, patients included in the pivotal study had prior treatment with at least one non-biologic Behçet's disease therapy, such as, but not limited to, topical corticosteroids, or systemic treatment.

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Abatacept (Orencia)	RA PsA	IV: weight-based dose at weeks 0, 2, and 4, followed by every 4 weeks Weight < 60 kg: 500 mg per dose Weight 60 to 100 kg: 750 mg per dose Weight > 100 kg: 1,000 mg per dose SC: 125 mg once weekly (For RA: if single IV loading dose is given, start first SC injection within one day of IV dose)	IV: 1,000 mg every 4 weeks SC: 125 mg/week
	PJIA	IV: weight-based dose at weeks 0, 2, and 4, followed by every 4 weeks Weight < 75 kg: 10 mg/kg per dose Weight 75 to 100 kg: 750 mg per dose Weight >100 kg: 1,000 mg per dose SC: weight-based dose once weekly Weight 10 to < 25 kg: 50 mg per dose Weight 25 to < 50 kg: 87.5 mg per dose Weight ≥ 50 kg: 125 mg per dose	IV: 1,000 mg every 4 weeks SC: 125 mg/week
Adalimumab (Humira)	RA	40 mg SC every other week Some patients with RA not receiving concomitant methotrexate may benefit from increasing the frequency to 40 mg every week.	40 mg/week
	PJIA	Weight 10 kg (22 lbs) to < 15 kg (33 lbs): 10 mg SC every other week Weight 15 kg (33 lbs) to < 30 kg (66 lbs): 20 mg SC every other week	40 mg every other week

Drug Name	Indication	Dosing Regimen	Maximum Dose
		Weight \geq 30 kg (66 lbs): 40 mg SC every other week	
	PsA AS	40 mg SC every other week	40 mg every other week
	CD	<p><u>Initial dose:</u> <i>Adults:</i> 160 mg SC on Day 1, then 80 mg SC on Day 15</p> <p><i>Pediatrics:</i> Weight 17 kg (37 lbs) to < 40 kg (88 lbs): 80 mg SC on Day 1, then 40 mg SC on Day 15 Weight \geq 40 kg (88 lbs): 160 mg SC on Day 1, then 80 mg SC on Day 15</p> <p><u>Maintenance dose:</u> <i>Adults:</i> 40 mg SC every other week starting on Day 29</p> <p><i>Pediatrics:</i> Weight 17 kg (37 lbs) to < 40 kg (88 lbs): 20 mg SC every other week starting on Day 29 Weight \geq 40 kg (88 lbs): 40 mg SC every other week starting on Day 29</p>	40 mg every other week
	UC	<p><u>Initial dose:</u> 160 mg SC on Day 1, then 80 mg SC on Day 15</p> <p><u>Maintenance dose:</u> 40 mg SC every other week starting on Day 29</p>	40 mg every other week
	PsO	<p><u>Initial dose:</u> 80 mg SC</p> <p><u>Maintenance dose:</u> 40 mg SC every other week starting one week after initial dose</p>	40 mg every other week
	UV	<p><i>Pediatrics:</i> Weight 10 kg (22 lbs) to < 15 kg (33 lbs): 10 mg SC every other week Weight 15 kg (33 lbs) to < 30 kg (66 lbs): 20 mg SC every other week Weight \geq 30 kg (66 lbs): 40 mg SC every other week</p> <p><i>Adults:</i></p>	40 mg every other week

Drug Name	Indication	Dosing Regimen	Maximum Dose
		Initial dose of 80 mg SC, followed by 40 mg SC every other week starting one week after the initial dose	
	HS	<p><i>For patients 12 years of age and older weighing at least 30 kg:</i></p> <p><u>Initial dose:</u> Weight 30 kg (66 lbs) to < 60 kg (132 lbs): 80 mg SC on Day 1, then 40 mg on Day 8 Weight ≥ 60 kg (132 lbs): 160 mg SC on Day 1, then 80 mg SC on Day 15</p> <p><u>Maintenance dose:</u> Weight 30 kg (66 lbs) to < 60 kg (132 lbs): 40 mg every other week Weight ≥ 60 kg (132 lbs): 40 mg SC once weekly starting on Day 29</p>	40 mg/week
Anakinra (Kineret)	RA	100 mg SC QD	100 mg/day
	NOMID	<p><u>Initial dose:</u> 1 – 2 mg/kg SC QD or divided BID</p> <p><u>Maintenance dose:</u> 8 mg/kg SC QD or divided BID</p>	8 mg/kg/day
Apremilast (Otezla)	PsO PsA BD	<p><u>Initial dose:</u> Day 1: 10 mg PO QAM Day 2: 10 mg PO QAM and 10 mg PO QPM Day 3: 10 mg PO QAM and 20 mg PO QPM Day 4: 20 mg PO QAM and 20 mg PO QPM Day 5: 20 mg PO QAM and 30 mg PO QPM</p> <p><u>Maintenance dose:</u> Day 6 and thereafter: 30 mg PO BID</p>	60 mg/day
Baricitinib (Olumiant)	RA	2 mg PO QD	2 mg/day
Brodalumab (Siliq)	PsO	<p><u>Initial dose:</u> 210 mg SC at weeks 0, 1, and 2</p> <p><u>Maintenance dose:</u> 210 mg SC every 2 weeks</p>	210 mg every 2 weeks
Certolizumab (Cimzia)	CD	<p><u>Initial dose:</u> 400 mg SC at 0, 2, and 4 weeks</p> <p><u>Maintenance dose:</u> 400 mg SC every 4 weeks</p>	400 mg every 4 weeks

Drug Name	Indication	Dosing Regimen	Maximum Dose
	RA PsA AS nr-axSpA	<u>Initial dose:</u> 400 mg SC at 0, 2, and 4 weeks <u>Maintenance dose:</u> 200 mg SC every other week (or 400 mg SC every 4 weeks)	400 mg every 4 weeks
	PsO	400 mg SC every other week. For some patients (with body weight \leq 90 kg), a dose of 400 mg SC at 0, 2 and 4 weeks, followed by 200 mg SC every other week may be considered.	400 mg every other week
Etanercept (Enbrel)	RA PsA	25 mg SC twice weekly or 50 mg SC once weekly	50 mg/week
	AS	50 mg SC once weekly	50 mg/week
	PJIA	Weight < 63 kg: 0.8 mg/kg SC once weekly Weight \geq 63 kg: 50 mg SC once weekly	50 mg/week
	PsO	<i>Adults:</i> <u>Initial dose:</u> 50 mg SC twice weekly for 3 months <u>Maintenance dose:</u> 50 mg SC once weekly <i>Pediatrics:</i> Weight < 63 kg: 0.8 mg/kg SC once weekly Weight \geq 63 kg: 50 mg SC once weekly	50 mg/week
Golimumab (Simponi)	AS PsA RA	50 mg SC once monthly	50 mg/month
	UC	<u>Initial dose:</u> 200 mg SC at week 0, then 100 mg SC at week 2 <u>Maintenance dose:</u> 100 mg SC every 4 weeks	100 mg every 4 weeks
Golimumab (Simponi Aria)	AS PsA RA	<u>Initial dose:</u> 2 mg/kg IV at weeks 0 and 4 <u>Maintenance dose:</u> 2 mg/kg IV every 8 weeks	2 mg/kg every 8 weeks
Guselkumab (Tremfya)	PsO	<u>Initial dose:</u> 100 mg SC at weeks 0 and 4 <u>Maintenance dose:</u> 100 mg SC every 8 weeks	100 mg every 8 weeks
Infliximab (Remicade, Renflexis, Inflectra)	CD, UC	<u>Initial dose:</u> <i>Adults/Pediatrics:</i> 5 mg/kg IV at weeks 0, 2 and 6 <u>Maintenance dose:</u>	CD, Adults: 10 mg/kg every 8 weeks

Drug Name	Indication	Dosing Regimen	Maximum Dose
		<p><i>Adults/Pediatrics:</i> 5 mg/kg IV every 8 weeks.</p> <p>For CD: Some adult patients who initially respond to treatment may benefit from increasing the dose to 10 mg/kg if they later lose their response</p>	<p>UC, Adults: 5 mg/kg every 8 weeks</p> <p>Pediatrics: 5 mg/kg every 8 weeks</p>
	PsA PsO	<p><u>Initial dose:</u> 5 mg/kg IV at weeks 0, 2 and 6</p> <p><u>Maintenance dose:</u> 5 mg/kg IV every 8 weeks</p>	5 mg/kg every 8 weeks
	RA	<p>In conjunction with MTX</p> <p><u>Initial dose:</u> 3 mg/kg IV at weeks 0, 2 and 6</p> <p><u>Maintenance dose:</u> 3 mg/kg IV every 8 weeks</p> <p>Some patients may benefit from increasing the dose up to 10 mg/kg or treating as often as every 4 weeks</p>	10 mg/kg every 4 weeks
	AS	<p><u>Initial dose:</u> 5 mg/kg IV at weeks 0, 2 and 6</p> <p><u>Maintenance dose:</u> 5 mg/kg IV every 6 weeks</p>	5 mg/kg every 6 weeks
Ixezumab (Taltz)	PsO (with or without coexistent PsA)	<p><u>Initial dose:</u> 160 mg (two 80 mg injections) SC at week 0, then 80 mg SC at weeks 2, 4, 6, 8, 10, and 12</p> <p><u>Maintenance dose:</u> 80 mg SC every 4 weeks</p>	80 mg every 4 weeks
	PsA	<p><u>Initial dose:</u> 160 mg (two 80 mg injections) SC at week 0</p> <p><u>Maintenance dose:</u> 80 mg SC every 4 weeks</p>	80 mg every 4 weeks
Natalizumab (Tysabri)	MS, CD	300 mg IV every 4 weeks	300 mg/4 weeks
Risankizumab-rzaa (Skyrizi)	PsO	150 mg SC at weeks 0, 4, and every 12 weeks thereafter	150 mg/12 weeks
Sarilumab (Kevzara)	RA	200 mg SC once every two weeks	200 mg/2 weeks

Drug Name	Indication	Dosing Regimen	Maximum Dose
Secukinumab (Cosentyx)	PsO (with or without PsA)	300 mg SC at weeks 0, 1, 2, 3, and 4, followed by 300 mg SC every 4 weeks. (for some patients, a dose of 150 mg may be acceptable)	300 mg every 4 weeks
	PsA	With loading dose: 150 mg SC at week 0, 1, 2, 3, and 4, followed by 150 mg SC every 4 weeks Without loading dose: 150 mg SC every 4 weeks If a patient continues to have active psoriatic arthritis, consider a dosage of 300 mg.	300 mg every 4 weeks
	AS	With loading dose: 150 mg SC at weeks 0, 1, 2, 3, and 4, followed by 150 mg SC every 4 weeks thereafter Without loading dose: 150 mg SC every 4 weeks	150 mg every 4 weeks
Tildrakizumab-asmn (Ilumya)	PsO	<u>Initial dose:</u> 100 mg SC at weeks 0 and 4 <u>Maintenance dose:</u> 100 mg SC every 12 weeks Ilumya should only be administered by a healthcare professional.	100 mg every 12 weeks
Tocilizumab (Actemra)	RA	IV: 4 mg/kg every 4 weeks followed by an increase to 8 mg/kg every 4 weeks based on clinical response SC: Weight < 100 kg: 162 mg SC every other week, followed by an increase to every week based on clinical response Weight ≥ 100 kg: 162 mg SC every week	IV: 800 mg every 4 weeks SC: 162 mg every week
	GCA	162 mg SC every week (every other week may be given based on clinical considerations)	SC: 162 mg every week
	PJIA	Weight < 30 kg: 10 mg/kg IV every 4 weeks or 162 mg SC every 3 weeks Weight ≥ 30 kg: 8 mg/kg IV every 4 weeks or 162 mg SC every 2 weeks	IV: 10 mg/kg every 4 weeks SC: 162 mg every 2 weeks

Drug Name	Indication	Dosing Regimen	Maximum Dose
	SJIA	IV: Weight < 30 kg: 12 mg/kg IV every 2 weeks Weight ≥ 30 kg: 8 mg/kg IV every 2 weeks SC: Weight < 30 kg: 162 mg SC every 2 weeks Weight ≥ 30 kg: 162 mg SC every week	IV: 12 mg/kg every 2 weeks SC: 162 mg every week
	CRS	Weight < 30 kg: 12 mg/kg IV per infusion Weight ≥ 30 kg: 8 mg/kg IV per infusion If no clinical improvement in the signs and symptoms of CRS occurs after the first dose, up to 3 additional doses of Actemra may be administered. The interval between consecutive doses should be at least 8 hours.	IV: 800 mg/infusion, up to 4 doses
Tofacitinib (Xeljanz)	PsA RA	5 mg PO BID	10 mg/day
	UC	10 mg PO BID for at least 8 weeks, then 5 or 10 mg BID thereafter. Discontinue after 16 weeks of 10 mg BID if adequate therapeutic benefit is not achieved.	20 mg/day
Tofacitinib extended-release (Xeljanz XR)	PsA RA	11 mg PO QD	11 mg/day
Upadacitinib (Rinvoq)	RA	15 mg PO QD	15 mg/day
Ustekinumab (Stelara)	PsO	Weight based dosing SC at weeks 0 and 4, followed by maintenance dose every 12 weeks <i>Adult:</i> Weight ≤ 100 kg: 45 mg Weight > 100 kg: 90 mg <i>Pediatrics (Age 12 years and older):</i> Weight < 60 kg: 0.75 mg/kg Weight 60 to 100 kg: 45 mg Weight > 100kg: 90 mg	90 mg every 12 weeks
	PsA	45 mg SC at weeks 0 and 4, followed by 45 mg every 12 weeks	45 mg every 12 weeks

Drug Name	Indication	Dosing Regimen	Maximum Dose
	PsA with co-existent PsO	Weight > 100 kg: 90 mg SC at weeks 0 and 4, followed by 90 mg every 12 weeks	90 mg every 12 weeks
	CD	Weight based dosing IV at initial dose, followed by 90 mg SC every 8 weeks Weight ≤ 55 kg: 260 mg Weight 55 kg to 85 kg: 390 mg Weight > 85 kg: 520 mg	90 mg every 8 weeks
Vedolizumab (Entyvio)	CD UC	<u>Initial dose:</u> 300 mg IV at weeks 0, 2, and 6 <u>Maintenance dose:</u> 300 mg IV every 8 weeks	300 mg every 8 weeks

VI. Product Availability

Drug Name	Availability
Abatacept (Orencia)	Single-use vial: 250 mg Single-dose prefilled syringe: 50 mg/0.4 mL, 87.5 mg/0.7 mL, 125 mg/mL Single-dose prefilled ClickJect™ autoinjector: 125 mg/mL
Adalimumab (Humira)	Single-dose prefilled pen: 80 mg/0.8 mL, 40 mg/0.8 mL, 40 mg/0.4 mL Single-dose prefilled syringe: 80 mg/0.8 mL, 40 mg/0.8 mL, 40 mg/0.4 mL, 20 mg/0.4 mL, 20 mg/0.2 mL, 10 mg/0.2 mL, 10 mg/0.1 mL Single-use vial for institutional use only: 40 mg/0.8 mL
Anakinra (Kineret)	Single-use prefilled syringe: 100 mg/0.67 mL
Apremilast (Otezla)	Tablets: 10 mg, 20 mg, 30 mg
Baricitinib (Olumiant)	Tablet: 2 mg
Brodalumab (Siliq)	Single-dose prefilled syringe: 210 mg/1.5 mL
Certolizumab pegol (Cimzia)	Lyophilized powder in a single-use vial for reconstitution: 200 mg Single-use prefilled syringe: 200 mg/mL
Etanercept (Enbrel)	Single-dose prefilled syringe: 25 mg/0.5 mL, 50 mg/mL Single-dose prefilled SureClick® Autoinjector: 50 mg/mL Multi-dose vial: 25 mg Enbrel Mini™ single-dose prefilled cartridge for use with AutoTouch™ reusable autoinjector: 50 mg/mL
Golimumab (Simponi)	Single-dose prefilled SmartJect® autoinjector: 50 mg/0.5 mL, 100 mg/1 mL Single-dose prefilled syringe: 50 mg/0.5 mL, 100 mg/1 mL

Drug Name	Availability
Golimumab (Simponi Aria)	Single-use vial: 50 mg/4 mL
Infliximab-dyyb (Inflectra)	Single-use vial: 100 mg/20 mL
Infliximab (Remicade)	Single-use vial: 100 mg/20 mL
Infliximab-abda (Renflexis)	Single-use vial: 100 mg/20 mL
Ixekizumab (Taltz)	Single-dose prefilled autoinjector: 80 mg/mL Single-dose prefilled syringe: 80 mg/mL
Guselkumab (Tremfya)	Single-dose prefilled syringe: 100 mg/mL
Natalizumab (Tysabri)	Single-use vial: 300 mg/15 mL
Risankizumab-rzaa (Skyrizi)	Single-dose prefilled syringe: 75 mg/0.83 mL
Sarilumab (Kevzara)	Single-dose prefilled syringe: 150 mg/1.14 mL, 200 mg/1.14 mL
Secukinumab (Cosentyx)	Single-dose Sensoready[®] pen: 150 mg/mL Single-dose prefilled syringe: 150 mg/mL Single-use vial: 150 mg
Tildrakizumab-asmn (Ilumya)	Single-dose prefilled syringe: 100 mg/1 mL
Tocilizumab (Actemra)	Single-use vial: 80 mg/4 mL, 200 mg/10 mL, 400 mg/20 mL Single-dose prefilled syringe: 162 mg/0.9 mL Single-dose prefilled autoinjector: 162 mg/0.9 mL
Tofacitinib (Xeljanz)	Tablets: 5 mg, 10 mg
Tofacitinib extended-release (Xeljanz XR)	Tablets: 11 mg
Upadacitinib (Rinvoq)	Tablets, extended-release: 15 mg
Ustekinumab (Stelara)	Single-use prefilled syringe: 45 mg/0.5 mL, 90 mg/mL Single-dose vial for SC: 45 mg/0.5 mL Single-dose vial for IV: 130 mg/26 mL (5 mg/mL)
Vedolizumab (Entyvio)	Single-use vial: 300 mg/20 mL

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Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy converted from “Actemra, Cimzia, Cosentyx, Enbrel, biologic DMARD NATL 06.09.17.docx”. Added Renflexis.	06.17	08.17
Added new FDA indication for Actemra – Giant Cell Arteritis. Added new FDA indication for Orencia – Psoriatic Arthritis.	07.17	11.17
Added new FDA indication for Actemra – cytokine release syndrome.	09.26.17	11.17
Simponi Aria: Added additionally FDA-approved indications of PsA and AS; Stelara: Added FDA-approved adolescent extension of PsO indication	11.27.17	02.18
Kevzara, Siliq, and Tremfya added to criteria. Revised redirections for contract compliance: Prefer up to two of four preferred agents (Humira, Enbrel, Cosentyx, and Otezla) where FDA-indicated, except for PsA where redirection is to both Humira and Enbrel and either Cosentyx or Otezla, and for RA where redirection is to Humira and Enbrel, then Xeljanz/Xeljanz XR, then Kevzara. Remicade is the preferred product for any IV agent where indicated.	11.30.17	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Removed off-label use of Enbrel from options for tx of HS. Humira maintenance dose for HS corrected to every week from every other week. Added Enbrel mini new dosage form. Added hyperlinked contents.		
AS, PsA, and RA: Removed Simponi Aria from trial of Remicade, and put in preferred position as parity with Remicade.	02.16.18	
2Q 2018 annual review: Taltz and Xeljanz/Xeljanz XR: criteria added for new FDA indication: PsA; added age requirements for all conditions where indicated; added prescriber specialist requirement for AS, NOMID; modified prescriber specialist from gastroenterologist to GI specialist for CD, HS, SJIA, UC; removed trial and failure option of PUVA or UVB from PsO; added trial and failure of cyclosporine, sulfasalazine, or leflunomide if intolerance or contraindication to MTX for PsA; added trial and failure of MTX or leflunomide or systemic corticosteroid for SJIA; removed requirement that member must not be in remission for induction therapy for CD; added coverage not authorized for Siliq in patients with Crohn's disease; references reviewed and updated.	01.30.18	05.18
Ilumya added to criteria.	05.01.18	08.18
4Q 2018 annual review: criteria added for new FDA indications: plaque psoriasis for Cimzia; ulcerative colitis for Xeljanz; newly FDA-approved subcutaneous Actemra dosing for PJIA added; criteria added for newly FDA approved agent Olumiant for RA; updated approval for SC Actemra for SJIA in patients 2 years and older; updated pediatric indication expansion for uveitis and adolescent indication expansion for hidradenitis suppurativa for Humira; modified prescriber specialist from GI specialist to gastroenterologist for CD, UC, HS, and SJIA; added trial and failure of immunosuppressants, or medical necessity for use of biologics in CD; allowed bypassing cDMARDs for axial PsA and required trial of NSAIDs; references reviewed and updated.	08.28.18	02.19
2Q 2019 annual review: removed trial and failure requirement of conventional DMARDs (e.g., MTX)/NSAIDs for biologic DMARDs for PsA per ACR/NPF 2018 guidelines; removed redirection for Stelara for PsO for members less than 18 years old; added new prefilled autoinjector formulation for Actemra; references reviewed and updated.	03.05.19	05.19
Criteria added for new FDA indication for Cimzia: non-radiographic axial spondyloarthritis; Criteria added for new FDA approved agent: Skyrizi for PsO; references reviewed and updated.	06.04.19	08.19
RT4: updated FDA-approved language to indicate Inflectra and Renflexis are approved for use in pediatric ulcerative colitis.	07.09.19	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Criteria added for new FDA indication for Otezla: Behçet’s disease; updated summary table with symbols; new FDA approved agent Rinvoq added to criteria for RA; references reviewed and updated.	09.03.19	11.19

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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