Clinical Policy: Biologic and Non-biologic DMARDs

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Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

The following are biologic and non-biologic disease-modifying anti-rheumatic drugs (DMARDs) requiring prior authorization: adalimumab-afzb (Abrilada™), tocilizumab (Actemra®), adalimumab-atto (Amjevita™), infliximab-axxq (Avsola™), tocilizumab-anoh (Avtozma®), bimekizumab-bkzx (Bimzelx®), certolizumab pegol (Cimzia®), secukinumab (Cosentyx®), adalimumab-adbm (Cyltezo®), etanercept (Enbrel®), vedolizumab (Entyvio®), adalimumab-bwwd (Hadlima™), adalimumab-fkjp (Hulio®), adalimumab (Humira®), adalimumab-adaz (Hyrimoz®), adalimumab-aacf (Idacio®), tildrakizumab-asmn (Ilumya™), ustekinumab-srlf (Imuldosa™), infliximab-dyyb (Inflectra®, Zymfentra®), sarilumab (Kevzara®), anakinra (Kineret®), baricitinib (Olumiant®), mirikizumab-mrkz (Omvoh™), abatacept (Orencia®), apremilast (Otezla® Otezla XR®), ustekinumab-aauz (Otulfi®), ustekinumab-ttwe (Pyzchiva®), infliximab (Remicade®), infliximab-abda (Renflexis™), upadacitinib (Rinvoq®, Rinvoq LQ®), ustekinumab-aekn (Selarsdi™), brodalumab (Siliq™), adalimumab-ryvk (Simlandi®), golimumab (Simponi®, Simponi Aria®), risankizumab-rzaa (Skyrizi®), deucravacitinib (Sotyktu™), ustekinumab-hmny (Starjemza™), ustekinumab (Stelara®), ustekinumab-stba (Steqeyma®), ixekizumab (Taltz®), tocilizumab-bavi (Tofidence™), guselkumab (Tremfya®), tocilizumab-aazg (Tyenne®), natalizumab-sztn (Tyruko®), natalizumab (Tysabri®), etrasimod (Velsipity™), ustekinumab-auub (Wezlana™), tofacitinib (Xeljanz®, Xeljanz® XR), ustekinumab-kfce (Yesintek™), adalimumab-aaty (Yuflyma®), adalimumab-aqvh (Yusimry™), ozanimod (Zeposia®).

FDA Approved Indication(s)

	AS	nr-axSpA	CD	UC	PJIA	SJIA	PsO	PsA	RA	Others
Abrilada	x		x	x	x		x	x	x	HS, UV
Actemra					x[#]	x[#]			x[#]	CRS[*], GCA[#], SSc-ILD[^], COVID-19 in the hospitalized setting
Amjevita	x		x	x	x		x	x	x	HS, UV
Avsola	x		x	x			x	x	x	
Avtozma					x[#]	x[#]			x[#]	CRS[*], COVID-19 in the hospitalized setting, GCA[#]
Bimzelx	x	x					x	x		HS
Cimzia	x	x	x		x		x	x	x	
Cyltezo/adalimumab-adbm	x		x	x	x		x	x	x	HS, UV
Cosentyx	x	x					x	x		ERA, HS

	AS	nr-axSpA	CD	UC	PJIA	SJIA	PsO	PsA	RA	Others
Enbrel	x				x		x	x	x	
Entyvio			x[#]	x[#]						
Hadlima/adalimumab-bwwd	x		x	x	x		x	x	x	HS, UV
Hulio/adalimumab-fkjp	x		x	x	x		x	x	x	HS, UV
Humira	x		x	x	x		x	x	x	HS, UV
Hyrimoz/adalimumab-adaz	x		x	x	x		x	x	x	HS, UV
Idacio/adalimumab-aacf	x		x	x	x		x	x	x	HS, UV
Ilumya							x			
Imuldosa			x[#]	x[#]			x[^]	x[^]		
Inflectra	x		x	x			x	x	x	
Kevzara					x				x	PMR
Kineret									x	DIRA, NOMID
Olumiant									x	COVID-19 in the hospitalized setting, alopecia areata
Omvoh			x[#]	x[#]						
Orencia					x[#]			x[#]	x[#]	aGVHD
Otezla/Otezla XR							x	x		BD
Otulfi			x[#]	x[#]			x[^]	x[^]		
Pyzchiva			x[#]	x[#]			x[^]	x[^]		
Remicade/unbranded Remicade	x		x	x			x	x	x	
Renflexis	x		x	x			x	x	x	
Rinvoq	x	x	x	x	x			x	x	AD, GCA
Rinvoq LQ					x			x		
Selarsdi			x[#]	x[#]			x[^]	x[^]		
Siliq							x			
Simlandi/adalimumab-ryvk	x		x	x	x		x	x	x	HS, UV
Simponi	x			x				x	x	
Simponi Aria	x				x			x	x	
Skyrizi			x[#]	x[#]			x	x		
Sotyktu							x			
Starjemza			x[#]	x[#]			x[^]	x[^]		
Stelara/ustekinumab (unbranded Stelara)			x[#]	x[#]			x[^]	x[^]		
Steqeyma			x[#]	x[#]			x[^]	x[^]		
Taltz	x	x					x	x		
Tofidence					x	x			x	COVID-19 in the hospitalized setting, GCA
Tremfya			x[#]	x[#]			x	x		
Tyenne					x[#]	x[#]			x[#]	CRS[*], COVID-19 in the hospitalized setting, GCA[#]
Tyruko			x							MS
Tysabri			x							MS
Velsipity				x						
Wezlana			x[#]	x[#]			x[^]	x[^]		
Xeljanz	x			x	x			x	x	

	AS	nr-axSpA	CD	UC	PJIA	SJIA	PsO	PsA	RA	Others
Xeljanz XR	x			x				x	x	
Yesintek			x[#]	x[#]			x[^]	x[^]		
Yuflyma/adalimumab-aaty	x		x	x	x		x	x	x	HS, UV
Yusimry	x		x	x	x		x	x	x	HS, UV
Zeposia				x						MS
Zymfentra			x	x						

If available as IV and SC, then: [*] =IV only; [#] =IV/SC; [^] = SC only; [±] =IR only
AD=atopic dermatitis; AS=ankylosing spondylitis; nr-axSpA=non-radiographic axial spondyloarthritis; CD=Crohn's disease; COVID-19=coronavirus disease 2019; 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; SSc-ILD=systemic sclerosis-associated interstitial lung disease; ERA=enthesitis-related arthritis; aGVHD=acute graft-versus-host disease; PMR=polymyalgia rheumatica

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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 Abrilada, Actemra, adalimumab-aacf, adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, adalimumab-bwwd, adalimumab-fkjp, adalimumab-ryvk, Amjevita, Avsola, Avtozma, Bimzelx, Cimzia, Cosentyx, Cyltezo, Enbrel, Entyvio, Hadlima, Hulio, Humira, Hyrimoz, Idacio, Ilumya, Imuldosa, Inflectra, Kevzara, Kineret, Olumiant, Omvoh, Orencia, Otezla, Otulfi, Pyzchiva, Remicade/unbranded Remicade, Renflexis, Rinvoq, Rinvoq LQ, Selarsdi, Siliq, Simlandi, Simponi, Simponi Aria, Skyrizi, Sotyktu, Starjemza, Stelara, Steqeyma, Taltz, Tofidence, Tremfya, Tyenne, Tyruko, Tysabri, ustekinumab (unbranded Stelara), Velsipity, Wezlana, Xeljanz, Xeljanz XR, Yesintek, Yuflyma, Yusimry, Zeposia, and Zymfentra are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Atopic Dermatitis (must meet all):
1. Diagnosis of atopic dermatitis affecting one of the following (a or b):
   a. At least 10% of the member's body surface area (BSA);
   b. Hands, feet, face, neck, scalp, genitals/groin, and/or intertriginous areas;
2. Request is for Rinvoq;
3. Prescribed by or in consultation with a dermatologist or allergist;
4. Age ≥ 12 years;
5. Failure of both of the following (a and b), unless contraindicated or clinically significant adverse effects are experienced:†
   †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. One formulary medium to very high potency topical corticosteroid used for ≥ 2 weeks;
   b. One non-steroidal topical therapy* used for ≥ 4 weeks: topical calcineurin inhibitor (e.g., tacrolimus 0.03% ointment, pimecrolimus 1% cream) or Eucrisa®;
      **These agents may require prior authorization*
6. Rinvoq is not prescribed concurrently with another biologic medication (e.g., Adbry®, Dupixent®) or JAK inhibitors (e.g., Olumiant®, Cibinqo®, Opzelura™) (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
7. Dose does not exceed maximum dose* indicated in Section V.
   **Maximum dose escalation allowed per prescriber information with documentation of inadequate Speresponse.*

Approval duration: 12 months

B. Axial Spondyloarthritis (must meet all)**:**
1. Diagnosis of AS or nr-axSpA;

2. Request is for one of the following: Abrilada, adalimumab-aacf, adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, adalimumab-bwwd, adalimumab-fkjp, adalimumab-ryvk, Amjevita, Avsola, Bimzelx, Cimzia, Cosentyx, Cyltezo, Enbrel, Hadlima, Hulio, Humira, Hyrimoz, Idacio, Inflectra, Remicade/unbranded Remicade, Renflexis, Rinvoq, Simlandi, Simponi, Simponi Aria, Taltz, Xeljanz, Xeljanz XR, Yuflyma, or Yusimry;
3. Prescribed by or in consultation with a rheumatologist;
4. Age ≥ 18 years;
5. Failure of at least TWO non-steroidal anti-inflammatory drugs (NSAIDs) at up to maximally indicated doses, each used for ≥ 4 weeks unless contraindicated, clinically significant adverse effects are experienced, or previously failed a biologic agent for AS or nr-axSpA;[†]
   [†]For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395
6. For nr-axSpA for Bimzelx, Cimzia or Taltz, member meets both of the following (a and b):[†]
   [†]For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. Failure of **Cosentyx** used for ≥ 3 consecutive months, unless contraindicated or clinically significant adverse effects are experienced;
   b. If member has not responded or is intolerant to one or more TNF blockers, failure of **Rinvoq**, unless member has cardiovascular risk and benefits do not outweigh the risk of treatment;
7. For AS, one of the following (a, b, c, d, e, f, or g):
   a. For Bimzelx, Cimzia, Simponi, Simponi Aria, or Taltz: Member meets ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (i, ii, and iii):[†]
      [†]For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
      i. One of the following (1, 2, or 3, *see Appendix D*):
         1) Failure of both of the following, each used for ≥ 3 consecutive months (a and b):
            a) One of the following adalimumab products: **adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Humira, Simlandi,** or **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06);
            b) **Enbrel**;
         2) If member has had a history of failure of one TNF blocker, then failure of ONE of the following TNF blockers used for ≥ 3 consecutive months: **Enbrel, adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Humira, Simlandi,** or **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06);
         3) History of failure of two TNF blockers and request is not for another TNF blocker;
      ii. Failure of **Cosentyx,** used for ≥ 3 consecutive months;
      iii. If member has not responded or is intolerant to one or more TNF blockers, **Xeljanz®/Xeljanz XR®** and **Rinvoq** each used for ≥ 3 consecutive months,

unless member has cardiovascular risk and benefits do not outweigh the risk of treatment;

b. If request is for Abrilada, adalimumab-aacf, adalimumab-bwwd, adalimumab-fkjp, adalimumab-ryvk, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, or Yusimry, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated**: adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Humira**, **Simlandi,** and **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06);†
†For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395, unless biosimilar is interchangeable per FDA Purple Book

c. For members initiating therapy with Humira: Failure of ONE of the following, used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated: **adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Simlandi, Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06)**, Cosentyx, Enbrel, Rinvoq,** or **Xeljanz/Xeljanz XR;**

d. For Remicade, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (i, ii, and iii):†
†For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
i. **Inflectra** and **Renflexis**;
ii. If member has failed Inflectra and Renflexis, then member must use **Avsola**;
iii. If member has failed Inflectra, Renflexis, and Avsola, then member must use **unbranded Remicade**;

e. For unbranded Remicade, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (i and ii): †
†For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
i. **Inflectra** and **Renflexis**;
ii. If member has failed Inflectra and Renflexis, then member must use **Avsola**;

f. For Avsola, member must use BOTH of the following, unless clinically significant adverse effects are experienced or both are contraindicated: **Inflectra** and **Renflexis;** †
†For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395

g. For Rinvoq, Xeljanz, Xeljanz XR: Member has not responded or is intolerant to one or more TNF blockers;

8. Member does not have combination use of biological disease-modifying antirheumatic drugs or JAK inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
9. Dose does not exceed maximum dose* indicated in Section V.
**For Cosentyx, maximum dose escalation allowed per prescriber information with documentation of inadequate response.*

Approval duration: 12 months

C. Behçet's Disease (must meet all)**:**
1. Diagnosis of oral ulcers in members with BD;
2. Request is for Otezla or Otezla XR;
3. Prescribed by or in consultation with a dermatologist or rheumatologist;
4. Age ≥ 18 years;
5. Failure of colchicine at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;[†]
   [†]For Illinois HIM requests, the step therapy requirement above does not apply as of 1/1/2026 per IL HB 5395
6. Dose does not exceed maximum dose indicated in Section V.

Approval duration: 12 months

D. Castleman's Disease (off-label) (must meet all)**:**
1. Diagnosis of Castleman's disease;
2. Disease is relapsed/refractory or progressive;
3. Request is for intravenous Actemra, Avtozma, Tofidence, or Tyenne;
4. Member has one of the following (a or b):
   a. Unicentric disease that is human immunodeficiency virus (HIV)-negative and human herpesvirus 8 (HHV-8)-negative;
   b. Multicentric disease;
5. Prescribed as second-line therapy as a single agent;
6. Member does not have combination use of biological disease-modifying antirheumatic drugs or JAK inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
7. Request meets one of the following (a or b):*
   a. Dose does not exceed 8 mg/kg per infusion every 2 weeks;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

   **Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration: 12 months

E. Crohn's Disease (must meet all)**:**
1. Diagnosis of CD;
2. Request is for one of the following: Abrilada, adalimumab-aacf, adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, adalimumab-bwwd, adalimumab-fkjp, adalimumab-ryvk, Amjevita, Avsola, Cyltezo, Cimzia, Entyvio, Hadlima, Hulio, Humira, Hyrimoz, Idacio, Imuldosa, Inflectra, Omvoh, Otulfi, Pyzchiva, Remicade/unbranded Remicade, Renflexis, Rinvoq, Selarsdi, Simlandi, Skyrizi, Starjemza, Stelara, Steqeyma, Tremfya, Tyruko, Tysabri, ustekinumab (unbranded Stelara), Wezlana, Yesintek, Yuflyma, Yusimry, or Zymfentra;
3. Prescribed by or in consultation with a gastroenterologist;
4. Member meets one of the following (a or b):
   a. For Abrilada, adalimumab-aacf, adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, adalimumab-bwwd, adalimumab-fkjp, adalimumab-ryvk, Amjevita, Avsola, Cyltezo, Hadlima, Hulio, Humira, Hyrimoz, Idacio, Inflectra,Remicade/unbranded Remicade, Renflexis, Simlandi, Yuflyma, Yusimry: Age ≥ 6 years;

b. For Cimzia, Entyvio, Imuldosa, Omvoh, Otulfi, Pyzchiva, Rinvoq, Selarsdi, Skyrizi, Starjemza, Stelara, Steqeyma, Tremfya, Tyruko, Tysabri, ustekinumab (unbranded Stelara), Wezlana, Yesintek, Zymfentra: Age ≥ 18 years;

5. If request is for Abrilada, adalimumab-aacf, adalimumab-bwwd, adalimumab-fkjp, adalimumab-ryvk, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, or Yusimry, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated: **adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Humira, Simlandi,** and **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06);†
   †For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395, unless biosimilar is interchangeable per FDA Purple Book
6. For members initiating therapy with Humira: Failure of ONE of the following, used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated: **adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Simlandi, Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06)**, Pyzchiva, Rinvoq, Skyrizi, Stelara, Steqeyma, Tremfya,** or **Yesintek;**
7. Member meets one of the following (a or b):†
   †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   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 clinically significant adverse effects are experienced, all are contraindicated, or previously failed a biologic agent for CD;
   b. Medical justification supports inability to use immunomodulators (*see Appendix E*);
8. For Cimzia, Entyvio, Omvoh, Tyruko, or Tysabri: Failure of ALL of the following, each used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated (a, b, and c, *see Appendix D*):†
   †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. One of the following adalimumab products, unless the member has had a history of failure of two TNF blockers and request is not for another TNF blocker: **adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Humira, Simlandi,** or **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06);
   b. **Skyrizi, ustekinumab product** (**Stelara, Pyzchiva, Steqeyma,** or **Yesintek),** and **Tremfya**;
   c. If member has not responded to TNF blockers or another approved systemic therapy, **Rinvoq,** unless member has cardiovascular risk and benefits do not outweigh the risk of treatment;
9. For members initiating therapy with Stelara: Failure of ONE of the following, used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated: **Pyzchiva, Steqeyma, Yesintek, adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Humira, Rinvoq, Simlandi, Skyrizi, Tremfya,** or **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06)**;**

10. For Imuldosa, Otulfi, Selarsdi, Starjemza, ustekinumab (unbranded Stelara), or Wezlana: Member meets BOTH of the following, used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated (a and b):
    a. Must use all of the following ustekinumab products: **Stelara, Pyzchiva, Steqeyma,** and **Yesintek**;†
       †For Illinois HIM requests, the step therapy requirement above does not apply as of 1/1/2026 per IL HB 5395, unless Stelara biosimilar is interchangeable per FDA Purple Book
    b. Failure of all of the following (i, ii, and iii):†
       †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
       i. ONE of the following adalimumab products, unless the member has had a history of failure of two TNF blockers and request is not for another TNF blocker: **adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Humira, Simlandi,** or **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06);
       ii. **Skyrizi** and **Tremfya**;
       iii. If member has not responded or is intolerant to one or more TNF blockers, **Rinvoq,** unless member has cardiovascular risk and benefits do not outweigh the risk of treatment;
11. For Skyrizi: If request is for vials or cartridges, quantity does not exceed one single dose vial or pre-filled cartridge per dose;
12. For Remicade, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (a, b, and c):†
    †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
    a. **Inflectra** and **Renflexis**;
    b. If member has failed Inflectra and Renflexis, then member must use **Avsola**;
    c. If member has failed Inflectra, Renflexis, and Avsola, then member must use **unbranded Remicade**;
13. For unbranded Remicade, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (a and b):†
    †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
    a. **Inflectra** and **Renflexis**;
    b. If member has failed Inflectra and Renflexis, then member must use **Avsola**;
14. For Avsola, member must use BOTH of the following, unless clinically significant adverse effects are experienced or both are contraindicated: **Inflectra** and **Renflexis**;†
    †For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395
15. For Zymfentra, provider attestation that member meets one of the following (a or b, *see Appendix D*):
    a. For Illinois HIM requests only: Has received IV infliximab prior to initiation;
    b. For all other requests, all of the following (i, ii, and iii):
       i. Has received three IV induction doses of an infliximab product prior to initiation;
       ii. Member is responding positively to an IV infliximab product;

iii. Member is unable to receive continued therapy with IV infliximab due to lack of caregiver or support system for assistance with administration and/or inadequate access to healthcare facility or home care interventions and/or lack of transportation to healthcare facility;

16. For Rinvoq, member meets one* of the following (a or b):
    a. Member has not responded to one or more TNF blockers;
    b. If TNF blockers are clinically inadvisable, member has received at least one approved systemic therapy;

    **Prior authorization may be required for TNF blockers and approved systemic therapies.*
17. Member does not have combination use of biological disease-modifying antirheumatic drugs or JAK inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
18. Dose does not exceed maximum dose* indicated in Section V.

    **For Avsola, Inflectra, Remicade/unbranded Remicade, Renflexis, maximum dose escalation allowed per prescriber information with documentation of inadequate response.*

Approval duration: 12 months

F. Cytokine Release Syndrome (must meet all)**:**
1. Request is for Actemra, Avtozma, or Tyenne;
2. Request is for intravenous formulation;
3. Age ≥ 2 years;
4. Member meets one of the following (a, b, or c):
    a. Member has a scheduled CAR T cell therapy (e.g., Abecma®, Breyanzi®, Carvykti™, Kymriah™, Tecartus®, Yescarta™);
    b. Used as supportive care in severe CRS related to blinatumomab therapy;
    c. Used as prophylaxis to reduce the risk of CRS when administering teclistamab-cqyv;
5. Request meets one of the following (a or b):*
    a. Dose does not exceed 800 mg per infusion for up to 4 total doses;
    b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

    **Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration: 3 months *(12 months for HIM Texas)*

G. Deficiency of Interleukin-1 Receptor Antagonist (must meet all)**:**
1. Diagnosis of DIRA confirmed by presence of loss-of-function *ILRN* mutations;
2. Request is for Kineret;
3. Prescribed by or in consultation with a rheumatologist;
4. Member does not have combination use of biological disease-modifying antirheumatic drugs or JAK inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
5. Dose does not exceed maximum dose indicated in Section V.

Approval duration: 12 months

H. Enthesitis-related Arthritis (must meet all)**:**
1. Diagnosis of ERA;
2. Request is for Cosentyx;

3. Prescribed by or in consultation with a rheumatologist;
4. Age ≥ 4 years and < 18 years;
5. Failure of at least TWO non-steroidal anti-inflammatory drugs (NSAIDs) at up to maximally indicated doses, each used for ≥ 4 weeks unless clinically significant adverse effects are experienced or all are contraindicated;†
   †For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395
6. Member meets one of the following (a or b):†
   †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. Failure of a ≥ 3 consecutive months 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 disease-modifying anti-rheumatic drug (e.g., sulfasalazine, leflunomide) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
7. Member does not have combination use of biological disease-modifying antirheumatic drugs or JAK inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
8. Dose does not exceed one of the following (a or b):
   a. Weight ≥ 15 kg and < 50 kg: 75 mg at weeks 0, 1, 2, 3, and 4, followed by maintenance dose of 75 mg every 4 weeks;
   b. Weight ≥ 50 kg: 150 mg at weeks 0, 1, 2, 3, and 4, followed by maintenance dose of 150 mg every 4 weeks.

Approval duration: 12 months

I. Giant Cell Arteritis (must meet all)**:**
1. Diagnosis of GCA;
2. Request is for Actemra, Avtozma, Rinvoq, Tofidence, or Tyenne;
3. Prescribed by or in consultation with a rheumatologist;
4. Age ≥ 18 years;
5. Failure of a systemic corticosteroid at up to maximally tolerated doses, unless clinically significant adverse effects are experienced, all are contraindicated, or previously failed a biologic agent for GCA;†
   †For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395
6. Member does not have combination use of biological disease-modifying antirheumatic drugs or JAK inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
7. Dose does not exceed maximum dose indicated in Section V.

Approval duration: 12 months

J. Acute Graft-versus-Host Disease (must meet all)**:**
1. Prescribed for prophylaxis of aGVHD;
2. Request is for intravenous formulation of Orencia;

3. Prescribed by or in consultation with an oncologist, hematologist, or bone marrow transplant specialist;
4. Age ≥ 2 years;
5. Member is undergoing HSCT from a matched or 1 allele-mismatched unrelated-donor;
6. Prescribed in combination with a calcineurin inhibitor and MTX;
7. Member does not have combination use of biological disease-modifying antirheumatic drugs or JAK inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
8. Request does not exceed 4 doses total;
9. Dose does not exceed maximum dose indicated in Section V.

Approval duration: 3 months *(12 months for HIM Texas)*

K. Hidradenitis Suppurativa (must meet all)**:**

1. Diagnosis of HS;
2. Request is for Abrilada, adalimumab-aacf, adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, adalimumab-bwwd, adalimumab-fkjp, adalimumab-ryvk, Amjevita, Bimzelx, Cosentyx, Cyltezo, Hadlima, Hulio, Humira, Hyrimoz, Idacio, Simlandi, Yuflyma, or Yusimry;
3. Prescribed by or in consultation with a dermatologist, rheumatologist, or gastroenterologist;
4. Member meets one of the following (a or b):
   a. Humira, Amjevita, Cyltezo, adalimumab-adbm, Hyrimoz, adalimumab-adaz, Simlandi, adalimumab-ryvk, Yuflyma, adalimumab-aaty: Age ≥ 12 years;
   b. Abrilada, adalimumab-aacf, adalimumab-bwwd, adalimumab-fkjp, Bimzelx, Cosentyx, Hadlima, Hulio, Idacio, Yusimry: Age ≥ 18 years;
5. Documentation of Hurley stage II or stage III (*see Appendix D*);
6. If request is for Abrilada, adalimumab-aacf, adalimumab-bwwd, adalimumab-fkjp, adalimumab-ryvk, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, or Yusimry, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated: **adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Humira, Simlandi**, and **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06);†
   †For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395, unless biosimilar is interchangeable per FDA Purple Book
7. For members initiating therapy with Humira: Failure of ONE of the following, used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated: **adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Simlandi, Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06), or **Cosentyx;**
8. For Bimzelx: Failure of both of the following, each used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated (a and b):†
   †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. One of the following, unless the member has had a history of failure of two TNF blockers and request is not for another TNF blocker: **adalimumab-aaty,**

adalimumab-adaz, adalimumab-adbm, Humira, Simlandi, or **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06);
   b. **Cosentyx**;
9. Failure of at least TWO of the following, each tried for ≥ 3 consecutive months from different therapeutic classes, at up to maximally indicated doses, unless clinically significant adverse effects are experienced, all are contraindicated, or previously failed a biologic agent for HS:†
   †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. Systemic antibiotic therapy (e.g., clindamycin, minocycline, doxycycline, rifampin);
   b. Oral retinoids (e.g., acitretin, isotretinoin);
   c. Hormonal treatment (e.g., estrogen-containing combined oral contraceptives, spironolactone);
10. Member does not have combination use of biological disease-modifying antirheumatic drugs or JAK inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
11. Dose does not exceed maximum dose* indicated in Section V.
    **For Cosentyx, maximum dose escalation allowed per prescriber information with documentation of inadequate response.*

Approval duration: 12 months

L. Kawasaki Disease (off-label) (must meet all)**:**
1. Diagnosis of Kawasaki disease;
2. Request is for an infliximab-containing product;
3. Prescribed by or in consultation with a cardiologist, allergist, immunologist, infectious disease specialist, or rheumatologist;
4. Age ≥ 6 years;
5. Failure of immune globulins (*Gammagard is preferred*), unless contraindicated or clinically significant adverse effects are experienced;
6. If request is for Remicade, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (a, b, and c):†
   †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. **Inflectra and Renflexis**;
   b. If member has failed Inflectra and Renflexis, then member must use **Avsola**;
   c. If member has failed Inflectra, Renflexis, and Avsola, then member must use **unbranded Remicade**;
7. For unbranded Remicade, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (a and b):†
   †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. **Inflectra** and **Renflexis**;
   b. If member has failed Inflectra and Renflexis, then member must use **Avsola**;
8. If request is for Avsola, member must use BOTH of the following, unless clinically significant adverse effects are experienced or both are contraindicated: **Inflectra** and **Renflexis**;†

†For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395

9. Member does not have combination use of biological disease-modifying antirheumatic drugs or JAK inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
10. Dose does not exceed maximum dose indicated in Section V.

Approval duration: 4 weeks (one time approval) *(12 months for HIM Texas)*

M. 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. Member does not have combination use of biological disease-modifying antirheumatic drugs or JAK inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
5. Dose does not exceed maximum dose indicated in Section V.

Approval duration: 12 months

N. Plaque Psoriasis (must meet all)**:**

1. Diagnosis of PsO and one of the following (a, b, or c):
   a. Request is for Abrilada, adalimumab-aacf, adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, adalimumab-bwwd, adalimumab-fkjp, adalimumab-ryvk, Amjevita, Bimzelx, Cyltezo, Cimzia, Cosentyx, Enbrel, Hadlima, Hulio, Humira, Hyrimoz, Idacio, Imuldosa, Ilumya, Otulfi, Pyzchiva, Selarsdi, Siliq, Simlandi, Skyrizi, Sotyktu, Starjemza, Stelara, Steqeyma, Taltz, Tremfya, ustekinumab (unbranded Stelara), Wezlana, Yesintek, Yuflyma, or Yusimry: PsO is moderate-to-severe as evidenced by involvement of one of the following (i or ii):
      i. ≥ 3% of total body surface area;
      ii. Hands, feet, scalp, face, or genital area;
   b. Request is for Avsola, Inflectra, Remicade/unbranded Remicade, or Renflexis: PsO is chronic-severe as evidenced by involvement of one of the following (i or ii):
      i. ≥ 10% of total body surface area;
      ii. Hands, feet, scalp, face, or genital area;
   c. Request is for Otezla/Otezla XR: Member meets one of the following (i or ii):
      i. Age ≥ 18 years;
      ii. Age 6 years to < 18 years, and both of the following (1 and 2):
         1) PsO is moderate-to-severe as evidenced by involvement of one of the following (a or b):
            a) ≥ 3% of total body surface area;
            b) Hands, feet, scalp, face, or genital area;
         2) Documentation that member weighs ≥ 20 kg;
2. Prescribed by or in consultation with a dermatologist or rheumatologist;
3. Member meets one of the following (a, b, c, d, or e):
   a. For Abrilada, adalimumab-aacf, adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, adalimumab-bwwd, adalimumab-fkjp, adalimumab-ryvk,

Amjevita, Avsola, Bimzelx, Cimzia, Cyltezo, Hadlima, Hulio, Humira, Hyrimoz, Idacio, Ilumya, Inflectra, Remicade/unbranded Remicade, Renflexis, Siliq, Simlandi, Skyrizi, Sotyktu, Yuflyma, Yusimry: Age ≥ 18 years;
   b. For Enbrel: Age ≥ 4 years;
   c. For Cosentyx, Imuldosa, Otezla, Otulfi, Pyzchiva, Selarsdi, Starjemza, Stelara, Steqeyma, Taltz, ustekinumab (unbranded Stelara), Wezlana, Yesintek: Age ≥ 6 years;
   d. For Otezla or Otezla XR (i and ii):
      i. Age ≥ 6 years;
      ii. If age < 18 years (1 or 2):
         1) Otezla: Weight ≥ 20 kg;
         2) Otezla XR: Weight ≥ 50 kg;
   e. For Tremfya (i and ii):
      i. Age ≥ 6 years;
      ii. If age < 18 years, weight ≥ 40 kg;
4. If request is for Abrilada, adalimumab-aacf, adalimumab-bwwd, adalimumab-fkjp, adalimumab-ryvk, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, or Yusimry, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated: **adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Humira**, **Simlandi,** and **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06);†
   †For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395, unless biosimilar is interchangeable per FDA Purple Book
5. For members initiating therapy with Humira: Failure of ONE of the following, used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated: **adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Simlandi, Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06),**Cosentyx, Enbrel, Otezla, Pyzchiva, Skyrizi, Stelara, Steqeyma, Tremfya,** or **Yesintek;**
6. Member meets one of the following, unless previously failed a biologic agent for PsO (a or b):†
   †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. Member has moderate-to-severe disease, and one of the following (i, ii, or iii):
      i. Failure of a ≥ 3 consecutive month trial of methotrexate (MTX) at up to maximally indicated doses;
      ii. Member has intolerance or contraindication to MTX (*see Appendix D*), and failure of a ≥ 3 consecutive month trial of cyclosporine or acitretin at up to maximally indicated doses, unless clinically significant adverse effects are experienced or both are contraindicated;
      iii. Member has intolerance or contraindication to MTX, cyclosporine, and acitretin, and failure of phototherapy, unless contraindicated or clinically significant adverse effects are experienced;
   b. Member has mild disease, and both of the following (i and ii):
      i. Request is for Otezla/Otezla XR;
      ii. Failure of one of the following, unless clinically significant adverse effects are experienced or all are contraindicated: calcipotriene, calcitriol, or tazarotene;

7. For Ilumya, member meets BOTH of the following, unless clinically significant adverse effects are experienced or all are contraindicated (a and b):†
   †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. One of the following (i, ii, or iii, *see Appendix D*):
      i. Failure of BOTH of the following, each used for ≥ 3 consecutive months (1 and 2):
         1) ONE of the following adalimumab products: **adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Humira, Simlandi,** or **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06);
         2) **Enbrel**;
      ii. If member has had a history of failure of one TNF blocker, then failure of ONE of the following TNF blockers used for ≥ 3 consecutive months: **Enbrel, adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Humira, Simlandi,** or **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06);
      iii. History of failure of two TNF blockers;
   b. Failure of ALL of the following, each used for ≥ 3 consecutive months: **Skyrizi**, **ustekinumab product (Stelara, Pyzchiva, Steqeyma,** or **Yesintek), Tremfya**, **Cosentyx**, **Otezla/Otezla XR**;
8. For Bimzelx, Cimzia, Siliq, Sotyktu, or Taltz and age ≥ 18 years: Failure of BOTH of the following, each used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated (a and b, *see Appendix D*):†
   †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. ONE of the following, unless the member has had a history of failure of two TNF blockers and request is not for another TNF blocker (i or ii):
      i. ONE of the following adalimumab products: **adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Humira, Simlandi,** or **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06);
      ii. **Enbrel**;
   b. FOUR of the following: **Otezla/Otezla XR, Skyrizi, ustekinumab product (Stelara, Pyzchiva, Steqeyma,** or **Yesintek), Tremfya**, **Cosentyx**;
9. For Taltz and age 6 to 17 years: Failure of TWO of the following, both used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated (a – e):†
   †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. **Cosentyx;**
   b. One of the following ustekinumab products: **Stelara, Pyzchiva, Steqeyma,** or **Yesintek;**
   c. **Tremfya;**
   d. **Otezla/Otezla XR;**
   e. **Enbrel**, unless the member has had a history of failure of two TNF blockers;

10. For members initiating therapy with Stelara: Member meets one of the following, used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated (a or b):
    a. For age 6 to 17: Failure of ONE of the following: **Pyzchiva, Steqeyma, Yesintek Cosentyx, Enbrel,** or **Otezla;**
    b. For age ≥ 18 years: Failure of ONE of the following: **Pyzchiva, Steqeyma, Yesintek**, **adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Cosentyx, Enbrel, Humira, Otezla/Otezla XR, Simlandi, Skyrizi, Tremfya,** or **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06)**;**
11. For Imuldosa, Otulfi, Selarsdi, Starjemza, ustekinumab (unbranded Stelara), or Wezlana: Member meets all of the following, used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated (a and b):
    a. Must use all of the following ustekinumab products: **Stelara, Pyzchiva, Steqeyma,** and **Yesintek**;†
    †For Illinois HIM requests, the step therapy requirement above does not apply as of 1/1/2026 per IL HB 5395, unless Stelara biosimilar is interchangeable per FDA Purple Book
    b. One of the following (i or ii):†
    †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
        i. Age 6 to 17 years: Failure of ONE of the following (1, 2, 3, or 4):
            1) **Cosentyx**;
            2) **Tremfya;**
            3) **Otezla/Otezla XR**;
            4) **Enbrel**, unless the member has had a history of failure of two TNF blockers;
        ii. Age ≥ 18 years: Failure of BOTH of the following (1 and 2):
            1) ONE of the following, unless the member has had a history of failure of two TNF blockers (a or b):
                a) ONE of the following adalimumab products: **adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Humira, Simlandi,** or **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06);
                b) **Enbrel**;
            2) THREE of the following: **Otezla/Otezla XR, Skyrizi, Tremfya**, **Cosentyx**;
12. For Imuldosa, Otulfi, Pyzchiva, Selarsdi, Starjemza, Stelara, Steqeyma, ustekinumab (unbranded Stelara), Wezlana, or Yesintek: Request is for SC formulation;
13. For Remicade, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (a, b, and c):†
    †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
    a. **Inflectra** and **Renflexis**;
    b. If member has failed Inflectra and Renflexis, then member must use **Avsola**;
    c. If member has failed Inflectra, Renflexis, and Avsola, then member must use **unbranded Remicade**;

14. For unbranded Remicade, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (a and b):†
    †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
    a. **Inflectra** and **Renflexis**;
    b. If member has failed Inflectra and Renflexis, then member must use **Avsola**;
15. For Avsola, member must use BOTH of the following, unless clinically significant adverse effects are experienced or both are contraindicated: **Inflectra** and **Renflexis**;†
    †For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395
16. Member meets one of the following (a or b):
    a. For Otezla/Otezla XR, if request is for concomitant use with biologic DMARD therapy (e.g., adalimumab, Enbrel, infliximab), member meets one of the following (i or ii):†
       †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
       i. Failure of a ≥ 3 consecutive month trial of MTX used in combination with the biologic DMARD at up to maximally indicated doses;
       ii. Member has intolerance or contraindication to MTX (*see Appendix D*), and failure of a ≥ 3 consecutive month trial of cyclosporine or acitretin used in combination with the biologic DMARD at up to maximally indicated doses, unless clinically significant adverse effects are experienced or both are contraindicated;
    b. For other agents indicated for PsO, member does not have combination use of biological disease-modifying antirheumatic drugs or JAK inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
17. Dose does not exceed maximum dose indicated in Section V.

Approval duration: 12 months

O. Polyarticular Juvenile Idiopathic Arthritis (must meet all)**:**
1. Diagnosis of PJIA as evidenced by ≥ 5 joints with active arthritis;
2. Request is for one of the following: Abrilada, adalimumab-aacf, adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, adalimumab-bwwd, adalimumab-fkjp, adalmumab-ryvk, Actemra, Amjevita, Avtozma, Cimzia, Cyltezo, Enbrel, Hadlima, Hulio, Humira, Hyrimoz, Idacio, Kevzara, Orencia, Rinvoq, Rinvoq LQ, Simlandi, Simponi Aria, Tofidence, Tyenne, Xeljanz, Xeljanz XR, Yuflyma, or Yusimry;
3. Prescribed by or in consultation with a rheumatologist;
4. Age ≥ 2 years;
5. If request is for Abrilada, adalimumab-aacf, adalimumab-bwwd, adalimumab-fkjp, adalimumab-ryvk, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, or Yusimry, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated: **adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Humira**, **Simlandi**, and **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06);†
   †For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395, unless biosimilar is interchangeable per FDA Purple Book
6. Member meets one of the following, unless previously failed a biologic agent for pJIA (a, b, c, or d):†

†For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395

a. Failure of a ≥ 3 consecutive month trial of MTX at up to maximally indicated doses;
b. If member has intolerance or contraindication to MTX (*see Appendix D*), failure of a ≥ 3 consecutive month trial of leflunomide or sulfasalazine at up to maximally indicated doses, unless clinically significant adverse effects are experienced or both are contraindicated;
c. For sacroiliitis/axial spine involvement (i.e., spine, hip), failure of a ≥ 4 week trial of an NSAID at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
d. Documentation of high disease activity;

7. For members initiating therapy with Humira: Failure of ONE of the following, used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated: **adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Simlandi, Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06), **Enbrel, Rinvoq/Rinvoq LQ,** or **Xeljanz;**
8. For Avtozma, Cimzia, Kevzara, Orencia, Simponi Aria, Tofidence, or Tyenne: Member meets BOTH of the following, unless clinically significant adverse effects are experienced or all are contraindicated (a and b):*†*
   †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. One of the following (i, ii, or iii, *see Appendix D*):
      i. Failure of BOTH of the following, each used for ≥ 3 consecutive months (1 and 2):
         1) ONE of the following adalimumab products**: adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Humira, Simlandi,** or **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06);
         2) **Enbrel**;
      ii. If member has had a history of failure of one TNF blocker, then failure of one of the following TNF blockers used for ≥ 3 consecutive months: **Enbrel, adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Humira, Simlandi,** or **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06);
      iii. History of failure of two TNF blockers and request is not for another TNF blocker;
   b. If member has not responded or is intolerant to one or more TNF blockers, **Xeljanz** and **Rinvoq/Rinvoq LQ,** used for ≥ 3 consecutive months, unless member has cardiovascular risk and benefits do not outweigh the risk of treatment;
9. For Actemra: Member meets ONE of the following, unless clinically significant adverse effects are experienced or all are contraindicated (a or b):*†*
   †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395

a. One of the following used for ≥ 3 consecutive months, unless the member has had a history of failure of two TNF blockers and request is not for another TNF blocker: **adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Humira, Simlandi, Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06), or **Enbrel**;
b. One of the following used for ≥ 3 consecutive months: **Xeljanz** or **Rinvoq/Rinvoq LQ,** unless member has cardiovascular risk and benefits do not outweigh the risk of treatment;

10. For Orencia: For members 2 to 5 years of age, prescribed route of administration is SC;
11. For Kevzara: Documentation that member weighs ≥ 63 kg;
12. For Rinvoq, Rinvoq LQ, Xeljanz, or Xeljanz oral solution: Member has not responded or is intolerant to one or more TNF blockers;
    **Prior authorization may be required for TNF blockers*
13. Member does not have combination use of biological disease-modifying antirheumatic drugs or JAK inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
14. Dose does not exceed maximum dose indicated in Section V.

Approval duration: 12 months

P. Polymyalgia Rheumatica (must meet all)**:**

1. Diagnosis of PMR per American College of Rheumatology/European Union League Against Rheumatism (ACR/EULAR) criteria as evidenced by both of the following (a and b, *see Appendix N*):
   a. Documentation that member presents with symptoms of PMR (e.g., bilateral shoulder aching; symmetrical aching; stiffness in shoulders, hip girdle, neck, and torso; morning stiffness);
   b. Evidence of one of the following (i or ii):
      i. Baseline erythrocyte sedimentation rate (ESR) ≥ 30 mm/hr;
      ii. Baseline c-reactive protein (CRP) ≥ 10 mg/L;
2. Request is for Kevzara;
3. Prescribed by or in consultation with a rheumatologist;
4. Age ≥ 50 years;
5. Member meets one of the following (a, b, or c):
   a. Failure of a systemic corticosteroid (e.g., prednisone) at maximally tolerated doses for ≥ 2 weeks, unless contraindicated or clinically significant adverse effects are experienced;
   b. Documentation of one episode of unequivocal PMR flare (e.g., shoulder and/or hip girdle pain associated with inflammatory stiffness) while attempting to taper corticosteroids at a dose ≥ 7.5 mg/day of prednisone equivalent;
   c. For Illinois HIM requests only: Inadequate response to corticosteroids or cannot tolerate corticosteroid taper;
6. Member does not have combination use of biological disease-modifying antirheumatic drugs or JAK inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
7. Dose does not exceed maximum dose indicated in Section V.

Approval duration: 12 months

Q. Psoriatic Arthritis (must meet all)**:**
1. Diagnosis of PsA or jPsA;
2. Request is for one of the following: Abrilada, adalimumab-aacf, adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, adalimumab-bwwd, adalimumab-fkjp, adalimumab-ryvk, Amjevita, Avsola, Bimzelx, Cimzia, Cosentyx, Cyltezo, Enbrel, Hadlima, Hulio, Humira, Hyrimoz, Idacio, Imuldosa, Inflectra, Orencia, Otezla, Otezla XR, Otulfi, Pyzchiva, Remicade/unbranded Remicade, Renflexis, Rinvoq, Rinvoq LQ, Selarsdi, Simlandi, Simponi, Simponi Aria, Skyrizi, Starjemza, Stelara, Steqeyma, Taltz, Tremfya, ustekinumab (unbranded Stelara), Wezlana, Xeljanz, Xeljanz XR, Yesintek, Yuflyma, or Yusimry;
3. Prescribed by or in consultation with a dermatologist or rheumatologist;
4. Member meets one of the following (a, b, c, d, or e):
   a. For Cosentyx, Enbrel, Orencia, Rinvoq, Rinvoq LQ, Simponi Aria, or Xeljanz: Age ≥ 2 years;
   b. For Imuldosa, Otulfi, Pyzchiva, Selarsdi, Starjemza, Stelara, Steqeyma, ustekinumab (unbranded Stelara), Wezlana, or Yesintek: Age ≥ 6 years;
   c. For Otezla or Otezla XR (i and ii):
      i. Age ≥ 6 years;
      ii. If age < 18 years (1 or 2):
         1) Otezla: Weight ≥ 20 kg;
         2) Otezla XR: Weight ≥ 50 kg;
   d. For Tremfya (i and ii):
      i. Age ≥ 6 years;
      ii. If age < 18 years, weight ≥ 40 kg;
   e. For Abrilada, adalimumab-aacf, adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, adalimumab-bwwd, adalimumab-fkjp, adalimumab-ryvk, Amjevita, Avsola, Bimzelx, Cimzia, Cyltezo, Hadlima, Hulio, Humira, Hyrimoz, Idacio, Inflectra, Remicade/unbranded Remicade, Renflexis, Simlandi, Simponi, Skyrizi, Taltz, Xeljanz XR, Yuflyma, or Yusimry: Age ≥ 18 years;
5. If request is for Abrilada, adalimumab-aacf, adalimumab-bwwd, adalimumab-fkjp, adalimumab-ryvk, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, or Yusimry, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated: **adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Humira, Simlandi**, and **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06);[†]
   [†]*For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395, unless biosimilar is interchangeable per FDA Purple Book*
6. For members initiating therapy with Humira: Failure of ONE of the following, used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated: **adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Simlandi, Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06)**, Cosentyx, Enbrel, Otezla, Pyzchiva, Rinvoq/Rinvoq LQ, Skyrizi, Stelara, Steqeyma, Tremfya, Xeljanz/Xeljanz XR,** or **Yesintek;**

7. For Cimzia, Bimzelx, Orencia, Simponi, Simponi Aria, or Taltz: If age ≥ 18 years, member meets ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (a, b, and c):†
   †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. One of the following (i, ii, or iii, *see Appendix D*):
      i. Failure of BOTH of the following, each used for ≥ 3 consecutive months (1 and 2):
         1) ONE of the following adalimumab products**: adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Humira, Simlandi**, or **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06);
         2) **Enbrel**;
      ii. If member has had a history of failure of one TNF blocker, then failure of one of the following TNF blockers used for ≥ 3 consecutive months: **Enbrel, adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Humira, Simlandi**, or **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06);
      iii. History of failure of two TNF blockers and request is not for another TNF blocker;
   b. Failure of a trial of ALL of the following, each used for ≥ 3 consecutive months: **Otezla/Otezla XR**, **Cosentyx, Skyrizi, ustekinumab product (Stelara, Pyzchiva, Steqeyma,** or **Yesintek), Tremfya**;
   c. If member has not responded or is intolerant to one or more TNF blockers, **Xeljanz/Xeljanz XR** and **Rinvoq,** each used for ≥ 3 consecutive months, unless member has cardiovascular risk and benefits do not outweigh the risk of treatment;
8. For Orencia: If member is 2 to 17 years of age, both of the following (a and b):
   a. Prescribed route of administration is SC;
   b. Failure of one of the following, used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated (i or ii):†
      †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
      i. Age 2 to 5 years (both 1, 2, and 3):
         1) **Enbrel**, unless the member has had a history of failure of two TNF blockers;
         2) **Cosentyx;**
         3) If member has not responded or is intolerant to one or more TNF blockers, **Rinvoq/Rinvoq LQ** and **Xeljanz**, unless member has cardiovascular risk and benefits do not outweigh the risk of treatment;
      ii. Age 6 to 17 years (both 1, 2, and 3):
         1) **Enbrel**, unless the member has had a history of failure of two TNF blockers;
         2) **Cosentyx, Otezla/Otezla XR, Tremfya, and ustekinumab product (Stelara, Pyzchiva, Steqeyma,** or **Yesintek)**;

3) If member has not responded or is intolerant to one or more TNF blockers, **Rinvoq/Rinvoq LQ** and **Xeljanz**, unless member has cardiovascular risk and benefits do not outweigh the risk of treatment;

9. For members initiating therapy with Stelara: Member meets ONE of the following, used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated (a or b):
   a. Age 6 to 17 years: Failure of ONE of the following: **Pyzchiva**, **Steqeyma**, **Yesintek, Cosentyx, Enbrel, Otezla/Otezla XR,** or **Rinvoq/Rinvoq LQ;**
   b. Age ≥ 18 years: Failure of ONE of the following: **Pyzchiva, Steqeyma, Yesintek**, **adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Cosentyx, Enbrel, Humira, Otezla/Otezla XR, Rinvoq/Rinvoq LQ, Simlandi, Skyrizi, Tremfya, Xeljanz/Xeljanz XR,** or **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06)**;**
10. For Imuldosa, Otulfi, Selarsdi, Starjemza, ustekinumab (unbranded Stelara), or Wezlana: Member meets BOTH of the following, used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated (a and b):
    a. Must use all of the following ustekinumab products: **Stelara, Pyzchiva, Steqeyma,** and **Yesintek**;†
       †For Illinois HIM requests, the step therapy requirement above does not apply as of 1/1/2026 per IL HB 5395, unless Stelara biosimilar is interchangeable per FDA Purple Book
    b. One of the following (i or ii):†
       †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
       i. Age 6 to 17 years: Failure of both of the following (1, 2, and 3):
          1) **Cosentyx, Otezla/Otezla XR, and Tremfya;**
          2) If member has not responded or is intolerant to one or more TNF blockers, **Rinvoq/Rinvoq LQ** and **Xeljanz**, unless member has cardiovascular risk and benefits do not outweigh the risk of treatment;
          3) **Enbrel,** unless the member has had a history of failure of two TNF blockers;
       ii. Age ≥ 18 years: ALL of the following (1, 2, and 3):
          1) One of the following (a, b, or c, *see Appendix D*):
             a) Failure of BOTH of the following, each used for ≥ 3 consecutive months (i and ii):
                i) ONE of the following adalimumab products**: adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Humira, Simlandi,** or **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06);
                ii) **Enbrel**;
             b) If member has had a history of failure of one TNF blocker, then failure of one of the following TNF blockers used for ≥ 3 consecutive months: **Enbrel, adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Humira, Simlandi,** or **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06);
             c) History of failure of two TNF blockers and request is not for another TNF blocker;

2) Failure of a trial of ALL of the following, each used for ≥ 3 consecutive months: **Otezla/Otezla XR**, **Cosentyx**, **Skyrizi**, **Tremfya**;
3) If member has not responded or is intolerant to one or more TNF blockers, **Xeljanz/Xeljanz XR** and **Rinvoq,** each used for ≥ 3 consecutive months, unless member has cardiovascular risk and benefits do not outweigh the risk of treatment;

9. For Imuldosa, Otulfi, Pyzchiva, Selarsdi, Starjemza, Stelara, Steqeyma, ustekinumab (unbranded Stelara), Wezlana, or Yesintek: Request is for SC formulation;
10. For Remicade, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (a, b, and c):†
    †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
    a. **Inflectra** and **Renflexis**;
    b. If member has failed Inflectra and Renflexis, then member must use **Avsola**;
    c. If member has failed Inflectra, Renflexis, and Avsola, then member must use **unbranded Remicade**;
11. For unbranded Remicade, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (a and b):†
    †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
    a. **Inflectra** and **Renflexis**;
    b. If member has failed Inflectra and Renflexis, then member must use **Avsola**;
12. For Avsola, member must use BOTH of the following, unless clinically significant adverse effects are experienced or both are contraindicated: **Inflectra** and **Renflexis**;†
    †For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395
13. For Rinvoq, Rinvoq LQ, Xeljanz, or Xeljanz XR: Member has not responded or is intolerant to one or more TNF blockers;
    **Prior authorization may be required for TNF blockers*
14. Member meets one of the following (a or b):
    a. For Otezla/Otezla XR, if request is for concomitant use with biologic DMARD therapy (e.g., adalimumab, Enbrel, infliximab), member meets one of the following (i or ii):†
       †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
       i. Failure of a ≥ 3 consecutive month trial of MTX used in combination with the biologic DMARD at up to maximally indicated doses;
       ii. Member has intolerance or contraindication to MTX (*see Appendix D*), and failure of a ≥ 3 consecutive month trial of cyclosporine or acitretin used in combination with the biologic DMARD at up to maximally indicated doses, unless clinically significant adverse effects are experienced or both are contraindicated;
    b. For other agents indicated for PsA, member does not have combination use of biological disease-modifying antirheumatic drugs or JAK inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
15. Dose does not exceed maximum dose* indicated in Section V.
    **For Cosentyx, maximum dose escalation allowed per prescriber information with documentation of inadequate response*

Approval duration: 12 months

R. Rheumatoid Arthritis (must meet all)**:**

1. Diagnosis of RA per ACR criteria (*see Appendix H*);
2. Request is for one of the following: Abrilada, Actemra, adalimumab-aacf, adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, adalimumab-bwwd, adalimumab-fkjp, adalimumab-ryvk, Amjevita, Avsola, Avtozma, Cimzia, Cyltezo, Enbrel, Hadlima, Hulio, Humira, Hyrimoz, Idacio, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Remicade/unbranded Remicade, Renflexis, Rinvoq, Simlandi, Simponi, Simponi Aria, Tofidence, Tyenne, Xeljanz, Xeljanz XR, Yuflyma, or Yusimry;
3. Prescribed by or in consultation with a rheumatologist;
4. Age ≥ 18 years;
5. If request is for Abrilada, adalimumab-aacf, adalimumab-bwwd, adalimumab-fkjp, adalimumab-ryvk, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, or Yusimry, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated: **adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Humira**, **Simlandi,** and **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06);[†]
   [†]For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395, unless biosimilar is interchangeable per FDA Purple Book
6. Member meets one of the following, unless previously failed a biologic agent for RA (a or b):[†]
   [†]For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   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 clinically significant adverse effects are experienced or all are contraindicated;
7. For members initiating therapy with Humira: Failure of ONE of the following, used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated: **adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Simlandi, Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06)**, Enbrel, Rinvoq,** or **Xeljanz/Xeljanz XR;**
8. For Kevzara: Member meets TWO of the following, unless clinically significant adverse effects are experienced or all are contraindicated (a – d, *see Appendix D*):[†]
   [†]For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. Failure of ≥ 3 consecutive months of ONE of the following adalimumab products: **adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Humira, Simlandi,** or **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06);
   b. Failure of ≥ 3 consecutive months of **Enbrel**;

c. History of failure of two TNF blockers;
d. If member has not responded or is intolerant to one or more TNF blockers, failure of ≥ 3 consecutive months of **Xeljanz/Xeljanz XR** or **Rinvoq**, unless member has cardiovascular risk and benefits do not outweigh the risk of treatment;

9. For Avtozma, Cimzia, Kineret, Olumiant, Orencia, Simponi, Simponi Aria, Tofidence, or Tyenne: Member meets BOTH of the following, unless clinically significant adverse effects are experienced or all are contraindicated (a and b):†
†For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. One of the following (i, ii, or iii, *see Appendix D*):
      i. Failure of both of the following, each used for ≥ 3 consecutive months (1 and 2):
         1) ONE of the following adalimumab products: **adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Humira, Simlandi,** or **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06);
         2) **Enbrel;**
      ii. If member has had a history of failure of one TNF blocker, then failure of one of the following TNF blockers used for ≥ 3 consecutive months: **Enbrel, adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Humira, Simlandi,** or **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06);
      iii. History of failure of two TNF blockers and request is not for another TNF blocker;
   b. If member has not responded or is intolerant to one or more TNF blockers, **Xeljanz/Xeljanz XR** and **Rinvoq,** each used for ≥ 3 consecutive months, unless member has cardiovascular risk and benefits do not outweigh the risk of treatment;

10. For Actemra: Member meets ONE of the following, unless clinically significant adverse effects are experienced or all are contraindicated (a or b):†
†For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. One of the following used for ≥ 3 consecutive months, unless the member has had a history of failure of two TNF blockers and request is not for another TNF blocker: **adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Humira, Simlandi, Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06), or **Enbrel**;
   b. One of the following used for ≥ 3 consecutive months: **Xeljanz/Xeljanz XR** or **Rinvoq,** unless member has cardiovascular risk and benefits do not outweigh the risk of treatment;

11. For Remicade, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (a, b and c):†
†For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. **Inflectra** and **Renflexis**;
   b. If member has failed Inflectra and Renflexis, then member must use **Avsola**;

c. If member has failed Inflectra, Renflexis, and Avsola, then member must use **unbranded Remicade**;

12. For unbranded Remicade, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (a and b):†
    †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
    a. **Inflectra** and **Renflexis**;
    b. If member has failed Inflectra and Renflexis, then member must use **Avsola**;
13. For Avsola, member must use BOTH of the following, unless clinically significant adverse effects are experienced or both are contraindicated: **Inflectra** and **Renflexis;**†
    †For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395
14. For Olumiant, Rinvoq, Xeljanz, Xeljanz XR: Member has not responded or is intolerant to one or more TNF blockers, unless member has cardiovascular risk and benefits do not outweigh the risk of treatment;
    **Prior authorization may be required for TNF blockers*
15. Documentation of one of the following baseline assessment scores (a or b):
    a. Clinical disease activity index (CDAI) score (*see Appendix I*);
    b. Routine assessment of patient index data 3 (RAPID3) score (*see Appendix J)*;
16. Member does not have combination use of biological disease-modifying antirheumatic drugs or JAK inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
17. Dose does not exceed maximum dose indicated in Section V.

Approval duration: 12 months

S. Systemic Juvenile Idiopathic Arthritis (must meet all)**:**

1. Diagnosis of SJIA;
2. Request is for Actemra, Avtozma, Tofidence, or Tyenne;
3. Prescribed by or in consultation with a dermatologist, rheumatologist, or gastroenterologist;
4. Age ≥ 2 years;
5. Member meets one of the following, unless previously failed a biologic agent for sJIA (a, b, or c):†
   †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. Failure of an NSAID at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
   b. Failure of a ≥ 3 consecutive months trial of MTX or leflunomide at up to maximally indicated doses, unless clinically significant adverse effects are experienced or both are contraindicated;
   c. 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. Member does not have combination use of biological disease-modifying antirheumatic drugs or JAK inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
7. Dose does not exceed maximum dose indicated in Section V.

Approval duration: 12 months

T. Systemic Sclerosis – Associated Interstitial Lung Disease (must meet all):
1. Diagnosis of SSc-ILD;
2. Request is for subcutaneous formulation of Actemra;
3. Prescribed by or in consultation with a pulmonologist or rheumatologist;
4. Member meets both of the following (a and b):
   a. Pulmonary fibrosis on high-resolution computed tomography (HRCT);
   b. Additional signs of SSc are identified (*see Appendix L)*;
5. Failure of a ≥ 3 consecutive months trial of cyclophosphamide or mycophenolate mofetil, at up to maximally indicated doses, unless both are contraindicated or clinically significant adverse effects are experienced;[†]
   [†]*For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395*
6. Baseline forced vital capacity (FVC) ≥ 40% of predicted;
7. Baseline carbon monoxide diffusing capacity (DLCO) ≥ 30% of predicted;
8. Member does not have combination use of biological disease-modifying antirheumatic drugs or JAK inhibitors (see *Section III: Diagnoses/Indications for which coverage is NOT authorized*);
9. Dose does not exceed 162 mg every week.

Approval duration: 12 months

U. Ulcerative Colitis (must meet all)**:**
1. Diagnosis of UC;
2. Request is for one of the following: Abrilada, adalimumab-aacf, adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, adalimumab-bwwd, adalimumab-fkjp, adalimumab-ryvk, Amjevita, Avsola, Cyltezo, Entyvio, Hadlima, Hulio, Humira, Hyrimoz, Idacio, Imuldosa, Inflectra, Omvoh, Otulfi, Pyzchiva, Remicade/unbranded Remicade, Renflexis, Rinvoq, Selarsdi, Simlandi, Simponi, Skyrizi, Starjemza, Stelara, Steqeyma, Tremfya, ustekinumab (unbranded Stelara), Velsipity, Wezlana, Xeljanz, Xeljanz XR, Yesintek, Yuflyma, Yusimry, Zeposia, or Zymfentra;
3. Prescribed by or in consultation with a gastroenterologist;
4. Member meets one of the following (a, b, c, or d):
   a. For Abrilada, adalimumab-aacf, adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, adalimumab-bwwd, adalimumab-fkjp, adalimumab-ryvk, Amjevita, Cyltezo, Entyvio, Hadlima, Hulio, Hyrimoz, Idacio, Imuldosa, Omvoh, Pyzchiva, Rinvoq, Selarsdi, Simlandi, Simponi, Skyrizi, Starjemza, Stelara, Steqeyma, Tremfya, ustekinumab (unbranded Stelara), Velsipity, Wezlana, Xeljanz, Xeljanz XR, Yesintek, Yuflyma, Yusimry, Zeposia, Zymfentra: Age ≥ 18 years;
   b. For Avsola, Inflectra, Remicade/unbranded Remicade, Renflexis: Age ≥ 6 years;
   c. For Humira: Age ≥ 5 years;
   d. For Simponi: If member is < 18 years old, then weight ≥ 15 kg;
5. If request is for Abrilada, adalimumab-aacf, adalimumab-bwwd, adalimumab-fkjp, adalimumab-ryvk, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, or Yusimry, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated: **adalimumab-aaty, adalimumab-adaz,**

adalimumab-adbm, Humira, Simlandi, and **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06);†
†For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395, unless biosimilar is interchangeable per FDA Purple Book

6. Documentation of a Mayo Score ≥ 6, modified Mayo Score ≥ 5, or Mayo Endoscopic Score ≥ 2 (*see Appendix F*);
7. Failure of an 8-week trial of systemic corticosteroids, unless contraindicated, clinically significant adverse effects are experienced, or previously failed a biologic agent for UC;†
   †For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395
8. For members initiating therapy with Humira: If ≥ 18 years, failure of ONE of the following, used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated: **adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Simlandi, Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06)**, Pyzchiva, Rinvoq, Skyrizi, Stelara, Steqeyma, Tremfya, Xeljanz/Xeljanz XR,** or **Yesintek;**
9. For Entyvio, Omvoh, Simponi, Velsipity, Zeposia in adults: Failure of ALL of the following, each used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated (a, b, and c, *see Appendix D*):†
   †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. THREE of the following: **Skyrizi**, **ustekinumab product (Stelara, Pyzchiva, Steqeyma,** or **Yesintek), Tremfya, adalimumab product** [**adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Humira, Simlandi,** or **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06)];
   b. If member has not responded or is intolerant to one or more TNF blockers, **Xeljanz/Xeljanz XR**, unless member has cardiovascular risk and benefits do not outweigh the risk of treatment;
   c. If member has not responded to TNF blockers or another approved systemic therapy, **Rinvoq**, unless member has cardiovascular risk and benefits do not outweigh the risk of treatment;
10. For members initiating therapy with Stelara: Failure of ONE of the following, used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated: **Pyzchiva, Steqeyma, Yesintek**, **adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Humira, Rinvoq, Simlandi, Skyrizi, Tremfya, Xeljanz/Xeljanz XR,** or **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06);
11. For Imuldosa, Otulfi, Selarsdi, Starjemza, ustekinumab (unbranded Stelara), Wezlana: Member meets ALL of the following, used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated (a, b, and c):
    a. THREE of the following (i – iv):
       i. Must use all of the following ustekinumab products: **Stelara, Pyzchiva, Steqeyma,** and **Yesintek**;†
       ii. Failure of **Skyrizi**;†

iii. Failure of **Tremfya**;†
iv. Failure of **adalimumab product** [**adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Humira, Simlandi,** or **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06)];†

b. If member has not responded or is intolerant to one or more TNF blockers, **Xeljanz/Xeljanz XR**, unless member has cardiovascular risk and benefits do not outweigh the risk of treatment;†
c. If member has not responded to TNF blockers or another approved systemic therapy, **Rinvoq**, unless member has cardiovascular risk and benefits do not outweigh the risk of treatment; †

†For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395
‡For Illinois HIM requests, the step therapy requirement above does not apply as of 1/1/2026 per IL HB 5395, unless Stelara biosimilar is interchangeable per FDA Purple Book

12. For Remicade, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (a, b, and c):†
†For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
    a. **Inflectra** and **Renflexis**;
    b. If member has failed Inflectra and Renflexis, then member must use **Avsola**;
    c. If member has failed Inflectra, Renflexis, and Avsola, then member must use **unbranded Remicade**;
13. For unbranded Remicade, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (a and b):†
†For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
    a. **Inflectra** and **Renflexis**;
    b. If member has failed Inflectra and Renflexis, then member must use **Avsola**;
14. For Avsola, member must use BOTH of the following, unless clinically significant adverse effects are experienced or both are contraindicated: **Inflectra** and **Renflexis**;†
†For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395
15. For Zymfentra, provider attestation that member meets one of the following (a or b, *see Appendix D*):
    a. For Illinois HIM requests only: Has received IV infliximab prior to initiation;
    b. For all other requests, all of the following (i, ii, and iii):
        i. Has received three IV induction doses of an infliximab product prior to initiation;
        ii. Member is responding positively to an IV infliximab product;
        iii. Member is unable to receive continued therapy with IV infliximab due to lack of caregiver or support system for assistance with administration and/or inadequate access to healthcare facility or home care interventions and/or lack of transportation to healthcare facility;
16. For Skyrizi: If request is for cartridges, quantity does not exceed one pre-filled cartridge per dose;
17. For Xeljanz/Xeljanz XR: Member has not responded or is intolerant to one or more TNF blockers;

Prior authorization may be required for TNF blockers

18. For Rinvoq: Member meets one* of the following (a or b):
    a. Member has not responded to one or more TNF blockers;
    b. If TNF blockers are clinically inadvisable, member has received at least one approved systemic therapy;

    **Prior authorization may be required for TNF blockers and approved systemic therapies.*
19. Member does not have combination use of biological disease-modifying antirheumatic drugs or JAK inhibitors (see *Section III: Diagnoses/Indications for which coverage is NOT authorized*);
20. Dose does not exceed maximum dose indicated in Section V.

Approval duration: 12 months

V. Uveitis (must meet all)**:**

1. Diagnosis of non-infectious intermediate, posterior, or panuveitis;
2. Request is for Abrilada, adalimumab-aacf, adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, adalimumab-bwwd, adalimumab-fkjp, adalimumab-ryvk, Amjevtia, Cyltezo, Hadlima, Hulio, Humira, Hyrimoz, Idacio, Simlandi, Yuflyma, or Yusimry;
3. Prescribed by or in consultation with an ophthalmologist or rheumatologist;
4. Member meets one of the following (a or b):
    a. For Humira, Amjevita, Cyltezo, adalimumab-adbm, Hyrimoz, adalimumab-adaz, Simlandi, adalimumab-ryvk, Yuflyma, adalimumab-aaty: Age ≥ 2 years;
    b. For Abrilada, adalimumab-aacf, adalimumab-bwwd, adalimumab-fkjp, Hadlima, Hulio, Idacio, Yusimry: Age ≥ 18 years;
5. If request is for Abrilada, adalimumab-aacf, adalimumab-bwwd, adalimumab-fkjp, adalimumab-ryvk, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, or Yusimry, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated: **adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Humira, Simlandi,** and **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06);†

    †For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395, unless biosimilar is interchangeable per FDA Purple Book
6. For members initiating therapy with Humira: Member must use ONE of the following, used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced, FDA-approved age limit does not overlap, or all are contraindicated: **adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Simlandi,** or **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06);
7. Failure of a ≥ 2 week trial of a systemic corticosteroid (e.g., prednisone) at up to maximally indicated doses, unless clinically significant adverse effects are experienced, all are contraindicated, or previously failed a biologic agent for UV;†

    †For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395
8. 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 clinically significant

adverse effects are experienced, all are contraindicated, or previously failed a biologic agent for UV;†

†For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395

9. Member does not have combination use of biological disease-modifying antirheumatic drugs or JAK inhibitors (see *Section III: Diagnoses/Indications for which coverage is NOT authorized*);
10. Dose does not exceed maximum dose indicated in Section V.

Approval duration: 12 months

W. Coronavirus-19 Infection:

1. Initiation of outpatient treatment will not be authorized as Kineret (authorized for emergency use only), Actemra (FDA-approved), Avtozma (FDA-approved), Tofidence (FDA-approved), Tyenne (FDA-approved), and Olumiant (FDA-approved) are authorized for use only in the hospitalized setting (*see Appendix M*).

Approval duration: Not applicable

X. Multiple Sclerosis:

1. For Tyruko, Tysabri, or Zeposia requests, refer to Tyruko, Tysabri, or Zeposia MS criteria, respectively.

Y. Alopecia Areata:

1. Use of Olumiant for the treatment of alopecia areata is a benefit exclusion and will not be authorized because it is considered cosmetic in nature.

Approval duration: Not applicable

Z. Other diagnoses/indications (must meet all):

1. If request is for Remicade, unbranded Remicade, or Avsola, member meets one of the following (a, b, or c):†

   †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395

   a. If request is for Remicade, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (i, ii, and iii):
      i. **Inflectra** and **Renflexis;**
      ii. If member has failed Inflectra and Renflexis, then member must use **Avsola**;
      iii. If member has failed Inflectra, Renflexis, and Avsola, then member must use **unbranded Remicade**;
   b. For unbranded Remicade, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (i and ii):
      i. **Inflectra** and **Renflexis**;
      ii. If member has failed Inflectra and Renflexis, then member must use **Avsola**;
   c. If request is for Avsola, member must use BOTH of the following, unless clinically significant adverse effects are experienced or both are contraindicated: **Inflectra** and **Renflexis**;

2. Must meet one of the following (a or b):
   a. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (i or ii):
      i. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: HIM.PA.33 for health insurance marketplace; or
      ii. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: HIM.PA.103 for health insurance marketplace; or
   b. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 2a above does not apply, refer to the off-label use policy for the relevant line of business: HIM.PA.154 for health insurance marketplace.

II. Continued Therapy

A. Coronavirus-19 Infection:

1. Continuation of therapy in the outpatient setting will not be authorized as Kineret (authorized for emergency use only), Actemra (FDA-approved), Avtozma (FDA-approved), Tofidence (FDA-approved), Tyenne (FDA-approved), and Olumiant (FDA-approved) are authorized for use only in the hospitalized setting (*see Appendix M*).

Approval duration: Not applicable

B. Kawasaki Disease (off-label)** (must meet all)**:

1. Re-authorization for infliximab is not permitted. Members must meet the initial approval criteria.

Approval duration: Not applicable

C. Multiple Sclerosis:

1. For Tyruko, Tysabri, or Zeposia requests, refer to Tyruko, Tysabri, or Zeposia MS criteria, respectively.

D. Alopecia Areata:

1. Use of Olumiant for the treatment of alopecia areata is a benefit exclusion and will not be authorized because it is considered cosmetic in nature.

Approval duration: Not applicable

E. All Other Indications in Section I** (must meet all)**:

1. Member meets one of the following (a, b, or c):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*

c. Documentation supports that member is currently receiving IV Actemra, IV Avtozma, or IV Tyenne for CAR T cell-induced CRS and member has not yet received 4 total doses;

2. Member meets one of the following (a, b, c, d, or e):
   a. For RA: Member is responding positively to therapy as evidenced by one of the following (i or ii):
      i. A decrease in CDAI (*see Appendix I*) or RAPID3 (*see Appendix J*) score from baseline;
      ii. Medical justification stating inability to conduct CDAI re-assessment, and submission of RAPID3 score associated with disease severity that is similar to initial CDAI assessment or improved;
   b. For HS: At least a 25% reduction in inflammatory nodules and abscesses;
   c. For AD: Member is responding positively to therapy as evidenced by, including but not limited to, reduction in itching and scratching;
   d. For PMR: Member is responding positively to therapy as evidenced by both of the following (i and ii):
      i. Documentation of decrease in signs and symptoms of PMR (e.g., bilateral shoulder aching; symmetrical aching; stiffness in shoulders, hip girdle, neck, and torso; morning stiffness);
      ii. Evidence of one of the following (1 or 2):
         1) Reduction CRP from baseline;
         2) Reduction of ESR from baseline;
   e. For all other indications: Member is responding positively to therapy;
3. If request is for Abrilada, adalimumab-aacf, adalimumab-bwwd, adalimumab-fkjp, adalimumab-ryvk, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, or Yusimry, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated: **adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Humira, Simlandi,** and **Yuflyma** (NDC 72606-030-09, 72606-030-10, 72606-023-04, 72606-023-07, 72606-024-01, 72606-030-06);†
   †For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395, unless biosimilar is interchangeable per FDA Purple Book
4. For Skyrizi: for CD or UC: If request is for cartridges, quantity does not exceed 1 pre-filled cartridge every 8 weeks;
5. If request is for Remicade, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (a, b, and c):†
   †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. **Inflectra** and **Renflexis**;
   b. If member has failed Inflectra and Renflexis, then member must use **Avsola**;
   c. If member has failed Inflectra, Renflexis, and Avsola, then member must use **unbranded Remicade**;
6. For unbranded Remicade, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (a and b):†
   †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. **Inflectra** and **Renflexis**;
   b. If member has failed Inflectra and Renflexis, then member must use **Avsola**;

7. If request is for Avsola, member must use BOTH of the following, unless clinically significant adverse effects are experienced or both are contraindicated: **Inflectra** and **Renflexis**;†
   †For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395
8. For Otezla/Otezla XR: For PsA and PsO, if member is between ages 6 to < 18 years, documentation that member meets one of the following (a or b):
   a. For Otezla: Weight ≥ 20 kg;
   b. For Otezla XR: Weight ≥ 50 kg
9. For Imuldosa, Otulfi, Pyzchiva, Selarsdi, Starjemza, Stelara, Steqeyma, ustekinumab (unbranded Stelara), Wezlana, Yesintek: Request is for SC formulation;
10. For Imuldosa, Otulfi, Selarsdi, Starjemza, ustekinumab (unbranded Stelara), Wezlana: member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated: **Stelara**, **Pyzchiva**, **Steqeyma**, and **Yesintek**;
11. Member meets one of the following (a or b):
    a. For Otezla/Otezla XR, if request is for concomitant use with biologic DMARD therapy (e.g., adalimumab, Enbrel, infliximab) for PsA or PsO, member meets one of the following (i or ii):†
       †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
       i. Failure of a ≥ 3 consecutive month trial of MTX used in combination with the biologic DMARD at up to maximally indicated doses;
       ii. Member has intolerance or contraindication to MTX (*see Appendix D*), and failure of a ≥ 3 consecutive month trial of cyclosporine or acitretin used in combination with the biologic DMARD at up to maximally indicated doses, unless clinically significant adverse effects are experienced or both are contraindicated;
    b. For agents other than Otezla/Otezla XR, member does not have combination use of biological disease-modifying antirheumatic drugs or JAK inhibitors (see *Section III: Diagnoses/Indications for which coverage is NOT authorized*);
12. If request is for a dose increase, new dose does not exceed maximum dose indicated in Section V.

Approval duration:
CRS, aGVHD – 3 months (4 doses total) *(12 months for HIM Texas)*
For all other indications – 12 months

F. Other diagnoses/indications (must meet all):
1. If request is for Remicade, unbranded Remicade, or Avsola, member meets one of the following (a, b, or c):†
   †For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395
   a. If request is for Remicade, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (i, ii, and iii):
      i. **Inflectra** and **Renflexis;**
      ii. If member has failed Inflectra and Renflexis, then member must use **Avsola**;

iii. If member has failed Inflectra, Renflexis, and Avsola, then member must use **unbranded Remicade**;

b. For unbranded Remicade, member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated (i and ii):
   i. **Inflectra** and **Renflexis**;
   ii. If member has failed Inflectra and Renflexis, then member must use **Avsola**;

c. If request is for Avsola, member must use BOTH of the following, unless clinically significant adverse effects are experienced or both are contraindicated: **Inflectra** and **Renflexis**;

2. Must meet one of the following (a or b):
   a. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (i or ii):
      i. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: HIM.PA.33 for health insurance marketplace; or
      ii. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: HIM.PA.103 for health insurance marketplace; or
   b. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 2a above does not apply, refer to the off-label use policy for the relevant line of business: HIM.PA.154 for health insurance marketplace.

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 – HIM.PA.154 for health insurance marketplace or evidence of coverage documents;

B. Combination use with biological disease-modifying antirheumatic drugs (bDMARDs) or potent immunosuppressants, including but not limited to any tumor necrosis factor (TNF) antagonists [e.g., Cimzia®, Enbrel®, Humira® and its biosimilars, Remicade® and its biosimilars, Simponi®], interleukin agents [e.g., Actemra® (IL-6RA) and its biosimilars, Arcalyst® (IL-1 blocker), Bimzelx® (IL-17A and F antagonist), Cosentyx® (IL-17A inhibitor), Ilaris® (IL-1 blocker), Ilumya™ (IL-23 inhibitor), Kevzara® (IL-6RA), Kineret® (IL-1RA), Omvoh™ (IL-23 antagonist), Siliq™ (IL-17RA), Skyrizi™ (IL-23 inhibitor), Spevigo® (IL-36 antagonist), Stelara® (IL-12/23 inhibitor) and its biosimilars, Taltz® (IL-17A inhibitor), Tremfya® (IL-23 inhibitor)], Janus kinase inhibitors (JAKi) [e.g., Cibinqo™, Olumiant™, Rinvoq™, Xeljanz®/Xeljanz® XR,], anti-CD20 monoclonal antibodies [Rituxan® and its biosimilars], selective co-stimulation modulators [Orencia®], integrin receptor antagonists [Entyvio®], tyrosine kinase 2 inhibitors [Sotyktu™], and sphingosine 1-phosphate receptor modulator [Velsipity™] because of the additive immunosuppression, increased risk of neutropenia, as well as increased risk of serious infections;

C. For Siliq: treatment of patients with Crohn's disease;

D. For Xeljanz/Xeljanz XR and Olumiant: alopecia areata (ICD10: L63), also referred to as patchy hair loss.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ACR: American College of Rheumatology
AD: atopic dermatitis
aGVHD: acute graft-versus-host disease
AS: ankylosing spondylitis
BD: Behçet's disease
CAR: chimeric antigen receptor
CD: Crohn's disease
CDAI: clinical disease activity index
CINCA: chronic infantile neurological, cutaneous, and articular syndrome
cJADAS: clinical juvenile arthritis disease activity score
COVID-19: coronavirus disease 2019
CRP: c-reactive protein
CRS: cytokine release syndrome
DIRA: deficiency of interleukin-1 receptor antagonist
DLCO: carbon monoxide diffusing capacity
DMARDs: disease-modifying antirheumatic drugs
ERA: enthesitis-related arthritis
ESR: erythrocyte sedimentation rate
EULAR: European Union League Against Rheumatism
FVC: forced vital capacity
GCA: giant cell arteritis
HS: hidradenitis suppurativa,
JAK: Janus kinase
JPsA: juvenile psoriatic arthritis
MS: multiple sclerosis
MTX: methotrexate
NOMID: neonatal-onset multisystem inflammatory disease
nr-axSpA: non-radiographic axial spondyloarthritis
NSAIDs: non-steroidal anti-inflammatory drugs
PJIA: polyarticular juvenile idiopathic arthritis
PMR: polymyalgia rheumatica
PsO: plaque psoriasis
PsA: psoriatic arthritiss
RA: rheumatoid arthritis
RAPID3: routine assessment of patient index data 3
SJIA: systemic juvenile idiopathic arthritis
SSc-ILD: systemic sclerosis-associated interstitial lung disease
TNF: tumor necrosis factor
UC: ulcerative colitis
UV: uveitis

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*** 1.5 – 2 mg/kg/day PO	3 mg/kg/day UV: 4 mg/kg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	UV* 2 - 3 mg/kg/day PO	
chlorambucil (Leukeran®)	**UV*** 0.2 mg/kg PO QD, then taper to 0.1 mg/kg PO QD or less	0.2 mg/kg/day
clindamycin (Cleocin®) + rifampin (Rifadin®)	**HS*** clindamycin 300 mg PO BID and rifampin 300 mg PO BID	clindamycin: 600 mg/day rifampin: 600 mg/day
corticosteroids Oral: e.g., prednisone, budesonide Medium to very high potency topical: e.g., desoximetasone 0.05%, fluocinolone acetonide 0.025%, mometasone 0.1% cream, triamcinolone acetonide 0.1%, augmented betamethasone dipropionate 0.05%, clobetasol propionate 0.05% cream, ointment, gel, or solution, halobetasol propionate 0.05% cream, ointment	**CD*** *Adult:* prednisone 40 mg – 60 mg PO QD for 1 to 2 weeks, then taper daily dose by 5 mg weekly until 20 mg PO QD, and then continue with 2.5 – 5 mg decrements weekly or IV 50 – 100 mg Q6H for 1 week budesonide (Entocort EC®) 6 – 9 mg PO QD *Pediatric:* Prednisone 1 to 2 mg/kg/day PO QD **AD, GCA*** Various **SJIA*** < 0.5 mg/kg/day PO of prednisone or equivalent **UC** *Adult:* Prednisone 40 mg – 60 mg PO QD, then taper dose by 5 to 10 mg/week budesonide (Uceris®) 9 mg PO QD *Pediatric:* Prednisone 1 to 2 mg/kg/day PO QD **UV*** prednisone 5 – 60 mg/day PO in 1 – 4 divided doses	Various

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	PsO Applied topically to the affected area(s) BID **PMR** Prednisone: 7.5 mg to 25 mg PO per day	
Cuprimine® (d-penicillamine)	**RA*** Initial dose: 125 or 250 mg PO QD Maintenance dose: 500 – 750 mg/day PO QD	1,500 mg/day
cyclophosphamide (Cytoxan®)	**UV*** 1 – 2 mg/kg/day PO **SSc-ILD*** • PO: 1 – 2 mg/kg/day • IV: 600 mg/m^2/month	PO: 2 mg/kg/day IV: 600 mg/m^2/month
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
Hormonal agents (e.g., estrogen-containing combined oral contraceptives, spironolactone)	**HS** varies	varies
hydroxychloroquine (Plaquenil®)	**RA*** Initial dose: 400 – 600 mg/day PO QD Maintenance dose: 200 – 400 mg/day PO QD	600 mg/day
Isotretinoin (Absorica®, Amnesteem®, Claravis®, Myorisan®, Zenatane®)	**HS** varies	varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
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** Initial dose (for low risk hepatotoxicity or myelosuppression): 100 mg PO QD for 3 days Maintenance dose: 20 mg PO QD **SJIA*** 100 mg PO every other day for 2 days, then 10 mg every other day **ERA** Weight < 20 kg: 10 mg every other day Weight 20 - 40 kg: 10 mg/day Weight > 40 kg: 20 mg/day	ERA, PJIA, RA: 20 mg/day SJIA: 10 mg every other day
6-mercaptopurine (Purixan®)	**CD*** 50 mg PO QD or 0.75 – 1.5 mg/kg/day PO	1.5 mg/kg/day
methotrexate (Trexall®, Otrexup™, Rasuvo®, RediTrex®, Xatmep™, Rheumatrex®)	**CD*** 15 – 25 mg/week IM or SC **GCA*** 20 – 25 mg/week PO **PsO** 10 to 25 mg/week IM, SC or PO or 2.5 mg PO Q12 hr for 3 doses/week **PJIA*** 10 – 20 mg/m^2/week PO, SC, or IM **RA** 7.5 mg/week PO, SC, or IM or 2.5 mg PO Q12 hr for 3 doses/week **SJIA*** 0.5 – 1 mg/kg/week PO or SC **UV*** 7.5 – 20 mg/week PO	30 mg/week
minocycline (Minocin®)	**HS*** 50 – 100 mg PO BID	200 mg/day
mycophenolate mofetil (Cellcept®)	**UV*** 500 – 1,000 mg PO BID	Adult: 3 g/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	SSc-ILD* PO: 1 – 3 g/day	Pediatric: 50mg/kg/day
NSAIDs (e.g., indomethacin, ibuprofen, naproxen, celecoxib)	**AS, nr-axSpA, ERA, PJIA*, sJIA*** Varies	Varies
Pentasa® (mesalamine)	**CD** 1,000 mg PO QID	4 g/day
Ridaura® (auranofin)	**RA** 6 mg PO QD or 3 mg PO BID	9 mg/day (3 mg TID)
sulfasalazine (Azulfidine®)	**PJIA*** 30-50 mg/kg/day PO divided BID **RA** Initial dose: 500 mg to 1,000 mg PO QD for the first week. Increase the daily dose by 500 mg each week up to a maintenance dose of 2 g/day. Maintenance dose: 2 g/day PO in divided doses **ERA** 30 to 50 mg/kg/day PO, given in 2 divided doses	PJIA, ERA: 2 g/day RA: 3 g/day UC: 4 g/day
tacrolimus (Prograf®)	**CD*** 0.27 mg/kg/day PO in divided doses or 0.15 – 0.29 mg/kg/day PO **UV*** 0.1-0.15 mg/kg/day PO	N/A
biologic 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
tacrolimus	**AD** Children ≥ 2 years and adults: Apply a thin layer topically to affected skin BID.	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
(Protopic®), pimecrolimus (Elidel®)	Treatment should be discontinued if resolution of disease occurs.	
Eucrisa® (crisaborole)	**AD** Apply to the affected areas BID	Varies
immune globulin (e.g., Gammagard®)	**Kawasaki disease** Varies based on formulation	Varies based on formulation

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, Avtozma, Tofidence, Tyenne	Known hypersensitivity to tocilizumab products	Risk of serious infections
Bimzelx	None reported	None reported
Cimzia	None reported	• 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	• 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 and biosimilars (Abrilada,	None reported	• Serious infections • Malignancies

Drug Name	Contraindication(s)	Boxed Warning(s)
Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, and Yusimry)		
Ilumya	Serious hypersensitivity reaction to tildrakizumab or to any of the excipients	None reported
Avsola, Inflectra, Remicade, Renflexis Zymfentra	• Doses > 5 mg/kg in patients with moderate-to-severe heart failure (*Avsola, Inflectra, Remicade, and Renflexis only*) • Known hypersensitivity to inactive components of the product or to any murine proteins	• Serious infections • Malignancy
Kevzara	Known hypersensitivity to sarilumab or any of the inactive ingredients	Risk of serious infections
Kineret	Known hypersensitivity to *E. coli*-derived proteins, Kineret, or any components of the product	None reported
Olumiant	None reported	• Serious infections • Mortality • Malignancies • Major adverse cardiovascular events • Thrombosis
Omvoh	History of serious hypersensitivity reaction to mirikizumab-mrkz or any of the excipients	None reported
Orencia	None reported	None reported
Otezla	Known hypersensitivity to apremilast or to any of the excipients in the formulation	None reported
Rinvoq, Rinvoq LQ	Known hypersensitivity to upadacitinib or any of the excipients in Rinvoq/Rinvoq LQ	• Serious infections • Mortality • Malignancies

Drug Name	Contraindication(s)	Boxed Warning(s)
		• Major adverse cardiovascular events • Thrombosis
Siliq	Patients with Crohn's disease	Suicidal ideation and behavior
Simponi, Simponi Aria	None reported	• Serious infections • Malignancies
Skyrizi	History of serious hypersensitivity reaction to risankizumab-rzaa or any of the excipients	None reported
Stelara and biosimilars (Imuldosa, Otulfi, Pyzchiva, Selarsdi, Steqeyma, Wezlana, Yesintek)	Clinically significant hypersensitivity to ustekinumab products or any of the 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, Tyruko	• Patients who have or have had progressive multifocal leukoencephalopathy • Patients who have had a hypersensitivity reaction to natalizumab products or any of its active ingredients	• Progressive multifocal leukoencephalopathy
Velsipity	• In the last 6 months, experienced myocardial infarction, unstable angina pectoris, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III or IV heart failure • History or presence of Mobitz type II second-degree or third-degree atrioventricular (AV) block, sick sinus syndrome, or sino-atrial block, unless the	None reported

Drug Name	Contraindication(s)	Boxed Warning(s)
	patient has a functioning pacemaker	
Xeljanz/ Xeljanz XR	None reported	• Serious infections • Mortality • Malignancies • Major adverse cardiovascular events • Thrombosis
Zeposia	• History of any of the following in the last 6 months: myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III or IV heart failure • Presence of Mobitz type II second-degree or third degree atrioventricular (AV) block, sick sinus syndrome, or sino-atrial block, unless the patient has a functioning pacemaker • Severe untreated sleep apnea • Concomitant use of a monoamine oxidase inhibitor	None reported

Appendix D: General Information

- 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:
  - For ulcerative colitis maintenance therapy, failure is defined as having two or more exacerbations requiring steroid therapy.

- 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.
- Hidradenitis suppurativa:
  - HS is sometimes referred to as: "acne inversa, acne conglobata, apocrine acne, apocrinitis, Fox-den disease, hidradenitis axillaris, HS, pyodermia 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.
- Ulcerative colitis: There is insufficient evidence to support the off-label weekly dosing of adalimumab for the treatment of moderate-to-severe UC. It is the position of Centene Corporation® that the off-label weekly dosing of adalimumab 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 adalimumab pivotal trial suggests further studies are needed to confirm the benefit of weekly adalimumab dosing for the treatment of UC in patients with inadequate or loss of therapeutic response to treatment with adalimumab 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 adalimumab for UC. The current market consensus is that weekly dosing of adalimumab is not medically necessary due to lack of evidence to support its benefit.
- Infliximab used in the treatment of unspecified iridocyclitis (anterior uveitis) has primarily been evaluated in case reports and uncontrolled case series. One phase II clinical trial by Suhler and associates (2009) reported the 2-year follow-up data of patients with refractory uveitis treated with intravenous infliximab as part of a prospective clinical trial. Their 1-year data, published in 2005 (Suhler, 2005) reported reasonable initial success, but an unexpectedly high incidence of adverse events. Of their 23 patients, 7 developed serious adverse events, including 3 thromboses, 1 malignancy, 1 new onset of congestive heart failure, and 2 cases of drug-induced lupus. The American Optometric Association anterior uveitis clinical practice guidelines recommend alternative therapies that include ophthalmic corticosteroids (e.g., prednisolone, dexamethasone, fluoromethalone) and anticholinergics (e.g., atropine, cyclopentolate, homatropine). If the disease has not responded to topical therapy, oral corticosteroids can be considered.
- ERA: Current International League of Associations for Rheumatology (ILAR) classification criteria divide JIA into 7 mutually exclusive categories defined by the number of joints involved, presence or absence of extraarticular manifestations, and presence or absence of additional markers including rheumatoid factor (RF) and HLA–B27. While the current ILAR classification criteria have been useful for identifying homogeneous groups of patients for research, more recent data suggest that these

categories may not entirely reflect the underlying genetic and clinical heterogeneity of the disease or be relevant for guiding treatment decisions. According to the 2019 American College of Rheumatology, current treatment guideline focuses treatment approaches based on broad clinical phenotypes rather than ILAR categories.

- TNF blockers:
  - Etanercept (Enbrel®), adalimumab (Humira®) and its biosimilars, infliximab (Remicade®) and its biosimilars (Avsola™, Renflexis™, Inflectra®, Zymfentra®), certolizumab pegol (Cimzia®), and golimumab (Simponi®, Simponi Aria®).
- Zymfentra is indicated as maintenance treatment only, starting at week 10 and thereafter. All patients must complete an intravenous induction regimen with an infliximab product before starting Zymfentra. To switch patients who are responding to maintenance therapy with an infliximab product administered intravenously, administer the first subcutaneous dose of Zymfentra in place of the next scheduled intravenous infusion and every two weeks thereafter.

Appendix E: Immunomodulator Medical Justification

- The following may be considered for medical justification supporting inability to use an immunomodulator for CD:
  - 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

Appendix F: Mayo Score, Modified Mayo Score, or Mayo Endoscopic Score

- Mayo Score: evaluates ulcerative colitis stage, based on four parameters: stool frequency, rectal bleeding, endoscopic evaluation and Physician's global assessment. Each parameter of the score ranges from zero (normal or inactive disease) to 3 (severe activity) with an overall score of 12.

Score	Decoding
0 – 2	Remission
3 – 5	Mild activity
6 – 10	Moderate activity
>10	Severe activity

- Modified Mayo Score: developed from the full Mayo score and evaluates ulcerative colitis stage, based on three parameters: stool frequency, rectal bleeding, and endoscopic

evaluation. The modified Mayo Score gives a maximum overall score of 9. The FDA currently accepts the modified Mayo Score for the assessment of disease activity in pivotal UC clinical trials.

- Mayo Endoscopic Score: tool used to assess severity based on endoscopic findings during a colonoscopy and ranges from 0 to 3. A score of 2 or higher means there is moderate-to-severe inflammation.

Score	Decoding
0	Normal or inactive disease
1	Mild disease (erythema, decreased vascular pattern, mild friability)
2	Moderate disease (marked erythema, absent vascular pattern, moderate friability, erosions)
3	Severe disease (spontaneous bleeding, ulcerations)

Appendix G: Dose Rounding Guidelines for Weight-Based Doses

Actemra, Avtozma, Tofidence, and Tyenne for Intravenous Use for PJIA and SJIA

Weight-based Dose Range	Vial Quantity Recommendation
≤ 83.99 mg	1 vial of 80 mg/4 mL
84 to 209.99 mg	1 vial of 200 mg/10 mL
210 to 419.99 mg	1 vial of 400 mg/20 mL
420 to 503.99 mg	1 vial of 80 mg/4 mL and 1 vial 400 mg/20 mL
504 to 629.99 mg	1 vial of 200 mg/10 mL and 1 vial 400 mg/20 mL
630 to 839.99 mg	2 vials 400 mg/20 mL
840 to 923.99 mg	1 vial of 80 mg/4 mL and 2 vials 400 mg/20 mL
924 to 1,049.99 mg	1 vial of 200 mg/10 mL and 2 vials 400 mg/20 mL
1050 to 1,259.99 mg	3 vials 400 mg/20 mL

Enbrel for PJIA, Pediatric PsO, and JPsA

Weight-based Dose Range	Vial Quantity Recommendation
≤ 25.99 mg	1 vial of 25 mg/0.5 mL
26 to 52.49 mg	1 vial of 50 mg/mL

Infliximab for All Indications

Weight-based Dose Range	Vial Quantity Recommendation
≤ 104.99 mg	1 vial of 100 mg/20 mL
105 to 209.99 mg	2 vials of 100 mg/20 mL
210 to 314.99 mg	3 vials of 100 mg/20 mL
315 to 419.99 mg	4 vials of 100 mg/20 mL
420 to 524.99 mg	5 vials of 100 mg/20 mL
525 to 629.99 mg	6 vials of 100 mg/20 mL
630 to 734.99 mg	7 vials of 100 mg/20 mL
735 to 839.99 mg	8 vials of 100 mg/20 mL

Kineret for NOMID

Weight-based Dose Range	Vial Quantity Recommendation
≤ 104.99 mg	1 syringe of 100 mg/0.67 mL
105 to 209.99 mg	2 syringes of 100 mg/0.67 mL
210 to 314.99 mg	3 syringes of 100 mg/0.67 mL
315 to 419.99 mg	4 syringes of 100 mg/0.67 mL
420 to 524.99 mg	5 syringes of 100 mg/0.67 mL
525 to 629.99 mg	6 syringes of 100 mg/0.67 mL
630 to 734.99 mg	7 syringes of 100 mg/0.67 mL
735 to 839.99 mg	8 syringes of 100 mg/0.67 mL

Orencia for Intravenous Use PJIA and SJIA

Weight-based Dose Range	Vial Quantity Recommendation
≤ 262.49 mg	1 vial of 250 mg
262.50 mg to524.99 mg	2 vials of 250 mg
525 to 787.49 mg	3 vials of 250 mg
787.50 mg to 1,049.99 mg	4 vials of 250 mg

Orencia for Subcutaneous Use for PJIA and SJIA

Weight-based Dose Range	Prefilled Syringe Quantity Recommendation
10 to 24.99 kg	1 syringe of 50 mg/0.4 mL
25 to 49.99 kg	1 syringe of 87.5 mg/0.7 mL
> 50 kg	1 syringe of 125 mg/mL

Simponi Aria for All Indications

Weight-based Dose Range	Vial Quantity Recommendation
≤ 52.49 mg	1 vial of 50 mg/4 mL
52.5 to 104.99 mg	2 vials of 50 mg/4 mL
105 to 157.49 mg	3 vials of 50 mg/4 mL
157.5 to 209.99 mg	4 vials of 50 mg/4 mL
210 to 262.49 mg	5 vials of 50 mg/4 mL

Stelara, Imuldosa, Otulfi, Pyzchiva, Selarsdi, Steqeyma, ustekinumab (unbranded Stelara), Wezlana, and Yesintek for PsO

Weight-based Dose Range	Quantity Recommendation
Subcutaneous, Syringe	
≤ 46.99 mg	1 syringe of 45 mg/0.5 mL
47 to 94.49 mg	1 syringe of 90 mg/1 mL
94.5 to 141.49 mg	1 syringe of 45 mg/0.5 mL and 1 syringe of 90 mg/1 mL
Subcutaneous, Vial	
≤ 46.99 mg	1 vial of 45 mg/0.5 mL
47 to 94.49 mg	2 vials of 45 mg/0.5 mL

Appendix H: The 2010 ACR Classification Criteria for RA
Add score of categories A through D; a score of ≥ 6 out of 10 is needed for classification of a patient as having definite RA.

A	**Joint involvement**	Score
	1 large joint	0
	2-10 large joints	1
	1-3 small joints (with or without involvement of large joints)	2
	4-10 small joints (with or without involvement of large joints)	3
	> 10 joints (at least one small joint)	5
B	**Serology (at least one test result is needed for classification)**	
	Negative rheumatoid factor (RF) *and* negative anti-citrullinated protein antibody (ACPA)	0
	Low positive RF *or* low positive ACPA * *Low: < 3 x upper limit of normal*	2
	High positive RF *or* high positive ACPA * *High: ≥ 3 x upper limit of normal*	3
C	**Acute phase reactants (at least one test result is needed for classification)**	
	Normal C-reactive protein (CRP) and normal erythrocyte sedimentation rate (ESR)	0
	Abnormal CRP or abnormal ESR	1
D	**Duration of symptoms**	
	< 6 weeks	0
	≥ 6 weeks	1

Appendix I: Clinical Disease Activity Index (CDAI) Score
The Clinical Disease Activity Index (CDAI) is a composite index for assessing disease activity in RA. CDAI is based on the simple summation of the count of swollen/tender joint count of 28 joints along with patient and physician global assessment on VAS (0–10 cm) Scale for estimating disease activity. The CDAI score ranges from 0 to 76.

CDAI Score	Disease state interpretation
≤ 2.8	Remission
> 2.8 to ≤ 10	Low disease activity
> 10 to ≤ 22	Moderate disease activity
> 22	High disease activity

Appendix J: Routine Assessment of Patient Index Data 3 (RAPID3) Score
The Routine Assessment of Patient Index Data 3 (RAPID3) is a pooled index of the three patient-reported ACR core data set measures: function, pain, and patient global estimate of status. Each of the individual measures is scored 0 – 10, and the maximum achievable score is 30.

RAPID3 Score	Disease state interpretation
≤ 3	Remission
3.1 to 6	Low disease activity
6.1 to 12	Moderate disease activity
> 12	High disease activity

Appendix K: Polyarticular Juvenile Idiopathic Arthritis Disease Activity
According to 2019 American College of Rheumatology/Arthritis Foundation Guideline for the Treatment of Juvenile Idiopathic Arthritis, disease activity (moderate/high and low) as defined by the clinical Juvenile Disease Activity score based on 10 joints (cJADAS-10) is provided as a general parameter and should be interpreted within the clinical context.
The cJADAS10 is a continuous disease activity score specific to JIA and consisting of the following three parameters totaling a maximum of 30 points:

- Physician's global assessment of disease activity measured on a 0-10 visual analog scale (VAS), where 0 = no activity and 10 = maximum activity;
- Parent global assessment of well-being measured on a 0-10 VAS, where 0 = very well and 10 = very poor;
- Count of joints with active disease to a maximum count of 10 active joints*

**ACR definition of active joint: presence of swelling (not due to currently inactive synovitis or to bony enlargement) or, if swelling is not present, limitation of motion accompanied by pain, tenderness, or both*

cJADAS-10	Disease state interpretation
≤ 1	Inactive disease
1.1 to 2.5	Low disease activity
2.51 to 8.5	Moderate disease activity
> 8.5	High disease activity

Appendix L: American College of Rheumatology (ACR) 2013 SSc Classification Criteria
While the majority of patients with SSc experience skin thickening and variable involvement of internal organs, there is no one confirmatory test for SSc. Similar to the IPF guidelines above, ACR lists HRCT as a diagnostic method for determining pulmonary fibrosis in SSc-ILD. The other diagnostic parameters below are drawn from ACR's scoring system purposed for clinical trials. While informative, ACR cautions that the scoring system parameters are not all inclusive of the myriad of SSc manifestations that may occur across musculoskeletal, cardiovascular, renal, neuromuscular, and genitourinary systems.

Examples of SSc skin/internal organ manifestations and associated laboratory tests:

- Skin thickening of the fingers
- Fingertip lesions
- Telangiectasia
- Abnormal nailfold capillaries
- Raynaud's phenomenon
- SSc-ILD
- Pulmonary arterial hypertension
- SSc-related autoantibodies
- Anticentromere
- Anti-topoisomerase I (anti-Scl-70)
- Anti-RNA polymerase III

Appendix M: Coronavirus-19 Infection:

- An EUA is an FDA authorization for the emergency use of an unapproved product or unapproved use of an approved product (i.e., drug, biological product, or device) in the United States under certain circumstances including, but not limited to, when the Secretary of HHS declares that there is a public health emergency that affects the national security or the health and security of United States citizens living abroad, and that involves biological agent(s) or a disease or condition that may be attributable to such agent(s).
- Kineret
  - The EUA decision was based on the results of the SAVE-MORE trial, which was a randomized, double-blinded, placebo-controlled study to evaluate the safety and efficacy of Kineret in adult patients with COVID-19 pneumonia who were at risk of developing severe respiratory failure (SRF). The primary endpoint of the study was the 11-point WHO Clinical Progressional ordinal Scale (CPS) which was compared between the two arms of treatment by Day 28. Patients treated with Kineret had lower odds of more severe disease according to the WHO-CPS at Day 28 compared to placebo (odds ratio: 0.37 [95% CI 0.26 to 0.50]).

Appendix N: PMR Classification Criteria Scoring Algorithm

Per 2012 EULAR/ACR Provisional Classification Criteria for PMR required criteria: age ≥ 50 years, bilateral shoulder aching, and abnormal CRP and/or ESR. A score of 4 or more is categorized a PMR in the algorithm without ultrasound (US) and a score of 5 or more is categorized as PMR in the algorithm with US.

Category	Points without US (0-6)	Points with US (0-8)
Morning stiffness duration > 45 minutes	2	2
Hip pain or limited range of motion	1	1
Absence of rheumatoid factor (RA) or anti-citrullinated protein antibody (ACPA)	2	2
Absence of other joint involvement	1	1
At least 1 shoulder with subdeltoid bursitis and/or biceps tenosynovitis and/or glenohumeral synovitis (either posterior or axillary) and at least 1 hip with synovitis and/or trochanteric bursitis	N/A	1
Both shoulders with subdeltoid bursitis, biceps tenosynovitis, or glenohumeral synovitis	N/A	1

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen* **Maximum dose escalation allowed per prescriber information with documentation of inadequate response*	Maximum Maintenance Dose
Abatacept (Orencia)* **Also see Appendix G: Dose Rounding Guidelines for Weight-Based Doses*	RA	• 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
	PsA	*Adult:* 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) *Pediatric:* SC: • Weight 10 kg to < 25 kg: 50 mg once weekly • Weight 25 to < 50 kg: 87.5 mg once weekly Weight ≥ 50 kg: 125 mg once weekly	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
	aGVHD	• Age ≥ 2 years and < 6 years: 15 mg/kg on day before transplantation, followed by 12	1,000 mg/dose

Drug Name	Indication	Dosing Regimen* **Maximum dose escalation allowed per prescriber information with documentation of inadequate response*	Maximum Maintenance Dose
		mg/kg on Days 5, 14, and 28 after transplantation • Age ≥ 6 years: 10 mg/kg (up to 1,000 mg maximum dose) on day before transplantation, followed by 10 mg/kg (up to 1,000 mg maximum dose) on Days 5, 14, and 28 after transplantation	
Adalimumab and biosimilars (Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry)	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	**Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hyrimoz, Idacio:** Weight 10 kg (22 lbs) to < 15 kg (33 lbs): 10 mg SC every other week **Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Idacio, Simlandi, Yuflyma:** Weight 15 kg (33 lbs) to < 30 kg (66 lbs): 20 mg SC every other week **Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry:** Weight ≥ 30 kg (66 lbs): 40 mg SC every other week	40 mg every other week
	PsA AS	40 mg SC every other week	40 mg every other week
	CD	Initial dose: *Adults:* 160 mg SC on Day 1, then 80 mg SC on Day 15 *Pediatrics:* **Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Idacio, Simlandi, Yuflyma:** Weight 17 kg (37 lbs) to < 40 kg (88 lbs): 80 mg SC on Day 1, then 40 mg SC on Day 15	40 mg every other week

Drug Name	Indication	Dosing Regimen* **Maximum dose escalation allowed per prescriber information with documentation of inadequate response*	Maximum Maintenance Dose
		Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry: Weight ≥ 40 kg (88 lbs): 160 mg SC on Day 1, then 80 mg SC on Day 15 Maintenance dose: *Adults:* 40 mg SC every other week starting on Day 29 *Pediatrics:* **Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Idacio, Simlandi, Yuflyma:** Weight 17 kg (37 lbs) to < 40 kg (88 lbs): 20 mg SC every other week starting on Day 29 **Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry:** Weight ≥ 40 kg (88 lbs): 40 mg SC every other week starting on Day 29	
	UC	Initial dose: *Adults: 160* mg SC on Day 1, then 80 mg SC on Day 15 Maintenance dose: *Adults:* 40 mg SC every other week starting on Day 29	*Adults:* 40 mg every other week
	PsO	Initial dose: 80 mg SC Maintenance dose: 40 mg SC every other week starting one week after initial dose	40 mg every other week
	HS	**Humira, Amjevita, Cyltezo, Hyrimoz, Simlandi, Yuflyma:** *For patients 12 years of age and older weighing at least 30 kg:* Initial dose: 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	40 mg/week

Drug Name	Indication	Dosing Regimen* **Maximum dose escalation allowed per prescriber information with documentation of inadequate response*	Maximum Maintenance Dose
		Maintenance dose: Weight 30 kg (66 lbs) to < 60 kg (132 lbs): 40 mg every other week Weight ≥ 60 kg (132 lbs): 40 mg SC every week or 80 mg SC every other week starting on Day 29 **Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry:** Initial dose: *Adults:* 160 mg SC on day 1, then 80 mg SC on Day 15 Maintenance dose: *Adults:* 40 mg SC every week or 80 mg SC every other week starting on Day 29	
	UV	**Humira, Amjevita, Cyltezo, Hyrimoz, Simlandi, Yuflyma:** *Pediatrics:* 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 ≥ 30 kg (66 lbs): 40 mg SC every other week **Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry:** *Adults:* Initial dose of 80 mg SC, followed by 40 mg SC every other week starting one week after the initial dose	40 mg every other week

<table>
<tr><th>Drug Name</th><th>Indication</th><th>Dosing Regimen*
*Maximum dose escalation allowed per prescriber information with documentation of inadequate response</th><th>Maximum Maintenance Dose</th></tr>
<tr><td>Adalimumab (Humira)</td><td>Pediatric UC</td><td><u>Initial dose:</u>
Pediatrics:<table><tr><th>Weight</th><th>Days 1 through 15</th></tr><tr><td>20 kg to less than 40 kg</td><td>Day 1: 80 mg
Day 8: 40 mg
Day 15: 40 mg</td></tr><tr><td>40 kg and greater</td><td>Day 1: 160 mg (single dose or split over two consecutive days
Day 8: 80 mg
Day 15: 80 mg</td></tr></table>
Pediatrics:<table><tr><th>Weight</th><th>Starting on Day 29*</th></tr><tr><td>20 kg to less than 40 kg</td><td>40 mg every other week or 20 mg every week</td></tr><tr><td>40 kg and greater</td><td>80 mg every other week or 40 mg every week</td></tr></table>*Continue the recommended pediatric dosage in patients who turn 18 years of age and who are well-controlled on Humira regimen.</td><td>Pediatrics: 80 mg every other week or 40 mg every week</td></tr>
<tr><td rowspan="3">Anakinra (Kineret)*

*Also see Appendix G: Dose Rounding Guidelines for Weight-Based Doses</td><td>RA</td><td>100 mg SC QD</td><td>100 mg/day</td></tr>
<tr><td>NOMID</td><td><u>Initial dose:</u>
1 – 2 mg/kg SC QD or divided BID
<u>Maintenance dose:</u>
8 mg/kg SC QD or divided BID</td><td>8 mg/kg/day</td></tr>
<tr><td>DIRA</td><td><u>Initial dose:</u>
1 – 2 mg/kg SC QD
<u>Maintenance dose:</u>
Adjust doses in 0.5 to 1 mg/kg increments.</td><td>8 mg/kg/day</td></tr>
<tr><td>Apremilast (Otezla, Otezla XR)</td><td>BD</td><td><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

<u>Maintenance dose:</u>
Day 6 and thereafter:
• Otezla: 30 mg PO BID</td><td>• Otezla: 60 mg/day
• Otezla XR: 75 mg/day</td></tr>
</table>

Drug Name	Indication	Dosing Regimen* **Maximum dose escalation allowed per prescriber information with documentation of inadequate response*	Maximum Maintenance Dose
		• Otezla XR: 75 mg PO QD	
	PsA, PsO	**Adults:** Initial dose: Otezla only: 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 Maintenance dose: Day 6 and thereafter: • Otezla: 30 mg PO BID • Otezla XR: 75 mg PO QD **Pediatric:** Otezla only: *Weight ≥ 50 kg:* Initial dose: 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 Maintenance dose: Day 6 and thereafter: • Otezla: 30 mg PO BID • Otezla XR: 75 mg PO QD *Weight 20 kg to < 50 kg:* Initial dose: 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	Adults: • Otezla: 60 mg/day • Otezla XR: 75 mg/day Pediatric: *Weight ≥ 50 kg:* • Otezla: 60 mg/day • Otezla XR: 75 mg/day *Weight 20 kg to < 50 kg:* 40 mg/day

Drug Name	Indication	Dosing Regimen* **Maximum dose escalation allowed per prescriber information with documentation of inadequate response*	Maximum Maintenance Dose
		Day 5: 20 mg PO QAM and 20 mg PO QPM Maintenance dose: Day 6 and thereafter, Otezla only: 20 mg PO BID	
Baricitinib (Olumiant)	RA	2 mg PO QD	2 mg/day
Bimekizumab-bkzx (Bimzelx)	PsO (with or without coexist PsA)	320 mg (given as 2 SC injections of 160 mg each) at Weeks 0, 4, 8, 12, and 16, then every 8 weeks thereafter For patients weighing ≥ 120 kg, consider a dosage of 320 mg every 4 weeks after Week 16.	320 mg/8 weeks (after loading doses) Weight ≥ 120 kg: 320 mg/4 weeks (after loading doses)
	AS nr-axSpA PsA	160 mg SC every 4 weeks	160 mg/4 weeks
	HS	320 mg SC at Weeks 0, 2, 4, 6, 8, 10, 12, 14, and 16, then every 4 weeks thereafter	320 mg/4 weeks (after loading doses)
Brodalumab (Siliq)	PsO	Initial dose: 210 mg SC at weeks 0, 1, and 2 Maintenance dose: 210 mg SC every 2 weeks	210 mg every 2 weeks
Certolizumab (Cimzia)	CD	Initial dose: 400 mg SC at 0, 2, and 4 weeks Maintenance dose: 400 mg SC every 4 weeks	400 mg every 4 weeks
	RA PsA AS nr-axSpA	Initial dose: 400 mg SC at 0, 2, and 4 weeks Maintenance dose: 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 ≤ 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

Drug Name	Indication	Dosing Regimen* **Maximum dose escalation allowed per prescriber information with documentation of inadequate response*	Maximum Maintenance Dose
	pJIA	Loading dose: • Weight 10 kg (22 lbs) to < 20 kg (44 lbs): 100 mg SC at week 0, 2, and 4 • Weight 20 kg (44 lbs) to < 40 kg (88 lbs): 200 mg SC at week 0, 2, and 4 • Weight ≥ 40 kg (88 lbs): 400 mg SC at week 0, 2, and 4 Maintenance dose: • Weight 10 kg (22 lbs) to < 20 kg (44 lbs): 50 mg SC at week 6 and every 2 weeks thereafter • Weight 20 kg (44 lbs) to < 40 kg (88 lbs): 100 mg SC at week 6 and every 2 weeks thereafter Weight ≥ 40 kg (88 lbs): 200 mg SC at week 6 and every 2 weeks thereafter	200 mg every 2 weeks
Deucravacitinib (Sotyktu)	PsO	6 mg PO daily	6 mg/day
Etanercept (Enbrel)* **Also see Appendix G: Dose Rounding Guidelines for Weight-Based Doses*	RA	25 mg SC twice weekly or 50 mg SC once weekly	50 mg/week
	PsA	*Adults:* 25 mg SC twice weekly or 50 mg SC once weekly *Pediatrics:* Weight < 63 kg: 0.8 mg/kg SC once weekly Weight ≥ 63 kg: 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 ≥ 63 kg: 50 mg SC once weekly	50 mg/week
	PsO*	*Adults:* Initial dose: 50 mg SC twice weekly for 3 months Maintenance dose: 50 mg SC once weekly	50 mg/week

Drug Name	Indication	Dosing Regimen* **Maximum dose escalation allowed per prescriber information with documentation of inadequate response*	Maximum Maintenance Dose
		Pediatrics: Weight < 63 kg: 0.8 mg/kg SC once weekly Weight ≥ 63 kg: 50 mg SC once weekly	
Etrasimod (Velsipity)	UC	2 mg PO QD	2 mg/day
Golimumab (Simponi)	AS PsA RA	50 mg SC once monthly	50 mg/month
	UC	Adults and pediatric patients 40 kg and greater: • Initial dose: 200 mg SC at Week 0, then 100 mg SC at Week 2 • Maintenance dose: 100 mg SC every 4 weeks Pediatric patients at least 15 kg to less than 40 kg: • Initial dose: 100 mg SC at Week 0, then 50 mg SC at Week 2 • Maintenance dose: 50 mg SC every 4 weeks	100 mg every 4 weeks
Golimumab (Simponi Aria)* **Also see Appendix G: Dose Rounding Guidelines for Weight-Based Doses*	AS PsA RA	Initial dose: 2 mg/kg IV at weeks 0 and 4 Maintenance dose: 2 mg/kg IV every 8 weeks	2 mg/kg every 8 weeks
	pJIA PsA (pediatric)	Initial dose: 80 mg/m^2 at weeks 0 and 4 Maintenance dose: 80 mg/m^2 IV every 8 weeks	80 mg/m^2 IV every 8 weeks
Guselkumab (Tremfya)	CD, UC	Induction: 200 mg IV at weeks 0, 4, and 8, or 400 mg SC at weeks 0, 4, and 8 Maintenance: 100 mg SC at week 16, and every 8 weeks thereafter, or 200 mg SC at week 12, and every 4 weeks thereafter	200 mg/4 weeks

Drug Name	Indication	Dosing Regimen* **Maximum dose escalation allowed per prescriber information with documentation of inadequate response*	Maximum Maintenance Dose
	PsA PsO	Initial dose: 100 mg SC at weeks 0 and 4 Maintenance dose: 100 mg SC every 8 weeks	100 mg every 8 weeks
	UC	Induction: 200 mg IV at weeks 0, 4, and 8 Maintenance: 100 mg SC at week 16, and every 8 weeks thereafter or 200 mg SC at week 12, and every 4 weeks thereafter	200 mg/4 weeks
Infliximab (Avsola, Inflectra, Remicade, Renflexis, Zymfentra)* **Also see Appendix G: Dose Rounding Guidelines for Weight-Based Doses*	CD, UC	Initial dose: **Avsola, Inflectra, Remicade, Renflexis:** *Adults/Pediatrics:* 5 mg/kg IV at weeks 0, 2 and 6 Maintenance dose: **Avsola, Inflectra, Remicade, Renflexis:** *Adults/Pediatrics:* 5 mg/kg IV every 8 weeks. *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** **Zymfentra:** *Adults:* 120 mg SC every 2 weeks starting at week 10	CD, Adults: 10 mg/kg IV every 8 weeks or 120 mg SC every 2 weeks UC, Adults: 5 mg/kg IV every 8 weeks or 120 mg SC every 2 weeks Pediatrics: 5 mg/kg IV every 8 weeks
	PsA PsO	Initial dose: 5 mg/kg IV at weeks 0, 2 and 6 Maintenance dose: 5 mg/kg IV every 8 weeks	5 mg/kg every 8 weeks
	RA	In conjunction with MTX Initial dose: 3 mg/kg IV at weeks 0, 2 and 6 Maintenance dose: 3 mg/kg IV every 8 weeks	10 mg/kg every 4 weeks

<table>
<tr><th>Drug Name</th><th>Indication</th><th>Dosing Regimen*
*Maximum dose escalation allowed per prescriber information with documentation of inadequate response</th><th>Maximum Maintenance Dose</th></tr>
<tr><td></td><td></td><td>Some patients may benefit from increasing the dose up to 10 mg/kg or treating as often as every 4 weeks*</td><td></td></tr>
<tr><td></td><td>AS</td><td><u>Initial dose:</u>
5 mg/kg IV at weeks 0, 2 and 6
<u>Maintenance dose:</u>
5 mg/kg IV every 6 weeks</td><td>5 mg/kg every 6 weeks</td></tr>
<tr><td></td><td>Kawasaki disease (off-label)</td><td>Single infusion of 10 mg/kg given over 2 hours</td><td>10 mg/kg</td></tr>
<tr><td>Ixekizumab (Taltz)</td><td>PsO (with or without coexistent PsA)</td><td><u>Adults:</u>
<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
<u>Maintenance dose:</u>
80 mg SC every 4 weeks

<u>Pediatrics (ages 6 to 17 years):</u>
<table>
<tr><th>Pediatric Patient's Weight</th><th>Starting Dose (Week 0)</th><th>Dose every 4 weeks (Q4W) Thereafter</th></tr>
<tr><td>> 50 kg</td><td>160 mg (two 80 mg injections)</td><td>80 mg</td></tr>
<tr><td>25 to 50 kg</td><td>80 mg</td><td>40 mg</td></tr>
<tr><td>< 25 kg</td><td>40 mg</td><td>20 mg</td></tr>
</table></td><td>80 mg every 4 weeks</td></tr>
<tr><td></td><td>PsA, AS</td><td><u>Initial dose:</u> 160 mg (two 80 mg injections) SC at week 0
<u>Maintenance dose:</u>
80 mg SC every 4 weeks</td><td>80 mg every 4 weeks</td></tr>
<tr><td></td><td>nr-axSpA</td><td><u>80 mg SC every 4 weeks</u></td><td>80 mg every 4 weeks</td></tr>
<tr><td>Mirikizumab-mrkz (Omvoh)</td><td>CD</td><td><u>Induction dose:</u>
900 mg IV at Weeks 0, 4, and 8

<u>Maintenance dose:</u>
300 mg SC at Week 12, and every 4 weeks</td><td>300 mg/4 weeks (after loading doses)</td></tr>
<tr><td></td><td>UC</td><td><u>Induction dose:</u>
300 mg IV at Weeks 0, 4, and 8</td><td>200 mg/4 weeks (after</td></tr>
</table>

Drug Name	Indication	Dosing Regimen* **Maximum dose escalation allowed per prescriber information with documentation of inadequate response*	Maximum Maintenance Dose
		Maintenance dose: 200 mg SC at Week 12, and every 4 weeks	loading doses)
Natalizumab (Tysabri) and its biosimilar natalizumab-sztn (Tyruko)	MS, CD	300 mg IV every 4 weeks	300 mg/4 weeks
Ozanimod (Zeposia)	MS, UC	Days 1-4: 0.23 mg PO QD Days 5-7: 0.46 mg PO QD Day 8 and thereafter: 0.92 mg PO QD	0.92 mg/day
Risankizumab-rzaa (Skyrizi)	PsO, PsA	150 mg SC at weeks 0, 4, and every 12 weeks thereafter	150 mg/12 weeks
	CD	Induction: 600 mg IV at Week 0, Week 4 and Week 8 Maintenance: 180 mg or 360 mg SC at Week 12 and every 8 weeks thereafter	IV: 600 mg/dose SC: 360 mg every 8 weeks
	UC	Induction: 1,200 mg IV at Week 0, Week 4 and Week 8 Maintenance: 180 mg or 360 mg SC at Week 12 and every 8 weeks thereafter	IV: 1,200 mg/dose SC: 360 mg every 8 weeks
Sarilumab (Kevzara)	RA, PMR, pJIA	200 mg SC once every two weeks	200 mg/2 weeks
Secukinumab (Cosentyx)	PsO (with or without PsA)	Adults: 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) Pediatric patients age 6 to 17 years and weight < 50 kg (PsO only): 75 mg SC at weeks 0, 1, 2, 3 and 4, followed by maintenance dose of 75 mg every 4 weeks Pediatric patients age 6 to 17 years and weight ≥ 50 kg (PsO only): 150 mg SC at weeks 0, 1, 2, 3 and 4, followed by maintenance dose of 150 mg every 4 weeks	Adults: 300 mg every 4 weeks Pediatric patients: 150 mg every 4 weeks

Drug Name	Indication	Dosing Regimen* **Maximum dose escalation allowed per prescriber information with documentation of inadequate response*	Maximum Maintenance Dose
	PsA	Adults: SC: • 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: 300 mg every 4 weeks and documentation supports inadequate response to a ≥ 3 consecutive month trial of 150 mg every 4 weeks or member has coexistent PsO** IV: • With loading dose: 6 mg/kg IV at week 0, followed by 1.75 mg/kg IV every 4 weeks. • Without loading dose: 1.75 mg/kg IV every 4 weeks. Pediatric: SC: • Pediatric patients age 2 to 17 years and weight ≥ 15 kg and < 50 kg: 75 mg SC at weeks 0, 1, 2, 3, and 4, followed by maintenance dose of 75 mg every 4 weeks. • Pediatric patients age 2 to 17 years old and weight ≥ 50 kg: 150 mg SC at weeks 0, 1, 2, 3, and 4, followed by a maintenance dose of 150 mg every 4 weeks.	Adults: 300 mg every 4 weeks Pediatric patients: 150 mg every 4 weeks
	AS, nr-axSpA	SC: • 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. *For AS only: 300 mg every 4 weeks, if documentation supports inadequate response to a ≥ 3 consecutive month trial of 150 mg every 4 weeks**	300 mg every 4 weeks nr-axSpA (SC): 150 mg every 4 weeks (after loading doses)

Drug Name	Indication	Dosing Regimen* **Maximum dose escalation allowed per prescriber information with documentation of inadequate response*	Maximum Maintenance Dose
		IV: • With loading dose: 6 mg/kg IV at week 0, followed by 1.75 mg/kg IV every 4 weeks. Without loading dose: 1.75 mg/kg IV every 4 weeks.	
	ERA	• Weight > 15 kg and < 50 kg: 75 mg at weeks 0, 1, 2, 3, and 4, followed by maintenance dose of 75 mg every 4 weeks • Weight ≥ 50 kg: 150 mg at weeks 0, 1, 2, 3, and 4, followed by maintenance dose of 150 mg every 4 weeks	Maintenance: • weight < 50 kg: 75 mg every 4 weeks • weight ≥ 50 kg: 150 mg every 4 weeks
	HS	300 mg SC at weeks 0, 1, 2, 3, and 4, followed by maintenance dose of 300 mg every 4 weeks *Consider increasing the dosage to 300 mg every 2 weeks if patient does not adequately respond**	300 mg every 2 weeks
Tildrakizumab-asmn (Ilumya)	PsO	Initial dose: 100 mg SC at weeks 0 and 4 Maintenance dose: 100 mg SC every 12 weeks Ilumya should only be administered by a healthcare professional.	100 mg every 12 weeks
Tocilizumab (Actemra)* and biosimilars (Avtozma, Tofidence, Tyenne)* **Also see Appendix G: Dose Rounding Guidelines for Weight-Based Doses*	PJIA	**Actemra, Avtozma, Tofidence, Tyenne:** • Weight < 30 kg: 10 mg/kg IV every 4 weeks • Weight ≥ 30 kg: 8 mg/kg IV every 4 weeks *See Appendix G for dose rounding guidelines* **Actemra, Avtozma, Tyenne:** • Weight < 30 kg: 162 mg SC every 3 weeks • Weight ≥ 30 kg: 162 mg SC every 2 weeks	IV: 10 mg/kg every 4 weeks SC: 162 mg every 2 weeks
	RA	**Actemra, Avtozma, Tofidence, Tyenne:** IV: 4 mg/kg every 4 weeks followed by an increase to 8 mg/kg every 4 weeks based on clinical response	IV: 800 mg every 4 weeks

Drug Name	Indication	Dosing Regimen* **Maximum dose escalation allowed per prescriber information with documentation of inadequate response*	Maximum Maintenance Dose
		Actemra, Avtozma, Tyenne: 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	SC: 162 mg every week
	SJIA	**Actemra, Avtozma, Tofidence, Tyenne:** IV: • Weight < 30 kg: 12 mg/kg IV every 2 weeks • Weight ≥ 30 kg: 8 mg/kg IV every 2 weeks *See Appendix G for dose rounding guidelines* **Actemra, Avtozma, Tyenne:** SC: • Weight < 30 kg: 162 mg SC every 2 weeks • Weight ≥ 30 kg: 162 mg SC every	IV: 12 mg/kg every 2 weeks SC: 162 mg every week
	GCA	**Actemra, Avtozma, Tofidence, Tyenne:** IV: 6 mg/kg every 4 weeks in combination with a tapering course of glucocorticoids **Actemra, Avtozma, Tyenne:** SC: 162 mg SC every week (every other week may be given based on clinical considerations)	IV: 6 mg/kg every 4 weeks SC: 162 mg every week
Tocilizumab (Actemra) and biosimilars (Avtozma, Tyenne)	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 tocilizumab may be administered. The interval between consecutive doses should be at least 8 hours.	IV: 800 mg/infusion, up to 4 doses
Tocilizumab (Actemra)	SSc-ILD	162 mg SC once weekly	SC: 162 mg every week
Tofacitinib (Xeljanz)	pJIA, PsA	• 10 kg ≤ body weight < 20 kg: 3.2 mg (3.2 mL oral solution) PO BID • 20 kg ≤ body weight < 40 kg: 4 mg (4 mL oral solution) PO BID • Body weight ≥ 40 kg: 5 mg (5 mL oral solution) PO BID	10 mg/day

Drug Name	Indication	Dosing Regimen* **Maximum dose escalation allowed per prescriber information with documentation of inadequate response*	Maximum Maintenance Dose
	RA AS	5 mg PO BID	
	UC	Induction: 10 mg PO BID for 8 weeks, up to 16 weeks Maintenance: 5 mg PO BID	Induction: 20 mg/day Maintenance: 10 mg/day
Tofacitinib extended-release (Xeljanz XR)	PsA RA AS	11 mg PO QD	11 mg/day
	UC	Induction: 22 mg PO QD for 8 weeks, up to 16 weeks Maintenance: 11 mg PO QD	Induction: 22 mg/day Maintenance: 11 mg/day
Upadacitinib (Rinvoq)	AS, nr-axSpA, RA	15 mg PO QD	15 mg/day
	GCA	15 mg PO QD in combination with a tapering course of corticosteroids 15 mg PO QD can be used as monotherapy following discontinuation of corticosteroids	15 mg/day
	AD	Age ≥ 12 years and ≥ 40 kg but < 65 years: 15 mg PO QD; if an adequate response is not achieved, consider increasing the dosage to 30 mg PO QD Age ≥ 65 years: 15 mg PO QD *If member's age < 65 years:* *if an adequate response is not achieved, consider increasing the dosage to 30 mg PO QD**	Age ≥ 12 years and ≥ 40 kg but < 65 years: 30 mg/day Age ≥ 65 years: 15 mg/day
	UC	• Induction: 45 mg PO Q for 8 weeks • Maintenance: 15 mg PO QD *A dosage of 30 mg PO QD may be considered for patients with refractory, severe, or extensive disease.**	30 mg/day
	CD	• Induction: 45 mg PO Q for 12 weeks	30 mg/day

Drug Name	Indication	Dosing Regimen* **Maximum dose escalation allowed per prescriber information with documentation of inadequate response*	Maximum Maintenance Dose
		• Maintenance: 15 mg PO QD *A dosage of 30 mg PO QD may be considered for patients with refractory, severe, or extensive disease.**	
	PsA	Age ≥ 18 years: 15 mg PO QD Age ≥ 2 years but < 18 years: Weight ≥ 30 kg: 15 mg PO QD	15 mg/day
	pJIA	Age ≥ 2 years: Weight ≥ 30 kg: 15 mg PO QD	15 mg/day
Upadacitinib (Rinvoq LQ)	PsA	Age ≥ 2 years but < 18 years: • Weight 10 kg to < 20 kg: 3 mg (3 mL oral solution) PO BID • Weight 20 kg to < 30 kg: 4 mg (4 mL oral solution) PO BID • Weight ≥ 30 kg: 6 mg (6 mL oral solution) PO BID	12 mg/day
	pJIA	Age ≥ 2 years: • Weight 10 kg to < 20 kg: 3 mg (3 mL oral solution) PO BID • Weight 20 kg to < 30 kg: 4 mg (4 mL oral solution) PO BID • Weight ≥ 30 kg: 6 mg (6 mL oral solution) PO BID	12 mg/day
Ustekinumab (Stelara), ustekinumab-srlf (Imuldosa), ustekinumab-aauz (Otulfi), ustekinumab-ttwe (Pyzchiva), ustekinumab-aekn (Selarsdi), ustekinumab-hmny (Starjemza), ustekinumab-stba	PsO	Weight based dosing SC at weeks 0 and 4, followed by maintenance dose every 12 weeks *Adult:* Weight ≤ 100 kg: 45 mg Weight > 100 kg: 90 mg *Pediatrics (age 6 years to 17 years):* **Stelara, Otulfi, Pyzchiva, Starjemza, Steqeyma, Wezlana, Yesintek:** Weight < 60 kg: 0.75 mg/kg **Stelara, Imuldosa, Otulfi, Pyzchiva, Selarsdi, Starjemza, Steqeyma, Wezlana, Yesintek:**	90 mg every 12 weeks

Drug Name	Indication	Dosing Regimen* **Maximum dose escalation allowed per prescriber information with documentation of inadequate response*	Maximum Maintenance Dose
(Steqeyma), ustekinumab-auub (Wezlana), ustekinumab-kfce (Yesintek) **Also see Appendix G: Dose Rounding Guidelines for Weight-Based Doses*		Weight 60 to 100 kg: 45 mg Weight > 100 kg: 90 mg	
	PsA	Weight based dosing SC at weeks 0 and 4, followed by maintenance dose every 12 weeks *Adult:* 45 mg SC at weeks 0 and 4, followed by 45 mg every 12 weeks *Pediatrics (age 6 years to 17 years):* Weight based dosing SC at weeks 0 and 4, then every 12 weeks thereafter. **Stelara, Otulfi, Pyzchiva, Starjemza, Steqeyma, Wezlana, Yesintek:** Weight < 60 kg: 0.75 mg/kg **Stelara, Imuldosa, Otulfi, Pyzchiva, Selarsdi, Starjemza, Steqeyma, Wezlana, Yesintek:** Weight ≥ 60 kg: 45 mg	45 mg every 12 weeks
	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, UC	Weight based dosing IV at initial dose: Weight ≤ 55 kg: 260 mg Weight > 55 kg to 85 kg: 390 mg Weight > 85 kg: 520 mg Maintenance dose: 90 mg SC every 8 weeks	90 mg every 8 weeks
Vedolizumab (Entyvio)	CD, UC	Initial dose: 300 mg IV at weeks 0 and 2, followed by 300 mg IV or 108 mg SC at week 6 Maintenance dose: 300 mg IV every 8 weeks or 108 mg SC every 2 weeks	IV: 300 mg every 8 weeks SC: 108 mg every 2 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
Adalimumab-afzb (Abrilada)	**Single-dose prefilled pen (Abrilada Pen):** 40 mg/0.8 mL **Single dose prefilled syringe:** 40 mg/0.8 mL, 20 mg/0.4 mL, 10 mg/0.2 mL **Single-dose glass vial for institutional use only:** 40 mg/0.8 mL
Adalimumab-atto (Amjevita)	**Single-dose prefilled SureClick autoinjector:** 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
Adalimumab-adbm (Cyltezo)	**Single-dose prefilled syringe:** 40 mg/0.4 mL, 40 mg/0.8 mL, 20 mg/0.4 mL, 10 mg/ 0.2 mL **Single-dose prefilled pen (Cyltezo Pen):** 40 mg/0.4 mL, 40 mg/0.8 mL
Adalimumab-bwwd (Hadlima)	**Single-dose prefilled autoinjector (Hadlima PushTouch):** 40 mg/0.8 mL, 40 mg/0.4 mL (citrate-free) **Single-dose prefilled syringe:** 40 mg/0.8 mL, 40 mg/0.4 mL (citrate-free) **Single-dose glass vial for institutional use only:** 40 mg/0.8 mL
Adalimumab-fkjp (Hulio)	**Single-dose prefilled pen (Hulio Pen):** 40 mg/0.8 mL **Single-dose prefilled syringe:** 40 mg/0.8 mL, 20 mg/0.4 mL
Adalimumab-adaz (Hyrimoz)	**Single-dose prefilled glass syringe (with BD UltraSafe Passive™ Needle Guard):** 20 mg/0.4 mL, 40 mg/0.8 mL, 40 mg/0.4 mL, 80 mg/0.8 mL **Single-dose prefilled pen (Sensoready® Pen):** 40 mg/0.8 mL, 40 mg/0.4 mL, 80 mg/0.8 mL **Single-dose prefilled glass syringe:** 10 mg/0.2 mL, 10 mg/0.1 mL, 20 mg/0.2 mL
Adalimumab-aacf (Idacio)	**Single-dose prefilled pen (Idacio Pen):** 40 mg/0.8 mL **Single-dose prefilled glass syringe:** 40 mg/0.8 mL **Single-dose institutional use vial kit:** 40 mg/0.8 mL
Adalimumab-ryvk (Simlandi)	**Single-dose autoinjector:** 40 mg/0.4 mL, 80 mg/0.8 mL **Single-dose prefilled glass syringe:** 20 mg/0.2 mL, 40 mg/0.4 mL, 80 mg/0.8 mL
Adalimumab-aaty (Yuflyma)	**Single-dose prefilled auto-injector (Yuflyma AI):** 40 mg/0.4 mL, 80 mg/0.8 mL

Drug Name	Availability
	Single-dose prefilled syringe with safety guard: 40 mg/0.4 mL, 80 mg/0.8 mL **Single-dose prefilled syringe:** 20 mg/0.2 mL, 40 mg/0.4 mL, 80 mg/0.8 mL
Adalimumab-aqvh (Yusimry)	**Single-dose prefilled pen (Yusimry Pen):** 40 mg/0.8 mL **Single-dose prefilled glass syringe:** 40 mg/0.8 mL
Anakinra (Kineret)	**Single-use prefilled syringe**: 100 mg/0.67 mL
Apremilast (Otezla, Otezla XR)	**Immediate-release tablets:** 10 mg, 20 mg, 30 mg **Extended-release tablet**: 75 mg **Treatment initiation pack**: 28-day starter pack of 10 mg, 20 mg, 30 mg tablets
Baricitinib (Olumiant)	**Tablet:** 1 mg, 2 mg
Bimekizumab-bkzx (Bimzelx)	**Single-dose prefilled syringe:** 160 mg/mL, 320 mg/2 mL **Single-dose prefilled autoinjector:** 160 mg/mL, 320 mg/2 mL
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
Deucravacitinib (Sotyktu)	**Tablet:** 6 mg
Etanercept (Enbrel)	**Single-dose prefilled syringe:** 25 mg/0.5 mL, 50 mg/mL **Single-dose prefilled SureClick® Autoinjector**: 50 mg/mL **Single-dose vial:** 25 mg/0.5 mL **Multi-dose vial for reconstitution:** 25 mg **Enbrel Mini™ single-dose prefilled cartridge for use with AutoTouch™ reusable autoinjector**: 50 mg/mL
Etrasimod (Velsipity)	**Tablet:** 2 mg
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
Golimumab (Simponi Aria)	**Single-use vial:** 50 mg/4 mL
Infliximab-axxq (Avsola)	**Single-use vial**: 100 mg/20 mL
Infliximab-dyyb (Inflectra)	**Single-use vial**: 100 mg/20 mL
Infliximab-dyyb (Zymfentra)	**Single-dose prefilled syringe:** 120 mg/mL **Single-dose prefilled syringe with needle shield:** 120 mg/mL **Single-dose prefilled pen:** 120 mg/mL
Infliximab (Remicade)	**Single-use vial**: 100 mg/20 mL
Infliximab-abda (Renflexis)	**Single-use vial:** 100 mg/20 mL

Drug Name	Availability
Ixekizumab (Taltz)	**Single-dose prefilled autoinjector**: 80 mg/mL **Single-dose prefilled syringe**: 20 mg/0.25 mL, 40 mg/0.5 mL, 80 mg/mL
Guselkumab (Tremfya)	**Single-dose prefilled syringe for SC:** 100 mg/mL, 200 mg/2 mL **Single-dose One-Press pen-injector for SC**: 100 mg/mL **Single-dose prefilled pen (Tremfya Pen) for SC:** 100 mg/mL, 200 mg/2 mL **Single-dose vial for IV:** 200 mg/20 mL
Mirikizumab-mrkz (Omvoh)	**Single-dose vial (for intravenous infusion):** 300 mg/15 mL (20 mg/mL) **Single-dose prefilled pen (for subcutaneous use):** 100 mg/mL, 200 mg/2 mL **Single-dose prefilled syringe (for subcutaneous use):** 100 mg/mL, 200 mg/2 mL
Natalizumab-sztn (Tyruko)	**Single-dose vial**: 300 mg/15 mL
Natalizumab-sztn (Tyruko)	**Single-dose vial**: 300 mg/15 mL
Natalizumab (Tysabri)	**Single-use vial**: 300 mg/15 mL
Ozanimod (Zeposia)	**Oral capsules:** 0.23 mg, 0.46 mg, 0.92 mg
Risankizumab-rzaa (Skyrizi)	*Subcutaneous injection* **Single-dose prefilled syringe:** 90 mg/mL, 150 mg/mL, 180 mg/1.2 mL **Single-dose prefilled pen:** 150 mg/mL **Single-dose prefilled cartridge:** 180 mg/1.2 mL, 360 mg/2.4 mL *Intravenous infusion* **Single-dose vial:** 600 mg/10 mL
Sarilumab (Kevzara)	**Single-dose prefilled syringes/pens:** 150 mg/1.14 mL, 200 mg/1.14 mL
Secukinumab (Cosentyx)	**Single-dose UnoReady pen:** 300 mg/2 mL **Single-dose Sensoready® pen:** 150 mg/mL **Single-dose prefilled syringe:** 75 mg/0.5 mL, 150 mg/mL, 300 mg/2 mL **Single-dose vial (for IV infusion):** 125 mg/5 mL
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
Tocilizumab-aazg (Tyenne)	**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
Tocilizumab-anoh (Avtozma)	**Single-dose 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

Drug Name	Availability
Tocilizumab-bavi (Tofidence)	**Single-dose vial:** 80 mg/4 mL, 200 mg/10 mL, 400 mg/20 mL
Tofacitinib (Xeljanz)	**Tablets**: 5 mg, 10 mg **Oral solution**: 1 mg/mL
Tofacitinib extended-release (Xeljanz XR)	**Tablets**: 11 mg, 22 mg
Upadacitinib (Rinvoq)	**Tablets, extended-release:** 15 mg, 30 mg, 45 mg
Upadacitinib (Rinvoq LQ)	**Oral solution:** 1 mg/mL
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)
Ustekinumab-aauz (Otulfi)	**Single-dose prefilled syringe for SC injection:** 45 mg/0.5 mL, 90 mg/mL **Single-dose vial for SC injection:** 45 mg/0.5 mL **Single-dose vial for IV infusion:** 130 mg/26 mL
Ustekinumab-aekn (Selarsdi)	**Single-dose prefilled syringe for SC injection:** 45 mg/0.5 mL, 90 mg/mL **Single-dose vial for IV infusion:** 130 mg/26 mL
Ustekinumab-auub (Wezlana)	**Single-dose prefilled syringe for SC injection:** 45 mg/0.5 mL, 90 mg/mL **Single-dose vial for SC injection:** 45 mg/0.5 mL **Single-dose prefilled autoinjector (ConfiPen) for SC injection:** 45 mg/0.5 mL, 90 mg/mL **Single-dose vial for IV infusion:** 130 mg/26 mL
Ustekinumab-hmny (Starjemza)	**Single-dose prefilled syringe for SC injection:** 45 mg/0.5 mL, 90 mg/mL **Single-dose vial for SC injection:** 45 mg/0.5 mL **Single-dose vial for IV infusion:** 130 mg/26 mL
Ustekinumab-kfce (Yesintek)	**Single-dose prefilled syringe for SC injection:** 45 mg/0.5 mL, 90 mg/mL **Single-dose vial for SC injection:** 45 mg/0.5 mL **Single-dose vial for IV infusion:** 130 mg/26 mL
Ustekinumab-srlf (Imuldosa)	**Single-dose prefilled syringe for SC injection:** 45 mg/0.5 mL, 90 mg/mL **Single-dose vial for IV infusion:** 130 mg/26 mL
Ustekinumab-stba (Steqeyma)	**Single-dose prefilled syringe for SC injection:** 45 mg/0.5 mL, 90 mg/mL **Single-dose vial for SC injection:** 45 mg/0.5 mL **Single-dose vial for IV infusion:** 130 mg/26 mL
Ustekinumab-ttwe (Pyzchiva)	**Single-dose prefilled syringe for SC injection:** 45 mg/0.5 mL, 90 mg/mL **Single-dose vial for SC injection:** 45 mg/0.5 mL **Single-dose vial for IV infusion:** 130 mg/26 mL

Drug Name	Availability
Vedolizumab (Entyvio)	**Lyophilized powder in a single-dose vial for reconstitution for IV infusion:** 300 mg **Single-dose prefilled syringe for SC injection:** 108 mg/0.68 mL **Single-dose prefilled Entyvio Pen for SC injection:** 108 mg/0.68 mL

VII. References

Prescribing Information

1. Abrilada Prescribing Information. New York, NY: Pfizer Inc.; April 2024. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/761118Orig1s012lbl.pdf. Accessed February 27, 2025.
2. Actemra Prescriber Information. Incheon, Republic of Korea: Celltrion, Inc; July 2025. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761420s001lbledt.pdf. Accessed August 14, 2025.
3. Amjevita Prescribing Information. Thousand Oaks, CA: Amgen Inc.; October 2025. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761024s026lbl.pdf. Accessed October 24, 2025.
4. Avsola Prescribing Information. Thousand Oaks, CA: Amgen Inc.; September 2021. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/761086s001lbl.pdf. Accessed February 27, 2025.
5. Avtozma Prescriber Information. Incheon, Republic of Korea: Celltrion, Inc; July 2025. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761420s001lbledt.pdf. Accessed August 14, 2025.
6. Bimzelx Prescriber Information. Smyrna, GA: UCB, Inc; November 2024. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/761151s010lbl.pdf. Accessed February 28, 2025.
7. Cimzia Prescribing Information. Smyrna, GA: UCB, Inc.; September 2024. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/125160s275lbl.pdf. Accessed February 27, 2025.
8. Cosentyx Prescribing Information. East Hanover, NJ: Novartis Pharmaceuticals Corporation; October 2024. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/125504Orig1s080,%20761349Orig1s005lbl.pdf. Accessed February 28, 2025.
9. Cyltezo Prescribing Information. Ridgefield, CT: Boehringer Ingelheim Pharmaceuticals, Inc.; October 2025. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761058s035lbl.pdf. Accessed October 28, 2025.
10. Enbrel Prescribing Information. Thousand Oaks, CA: Immunex Corporation: September 2024. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/103795s5600lbl.pdf. Accessed February 27, 2025.

11. Entyvio Prescribing Information. Deerfield, IL: Takeda Pharmaceuticals America Inc.; April 2024. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/761359s000lbl.pdf. Accessed February 28, 2025.
12. Hadlima Prescribing Information. Jersey City, NJ: Organon & Co.; June 2024. Available at: https://www.organon.com/product/usa/pi_circulars/h/hadlima/hadlima_pi.pdf. Accessed February 27, 2025.
13. Hulio Prescribing Information. Morgantown, WV: Myland Pharmaceuticals Inc.; February 2025. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761154s009lbl.pdf. Accessed February 27, 2025.
14. Humira Prescribing Information. North Chicago, IL: AbbVie, Inc.; November 2023. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/125057s423lbl.pdf. Accessed February 27, 2025.
15. Hyrimoz Prescribing Information. Princeton, NJ: Sandoz Inc.; October 2025. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761071s031lbl.pdf. Accessed October 28, 2025.
16. Idacio Prescribing Information. Lake Zurich, IL. Fresenius Kabi.; June 2024. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/761255s008lbl.pdf. Accessed February 27, 2025.
17. Ilumya Prescribing Information. Whitehouse Station, NJ: Merck & Co., Inc.; April 2024. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/761067s018lbl.pdf. Accessed February 28, 2025.
18. Imuldosa Prescribing Information. Raleigh, North Carolina: Accord BioPharm Inc.; October 2024. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/761364s000lbl.pdf. Accessed February 28, 2025.
19. Inflectra Prescribing Information. Lake Forest, IL: Hospira, a Pfizer Company; June 2021. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/125544s018lbl.pdf. Accessed February 27, 2025.
20. Kevzara Prescribing Information. Bridgewater, NJ: Sanofi-Aventis U.S. LLC; June 2024. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/761037s015lbl.pdf. Accessed February 27, 2025.
21. Kineret Prescribing Information. Stockholm, Sweden: Swedish Orphan Biovitrum AB; September 2024. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/103950s5198lbl.pdf. Accessed February 27, 2025.
22. Olumiant Prescribing Information. Indianapolis, IN: Eli Lilly and Company; June 2022. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/207924s004lbl.pdf. Accessed February 27, 2025.
23. Omvoh Prescribing Information. Indianapolis, IN; Eli Lilly and Company; January 2025. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761279s003lbl.pdf. Accessed February 6, 2025.

24. Orencia Prescribing Information. Princeton, NJ: Bristol-Meyers Squibb Company; May 2024. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/125118s255lbl.pdf. Accessed February 27, 2025.
25. Otezla/Otezla XR Prescribing Information. Summit, NJ: Amgen Inc.; August 2025. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/210745s000lbl.pdf. Accessed October 24, 2025.
26. Otulfi Prescribing Information. Lake Zurich, IL: Fresenius Kabi; March 2025. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761379Orig1s002lbl.pdf. Accessed April 3, 2025.
27. Pyzchiva Prescribing Information. Incheon, Republic of Korea: Samsung Bioepis Co; December 2024. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/761373s002,761425s002lbl.pdf. Accessed February 28, 2025.
28. Remicade Prescribing Information. Horsham, PA: Janssen Biotech, Inc.; October 2021. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/103772s5401lbl.pdf. Accessed February 27, 2025.
29. Renflexis Prescribing Information. Kenilworth, NJ: Merck & Co; December 2023. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/761054s021lbl.pdf. Accessed February 27, 2025.
30. Rinvoq/Rinvoq LQ Prescribing Information. North Chicago, IL: AbbVie Inc.; October 2025. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/211675Orig1s028,218347Orig1s005lbl.pdf. Accessed October 15, 2025.
31. Selarsdi Prescribing Information. Leesburg, VA: Alvotech USA Inc; October 2024. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/761343s001s003lbl.pdf. Accessed February 28, 2025.
32. Siliq Prescribing Information. Bridgewater, NJ: Valeant Pharmaceuticals North America LLC; August 2024. Available at: https://www.bauschhealth.com/Portals/25/Pdf/PI/Siliq-pi.pdf. Accessed February 28, 2025.
33. Simlandi Prescribing Information. Parsippany, NJ. Teva Pharmaceuticals.; October 2025. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761299s025lbl.pdf. Accessed October 28, 2025.
34. Simponi Prescribing Information. Horsham, PA; Janssen Biotech; October 2025. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/125289s157lbl.pdf. Accessed October 15, 2025.
35. Simponi Aria Prescribing Information. Horsham, PA; Janssen Biotech; February 2021. Available at: https://www.janssenlabels.com/package-insert/product-monograph/prescribing-information/SIMPONI+ARIA-pi.pdf. Accessed February 27, 2025.
36. Skyrizi Prescribing Information. North Chicago, IL: Abbvie Inc. September 2025. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761105s039,761262s011lbl.pdf. Accessed September 11, 2025.

37. Sotyktu Prescribing Information. Princeton, NJ: Bristol-Myers Squibb Company; September 2022. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/214958s000lbl.pdf. Accessed February 28, 2025.
38. Starjemza Prescribing Information. Guangzhou, Guangdong, China: Bio-Thera Solutions, Ltd; May 2025. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761419s000lbl.pdf. Accessed June 12, 2025.
39. Stelara Prescribing Information. Horsham, PA: Janssen Biotech; November 2024. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/125261s166,761044s014lbl.pdf. Accessed February 28, 2025.
40. Steqeyma Prescriber Information. Incheon, Republic of Korea. Celltrion Inc.; June 2025. Available at: https://cellhomeblob.blob.core.windows.net/pdf/2025_05_13_draft-labeling-text.pdf. Accessed June 25, 2025.
41. Taltz Prescribing Information. Indianapolis, IN: Eli Lilly and Company; August 2024. Available at: https://uspl.lilly.com/taltz/taltz.html#s11. Accessed February 28, 2025.
42. Tofidence Prescribing Information. Cambridge, MA: Biogen MA Inc; December 2024. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/761354s004lbl.pdf. Accessed February 27, 2025.
43. Tyenne Prescribing Information. Lake Zurich, IL: Fresenius Kabi USA, LLC; February 2025. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761275s008lbl.pdf. Accessed March 17, 2025.
44. Tremfya Prescribing Information. Horsham, PA: Janssen Biotech, Inc.; September 2025. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761061s028s029lbl.pdf. Accessed September 30, 2025.
45. Tyruko Prescribing Information. Princeton, NJ: Sandoz Inc; August 2023. Available at https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/761322s000lblcorrection.pdf. Accessed February 28, 2025.
46. Tysabri Prescribing Information. Cambridge, MA: Biogen Inc; October 2023. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/125104Orig1s980lbl.pdf. Accessed February 28, 2025.
47. Velsipity Prescribing Information. New York, NY: Pfizer Inc.; June 2024. Available at: https://labeling.pfizer.com/ShowLabeling.aspx?id=19776. Accessed February 27, 2025.
48. Wezlana Prescribing Information. Thousand Oaks, California: Amgen Inc.; December 2024. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/761285s001,761331s001lbl.pdf. Accessed February 28, 2025.
49. Xeljanz/Xeljanz XR Prescribing Information. New York, NY: Pfizer Labs; October 2025. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/203214s039,213082s011lbl.pdf. Accessed October 24, 2025.

50. Yesintek Prescribing Information. Cambridge, MA. Biocon Biologics Inc; November 2024. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/761406s000lbl.pdf. Accessed February 28, 2025.
51. Yuflyma Prescribing Information. Incheon, Republic of Korea. Celltrion, Inc.; October 2025. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761219s018lbl.pdf. Accessed October 28, 2025.
52. Yusimry Prescribing Information. Redwood City, CA. Coherus BioSciences, Inc.; September 2023. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/761216s004lbl.pdf. Accessed February 27, 2025.
53. Zeposia Prescribing Information. Summit, NJ: Celgene Corporation; August 2024. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/209899s011s012lbl.pdf. Accessed February 28, 2025.
54. Zymfentra Prescribing Information. Incheon, Republic of Korea: Celltrion, Inc; February 2024. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/761358Orig1s001lbl.pdf. Accessed February 27, 2025.

Castleman's Disease

55. Actemra. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed February 28, 2025.
56. Kapriniotis K, Lampridis S, Mitsos S, et al. Biologic agents in the treatment of multicentric Castleman Disease. *Turk Thorac J.* 2018; 19(4):220-5. DOI: 10.5152/TurkThoracJ.2018.18066.

Rheumatoid Arthritis

57. Aletaha D, Neogi T, Silman AJ, et al. 2010 Rheumatoid Arthritis Classification Criteria. *Arthritis and Rheumatism.* September 2010;62(9):2569-2581.
58. Beukelman T, Patkar NM, Saag KG, et al. 2011 American College of Rheumatology recommendations for the treatment of juvenile idiopathic arthritis: initiation and safety monitoring of therapeutic agents for the treatment of arthritis and systemic features. *Arthritis Care Res*. 2011; 63(4):465-482.
59. Fraenkel L, Bathon JM, England BR, et al. 2021 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. Arthritis Care & Research. 2021; 73(7):924-939. DOI 10.1002/acr.24596.
60. Onel KB, Horton DB, Lovell DJ, et al. 2021 American College of Rheumatology Guideline for the Treatment of Juvenile Idiopathic Arthritis: Therapeutic Approaches for Oligoarthritis, Temporomandibular Joint Arthritis, and Systemic Juvenile Idiopathic Arthritis. Arthritis & Rheumatology 2022; 74:553-569. DOI 10.1002/art.42037.
61. Smolen JS, Landewe RB, Dergstra SA, et al. 2022 update of the EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs. Arthritis Rheumatology. 2023 January; 32:3-18. DOI:10.1136/ard-2022-223356.
62. Dhaon P, Das SK, Srivastava R, et al. Performances of clinical disease activity index (CDAI) and simplified disease activity index (SDAI) appear to be better than the gold standard disease assessment score (DAS-28-CRP) to assess rheumatoid arthritis patients. *Int J Rheum Dis*. 2018; 21:1933-1939.

63. England BR, Tiong BK, and Bergman MJ, et al. 2019 Update of the American College of Rheumatology Recommended Rheumatoid Arthritis Disease Activity Measures. Arthritis Care Res (Hoboken). 2019 Dec;71(12):1540-1555. doi: 10.1002/acr.24042.

Axial Spondylitis

64. Boulos P, Dougados M, MacLeod SM, et al. Pharmacological Treatment of Ankylosing Spondylitis. *Drugs*. 2005; 65: 2111-2127.
65. Braun J, Davis J, Dougados M, et al. First update of the international ASAS consensus statement for the use of anti-TNF agents in patients with ankylosing spondylitis. *Ann Rheum Dis*. 2006;65:316-320.
66. Braun J, van den Berg R, Baraliako X, et al. 2010 Update of the ASAS/EULAR recommendations for the management of ankylosing spondylitis. *Ann Rheum Dis.* 2011; 70:896-904.
67. van der Heijde D, Ramiro S, Landewe R, et al. 2016 update of the ASAS-EULAR management recommendations for axial spondyloarthritis. *Ann Rheum Dis*. 2017;76:978-991. doi:10.1136/annrheumdis-2016-210770.
68. Zochling J, van der Heijde D, Burgos-Vargas, R, et al. ASAS/EULAR recommendations for the management of ankylosing spondylitis. *Ann Rheum Dis*. 2006;65:442-452.
69. Ward MM, Deodhar A, Gensler L, et al. 2019 Update of the American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network recommendations for the treatment of anklyosing spondylitis and nonradiographic axial spondyloarthritis. Arthritis & Rheumatology. 2019; 71(10):1599-1613. DOI 10.1002/ART.41042.
70. Ramiro S, Nikiphorou E, Sepriano A, et al. ASAS-EULAR recommendations for the management of axial spondyloarthritis: 2022 update. Ann Rheum Dis. 2023 Jan;82(1):19-34. doi: 10.1136/ard-2022-223296.

Crohn's Disease/Ulcerative Colitis

71. Feuerstein JD, Ho EY, Shmidt E, et al. AGA Clinical practice guidelines on the medical management of moderate to severe luminal and perianal fistulizing Crohn's disease. Gastroenterology 2021; 160:2496-2508. https://doi.org/10.1053/j.gastro.2021.04.022.
72. Feuerstein JD, Isaacs KL, Schneider Y, et al. AGA Clinical practice guidelines on the management of moderate to severe ulcerative colitis. Gastroenterology 2020;158:1450–1461. https://doi.org/10.1053/j.gastro.2020.01.006.
73. Lichtenstein GR, Loftus EV, Isaacs KL et al. ACG Clinical Guideline: Management of Crohn's Disease in Adults. Am J Gastroenterol. 2018 Apr;113(4):481-517. doi: 10.1038/ajg.2018.27.
74. Rubin DT, Ananthakrishnan AN, Siegel CA, Sauer BG, Long MD. ACG Clinical Guideline: Ulcerative Colitis in Adults. Am J Gastroenterol. 2019 March;114(3):384-413. doi: 10.14309/ajg.0000000000000152.
75. Ulcerative Colitis: Clinical Trial Endpoints Guidance for Industry. Silver Spring, MD. Food and Drug Administration.; July 2016. Available at: https://www.fda.gov/files/drugs/published/Ulcerative-Colitis--Clinical-Trial-Endpoints-Guidance-for-Industry.pdf. Accessed February 3, 2025.
76. Naegeli AN, Hunter T, Dong Y, et al. Full, Partial, and Modified Permutations of the Mayo Score: Characterizing Clinical and Patient-Reported Outcomes in Ulcerative Colitis Patients. Crohns Colitis 360. 2021 Feb 23;3(1):otab007. doi: 10.1093/crocol/otab007. PMID: 36777063; PMCID: PMC9802037.

77. Singh S, Loftus EV Jr, Limketkai BN, et al. AGA Living Clinical Practice Guideline on Pharmacological Management of Moderate-to-Severe Ulcerative Colitis. Gastroenterology. 2024 Dec;167(7):1307-1343. doi: 10.1053/j.gastro.2024.10.001. PMID: 39572132.
78. Buchner AM, Farraye FA, Iacucci M. AGA Clinical Practice Update on Endoscopic Scoring Systems in Inflammatory Bowel Disease: Commentary. Clin Gastroenterol Hepatol. 2024 Nov;22(11):2188-2196. doi: 10.1016/j.cgh.2024.06.048. Epub 2024 Sep 20. PMID: 39297813.

Psoriasis/Psoriatic Arthritis

79. Singh JA, Guyatt G, Ogdie A, et al. 2018 American College of Rheumatology/National Psoriasis Foundation Guideline for the treatment of psoriatic arthritis. American College of Rheumatology. 2019; 71(1):5-32. doi: 10.1002/art.40726.
80. Gossec L, Baraliakos X, Kerschbaumer A, et al. EULAR recommendations for the management of psoriatic arthritis with pharmacological therapies: 2019 update. Ann Rheum Dis. 2020;79:700–712. doi:10.1136/annrheumdis-2020-217159.
81. Singh JA, Guyatt G, Ogdie A, et al. 2018 American College of Rheumatology/National Psoriasis Foundation Guideline for the treatment of psoriatic arthritis. American College of Rheumatology. 2019; 71(1):5-32. doi: 10.1002/art.40726.
82. Elmets CA, Korman NJ, Prater EF, et al. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis with topical therapy and alternative medicine modalities for psoriasis severity measures. J Am Acad Dermatol. 2021 Feb;84(2):432-470. doi: 10.1016/j.jaad.2020.07.087.
83. Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. J Am Acad Dermatol. 2019 Apr;80(4):1029-1072. doi: 10.1016/j.jaad.2018.11.057.
84. Menter A, Gelfand JM, Connor C, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management of psoriasis with systemic nonbiologic therapies. J Am Acad Dermatol. 2020 Jun;82(6):1445-1486. doi: 10.1016/j.jaad.2020.02.044.

Hidradenitis Suppurativa

85. Alikhan A, Sayed C, Alavi A, et al. North American Clinical Management Guidelines for Hidradenitis Suppurativa: a publication from the United States and Canadian Hidradenitis Suppurativa Foundations. Part II: topical, intralesional, and systemic medical management. *J Am Acad Dermatol*. 2019; pii: S0190-9622(19)30368-8. doi: 10.1016/j.jaad.2019.02.068.
86. Hendricks A, J, Hsiao J, L, Lowes M, A, Shi V, Y: A Comparison of International Management Guidelines for Hidradenitis Suppurativa. Dermatology 2021;237:81-96. doi: 10.1159/000503605.

Behçet's Syndrome

87. Hatemi G, Christensen R, Bang D, et al. 2018 update of the EULAR recommendations for the management of Behçet's syndrome Annals of the Rheumatic Diseases 2018;77:808-818.
88. Adil A, Goyal A, and Quint JM. Behcet Disease. 2022 December 1. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; January 2022. PMID: 29262080.

Uveitis

89. Suhler EB, Smith JR, Wertheim MS, et al. A prospective trial of infliximab therapy for refractory uveitis: Preliminary safety and efficacy outcomes. *Arch Ophthalmol*. 2005;123(7):903-912.

90. Suhler EB, Smith JR, Giles TR, et al. Infliximab therapy for refractory uveitis: 2-year results of a prospective trial. *Arch Ophthalmol*. 2009;127(6):819-822.
91. Dick AD, FMedSci, FRCOphth, et al. Guidance on noncorticosteroid systemic immunomodulatory therapy in noninfectious uveitis: Fundamentals Of Care for Uveitis (FOCUS) Initiative. Ophthalmology 2018;125:757-773. https://doi.org/10.1016/j.ophtha.2017.11.017.
92. Rosenbaum JT, Bodaghi B, and Couto C et al. New observations and emerging ideas in diagnosis and management of non-infectious uveitis: A review. Semin Arthritis Rheum. 2019 Dec;49(3):438-445. doi: 10.1016/j.semarthrit.2019.06.004.

Kawasaki Disease

93. McCrindle B, Rowley AH, Newburger JW, et al. Diagnosis, treatment, and long-term management of Kawasaki disease. Circulation. 2017;135:e927-e999.
94. Gorelik M, Chung SA, Ardalan K, Binstadt BA, et al. 2021 American College of Rheumatology/Vasculitis Foundation Guideline for the Management of Kawasaki Disease. Arthritis Care Res (Hoboken). 2022 Apr;74(4):538-548. doi: 10.1002/acr.24838.

Polymyalgia Rheumatica

95. Dejaco C, Singh YP, and Perel P et al. European League Against Rheumatism; American College of Rheumatology. 2015 recommendations for the management of polymyalgia rheumatica: a European League Against Rheumatism/American College of Rheumatology collaborative initiative. Arthritis Rheumatol. 2015 Oct;67(10):2569-80. doi: 10.1002/art.39333.
96. Dasgupta B, Cimmino MA, Maradit-Kremers H, et al. 2012 provisional classification criteria for polymyalgia rheumatica: a European League Against Rheumatism/American College of Rheumatology collaborative initiative. Ann Rheum Dis. 2012 Apr;71(4):484-92. doi: 10.1136/annrheumdis-2011-200329.

Miscellaneous

97. Clowse MEB, Forger F, Hwang C, et al. Minimal to no transfer of certolizumab pegol into breast milk: results from CRADLE, a prospective, postmarketing, multicenter, pharmacokinetic study. *Ann Rheum Dis.* 2017;76:1980-1896. doi:10.1136/annrheumdis-2017-211384.
98. Ringold S, Angeles-Han ST, Beukelman T, et al. 2019 American College of Rheumatology/Arthritis Foundation guideline for the treatment of juvenile idiopathic arthritis: therapeutic approaches for non-systemic polyarthritis, sacroiliitis, and enthesitis. *Arthritis Care & Res.* 2019; 71(6):717-734. doi: 10.1002/acr.23870.
99. Kowal-Bielecka O, Fransen J, Avouac J, et al. Update of EULAR recommendations for the treatment of systemic sclerosis. *Annals of the Rheumatic Diseases*. 2017;76:1327-1339.
100. Cottin V and Brown K. Interstitial lung disease associated with systemic sclerosis (SSc-ILD). *Respiratory Research.* 2019; 20(13). doi: 10.1186/s12931-019-0980-7.
101. Khanna D, Lin CJF, Furst DE, et al. Tocilizumab in systemic sclerosis: a randomized, double-blind, placebo-controlled, phase 3 trial. *Lancet*. 2020; 8(10:963-974. doi: 10.1016/S2213-2600(20)30318-0.
102. van den Hoogen F, Khanna D, Fransen J, et al. 2013 classification criteria for systemic sclerosis: an American College of Rheumatology/European League against Rheumatism Collaborative Initiative. Ann Rheum Dis. 2013; 72:1747-1755.

103. Kineret Fact Sheet for Healthcare Providers: Emergency Use Authorization for Kineret. Stockholm, Sweden: Swedish Orphan Biovitrum AB; November 2022. Available at: https://kineretrxhcp.com/pdf/Fact%20Sheet%20for%20Healthcare%20Providers.pdf. Accessed February 10, 2023.
104. Eichenfield F, Tom WL, Chamlin SL, et al. Guidelines of Care for the Management of Atopic Dematitis. *J Am Acad Dermatol*. 2014 February; 70(2): 338–351.
105. Sidbury R, Alikhan A, Bercovitch L, et al. Guidelines of care for the management of atopic dermatitis in adults with topical therapies. J Am Acad Dermatol. 2023 Jul;89(1):e1-e20. doi: 10.1016/j.jaad.2022.12.029.
106. Davis DMR, Drucker AM, Alikhan A, et al. Guidelines of care for the management of atopic dermatitis in adults with phototherapy and systemic therapies. J Am Acad Dermatol. 2023 Nov 3:S0190-9622(23)02878-5. doi: 10.1016/j.jaad.2023.08.102.
107. Chu DK, Schneider L, Asiniwasis RN, et al. Atopic dermatitis (eczema) guidelines: 2023 American Academy of Allergy, Asthma and Immunology/American College of Allergy, Asthma, and Immunology Joint Task Force on Practice Parameters GRADE- and Institute of Medicine-based recommendations. Ann Allergy Asthma Immunol. 2023 Dec 18:S1081-1206(23)01455-2. doi: 10.1016/j.anai.2023.11.009.
108. Kuemmerle-Deschner JB, Ozen S, and Tyrrell PN, et al. Diagnostic criteria for cryopyrin-associated periodic syndrome (CAPS). Ann Rheum Dis. 2017 Jun;76(6):942-947. doi: 10.1136/annrheumdis-2016-209686.
109. Aksentijevich I, Nowak M, Mallah M, and Chae JJ, et al. De novo CIAS1 mutations, cytokine activation, and evidence for genetic heterogeneity in patients with neonatal-onset multisystem inflammatory disease (NOMID): a new member of the expanding family of pyrin-associated autoinflammatory diseases. Arthritis Rheum. 2002 Dec;46(12):3340-8. doi: 10.1002/art.10688.
110. Fautrel B, Mitrovic S, De Matteis A, et al. EULAR/PReS recommendations for the diagnosis and management of Still's disease, comprising systemic juvenile idiopathic arthritis and adult-onset Still's disease. Ann Rheum Dis. 2024 Nov 14;83(12):1614-1627. doi: 10.1136/ard-2024-225851. PMID: 39317417; PMCID: PMC11672000.
111. Maz Mehrdad, Chung SA, Abril A, et al, 2021 American College of Rheumatology/Vasculitis Foundation guideline for the management of giant cell arteritis and Takayasu arteritis. *Arthritis Care & Research*. 2021; 73(8):1071-1087. DOI 10.1002/acr.24632.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J0129	Injection, abatacept, 10 mg
J0139	Injection, adalimumab, 1 mg
J0717	Injection, certolizumab pegol, 1 mg
J1438	Injection, etanercept, 25 mg
J1602	Injection, golimumab, 1 mg, for intravenous use

HCPCS Codes	Description
J1628	Injection, guselkumab, 1 mg
J1745	Injection, infliximab, excludes biosimilar, 10 mg
J2267	Injection, mirikizumab-mrkz, 1 mg
J2323	Injection, natalizumab, 1 mg
J2327	Injection, risankizumab-rzaa, intravenous, 1 mg
J3245	Injection, tildrakizumab, 1 mg
J3247	Injection, secukinumab, intravenous, 1 mg
J3262	Injection, tocilizumab, 1 mg
J3357	Ustekinumab, for subcutaneous injection,1 mg
J3358	Ustekinumab, for intravenous injection, 1 mg
J3380	Injection, vedolizumab, intravenous, 1 mg
Q5103	Injection, infliximab-dyyb, biosimilar, (inflectra), 10 mg
Q5104	Injection, infliximab-abda, biosimilar, (renflexis), 10 mg
Q5140	Injection, adalimumab-fkjp, biosimilar, 1 mg
Q5141	Injection, adalimumab-aaty, biosimilar, 1 mg
Q5142	Injection, adalimumab-ryvk biosimilar, 1 mg
Q5143	Injection, adalimumab-adbm, biosimilar, 1 mg
Q5144	Injection, adalimumab-aacf (idacio), biosimilar, 1 mg
Q5145	Injection, adalimumab-afzb (abrilada), biosimilar, 1 mg
Q5133	Injection, tocilizumab-bavi (tofidence), biosimilar, 1 mg
Q5135	Injection, tocilizumab-aazg (tyenne), biosimilar, 1 mg
Q5156	Injection, tocilizumab-anoh (avtozma), biosimilar, 1 mg
Q5134	Injection, natalizumab-sztn (tyruko), biosimilar, 1 mg
Q5098	Injection, ustekinumab-srlf (imuldosa), biosimilar, 1 mg
Q5099	Injection, ustekinumab-stba (steqeyma), biosimilar, 1 mg
Q5100	Injection, ustekinumab-kfce (yesintek), biosimilar, 1 mg
Q5137	Injection, ustekinumab-auub (wezlana), biosimilar, subcutaneous, 1 mg
Q5138	Injection, ustekinumab-auub (wezlana), biosimilar, intravenous, 1 mg
Q9996	Injection, ustekinumab-ttwe (pyzchiva), subcutaneous, 1 mg
Q9997	Injection, ustekinumab-ttwe (pyzchiva), intravenous, 1 mg
Q9998	Injection, ustekinumab-aekn (selarsdi), 1 mg
Q9999	Injection, ustekinumab-aauz (otulfi), biosimilar, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2021 annual review: added criteria for new indication of DIRA for Kineret; added additional criteria related to diagnosis of PsO per 2019 AAD/NPF guidelines specifying involvement of areas that severely impact daily function OR at least 3% BSA involvement for moderate-to-severe, at least 10% BSA involvement for chronic-severe; added biosimilar redirection to other diagnoses/indications; added alopecia areata as indication not coverable for Xeljanz/Xeljanz XR requests	05.04.21	05.21

Reviews, Revisions, and Approvals	Date	P&T Approval Date
(cosmetic); updated CDAI table with ">" to prevent overlap in classification of severity; updated reference for HIM off-label use to HIM.PA.154 (replaces HIM.PHAR.21); clarified that different therapeutic classes must be tried for HS, each for 3 months; references reviewed and updated. RT4: updated criteria to reflect pediatric extension for UC to include patients 5 years of age and older. RT4: added criteria for new FDA indication, SSc-ILD		
RT4: updated Cosentyx PsO age requirement from ≥ 18 years to ≥ 6 years per FDA pediatric expansion; added new 75 mg/0.5 mL prefilled syringe for pediatric patients. RT4: added new Skyrizi 150 mg/mL prefilled pen and syringe formulations.	06.04.21	
RT4: added Zeposia to the policy for its newly FDA-approved indication for ulcerative colitis. SSc-ILD: added rheumatologist prescriber option per specialist feedback and added baseline FVC/DLCO requirements. Per June SDC and prior clinical guidance, modified Avsola to parity status with Inflectra and Renflexis; added Avsola to list of biosimilar infliximab products that must be used prior to Remicade. RT4: added information regarding Actemra and Olumiant EUA for COVID-19 hospitalized patients.	06.14.21	08.21
Added requirement of concomitant treatment with MTX and bDMARD if request is for concomitant treatment with Otezla and bDMARD; added dose escalation guideline on Stelara for CD, UC, PsO and PsA; revised place in therapy for Xeljanz per FDA announcement and allowed bypassing Xeljanz if member had cardiovascular risk and benefits do not outweigh the risk of treatment.	08.23.21	11.21
2Q 2022 annual review: added newly FDA-approved indications: AD, AS, UC, and PsA for Rinvoq, aGVHD for IV Orencia, ERA for Cosentyx, PsA for Skyrizi, AS for Xeljanz/Xeljanz XR, IV formulation for Actemra for GCA; FDA use extension to mild PsO for Otezla after failure of at least one topical therapy; pediatric use extension down to 2 years and older for PsA for Cosentyx; removed oral and topical steroid requirement for Behçet's disease; added off-label use for Kawasaki disease for infliximab; for moderate-to-severe PsO, allowed phototherapy as alternative to systemic conventional DMARD if contraindicated or clinically significant adverse effects are experienced; for Olumiant, Rinvoq, and Xeljanz, updated place in therapy after TNFi per FDA labeling; revised redirection from Remicade to biosimilars to "must use" language; for Stelara requests via the pharmacy benefit, added that member must use prefilled syringe formulation if request is for the 45 mg vial; reiterated requirement against combination biologic DMARD use from Section	05.02.22	05.22

Reviews, Revisions, and Approvals	Date	P&T Approval Date
III to Sections I and II; removed unspecified iridocyclitis (ICD10 H20.9) from Section III; clarified other diagnoses/indications section to enforce biosimilar redirection intent; references reviewed and updated.		
Per May SDC and prior clinical guidance, modified Kevzara redirection in RA from all to two of the following: Humira, Enbrel, Xeljanz/Xeljanz XR, Rinvoq; revised Rinvoq lower age limit for AD from 18 to 12 years per PI; RT4: revised FDA approved indications to include treatment of alopecia and hospitalized COVID-19; reiterated that Olumiant is not covered for COVID-19 since it is FDA-approved for use only in the hospital setting; added alopecia areata to the list of indications for which coverage is NOT authorized, since its use is cosmetic in nature and thus a benefit exclusion; RT4: updated Skyrizi with Crohn's disease indication along with new vial and prefilled cartridge formulations and new contraindication; references reviewed and updated.	07.07.22	
RT4: for Stelara for PsA, updated criteria and dosing per FDA approved pediatric extension. Template changes applied to other diagnoses/indications and continued therapy section.	09.09.22	
Per August SDC and prior clinical guidance, modified Remicade redirection to be stepwise, first requiring Inflectra and Renflexis, then if member has failed Inflectra and Renflexis member must use Avsola; for Avsola added redirection to Inflectra and Renflexis; RT4: for Skyrizi, added new 180 mg/1.2 mL single-dose prefilled cartridge dosage form and quantity limit stating that only one single dose vial or pre-filled cartridge is allowed per dose for CD; RT4: added Sotyktu to the policy for its newly FDA-approved indication for PsO; RT4: criteria added for new FDA indication for Rinvoq: nr-axSpA.	08.23.22	11.22
RT4: added information regarding Kineret EUA for COVID-19 hospitalized patients; added HCPCS code: [J2327].	12.02.22	
Per February SDC, added Amjevita to policy with criteria requiring use of preferred formulary NDCs along with reference to Appendix N; added Amjevita as an alternative option to Humira for applicable indications.	02.13.23	
For PsO, added requirement of preferred biologic agents before trial of Sotyktu.	03.10.23	
2Q 2023 annual review: RT4: for Actemra, revised criteria for COVID-19 emergency authorized use to FDA-approved indication; updated off-label dosing for Appendix B; removed Actemra from Appendix M since Actemra does not have EUA and is now approved for COVID-19; for AS, pJIA, PsO, PsA, RA, CD, and UC, added TNFi criteria to allow bypass if member has had history of failure of	04.19.23	05.23

Reviews, Revisions, and Approvals	Date	P&T Approval Date
two TNF blockers; references reviewed and updated. For PsA, updated criteria from "Xeljanz/Xeljanz XR **or** Rinvoq" to "Xeljanz/Xeljanz XR **and** Rinvoq" to align with commercial policy and to allow trial of both JAK inhibitors after trial of TNF-blockers. RT4: for Kevzara, added criteria for newly approved PMR indication to policy and added Appendix O for PMR Classification Criteria Scoring Algorithm; for Amjevita, updated FDA approved indications to reflect new HS indication, added Amjevita to HS criteria, updated biosimilar dosing in section V, and added 10 mg/0.2 mL prefilled glass syringe dosage form; for PsO, corrected Otezla misspelling for "request is for Otezla" criteria.		
RT4: for Rinvoq, criteria added for new FDA indication: Crohn's disease; updated Appendix C to align boxed warnings among JAK inhibitors and to align with individual prescriber information; RT4: for Cosentyx, added new dosage forms (UnoReady Pen and 300 mg/2 mL dose of pre-filled syringe) to policy.	05.25.23	
Added Humira biosimilars Abrilada, unbranded adalimumab-adaz, unbranded adalimumab-fkjp, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Yuflyma, and Yusimry to policy; for Amjevita request criteria, removed "preferred formulary" language; added HCPCS codes [Q5131] and [C9399]. Per July SDC: for AS, CD, PsO, pJIA, PsA, RA, and UC, modified redirection from "Humira or Amjevita" to "one of the following adalimumab products: Humira, Hadlima, or adalimumab-adaz"; added requirement for Humira biosimilars that member must use all preferred adalimumab products: Humira, Hadlima, and unbranded adalimumab-adaz (NDC 61314-0327-20, 61314-0327-96, 61314-0327-64, 61314-0327-94); removed criteria requiring use of preferred Amjevita NDCs and Appendix with Amjevita NDC references.	07.25.23	
Per August SDC: for Stelara, removed redirection criteria for requests that are above the labeled maximum dose.	08.22.23	
RT4: for Amjevita, added new strengths for prefilled autoinjector 40 mg/0.4 mL, 80 mg/0.8 mL and prefilled syringe 20 mg/0.2 mL, 40 mg/0.4 mL, 80 mg/0.8 mL in section VI; RT4: for Abrilada, Hulio/ adalimumab-fkjp, Hyrimoz/ adalimumab-adaz, and Yusimry, updated FDA approved indications, approval criteria, and dosing in section V to reflect new UV indication; RT4: for Entyvio, added new dosage forms (prefilled syringe and Entyvio Pen) for SC injection to sections V and VI; for section VI, revised Entyvio formulation from "single-use vial" to "lyophilized powder in a single-dose vial for reconstitution for IV infusion: 300 mg" per PI; for Entyvio: for CD, added "request is for IV formulation" in initial approval and continued therapy sections; RT4: added newly approved biosimilar Tofidence to	09.19.23	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
FDA approved indication section, pJIA, RA, sJIA criteria, and section V; RT4: Tyruko (a Tysabri biosimilar) added to FDA approved indications, approval criteria, and section V to reflect new CD and MS indication; RT4: for Yuflyma, added new strengths for auto-injector 80 mg/0.8 mL, prefilled syringe with safety guard 80 mg/0.8 mL, and prefilled syringe 20 mg/0.2 mL and 80 mg/0.8 mL and updated Yuflyma pediatric weight base dosing for pJIA and CD in section V; RT4: for Idacio, updated FDA approved indications, approval criteria, and dosing in section V to reflect new HS indication; RT4: for Cosentyx, added new dosage form single-dose vial 125 mg/ 5 mL for intravenous infusion, added IV specific dosing for AS, nr-axSpA and PsA; RT4: for PsA, added newly approved JPsA indication for Enbrel; added Tofidence to section III.B; added HCPCS code [Q5132].		
Per August SDC: for CD, PsO, PsA, UC, and continued therapy, removed criteria "for Stelara: if request is through the pharmacy benefit for 45 mg/0.5 mL vial formulation, member must use Stelara pre-filled syringe"; RT4: for PsO, added Bimzelx to criteria; RT4: for CD and UC, added Zymfentra to criteria; RT4: for UC, added Velsipity to criteria; RT4: for UC, added Omvoh to criteria.	08.22.23	12.23
Per December SDC, added Cyltezo with specific NDCs to list of preferred adalimumab products. RT4: for Orencia, updated PsA criteria with pediatric extension to include ages 2 years and older; for pJIA, added "for Orencia: members 2 to 17 years of age, prescribed route of administration is SC" to align with Medicaid criteria; RT4: for Cosentyx, added newly approved HS indication to criteria; RT4: for Idacio, added newly approved UV indication to criteria; RT4: for Idacio, added new dosage formulation [single-dose institutional use vial kit: 40 mg/0.8 mL]; for CD and pJIA, updated Idacio pediatric dosing in section V; RT4: added newly approved biosimilar Wezlana to criteria; added Wezlana to section III.B; for AD initial criteria, removed systemic immunosuppressant therapy step criterion per updated guideline and competitor analysis and in alignment with previously P&T approved approach; for Appendix B, removed AD systemic immunosuppressant therapy therapeutic alternatives.	02.12.24	02.24
Revised HCPCS code description [J3380] and add HCPCS codes [C9166, C9168, Q5133, Q5134].	02.22.24	
2Q 2024 annual review: RT4: for UV, added Yuflyma to criteria; for Castleman's disease, added member has either unicentric disease with HIV-negative and HHV-8-negative or multicentric disease as supported by NCCN compendium and updated duration from "6 months or to member's renewal date, whichever is longer" to "6 months"; for cytokine release syndrome, added "i.e., inadequate	03.25.24	05.24

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response to steroids, vasopressors" as examples for refractory CRS; for Appendix D, removed AS and nr-axSpA guideline, CRADLE trial for Cimzia, and pediatric pharmacokinetic studies for Stelara; for Appendix M, added Actemra information as an FDA-approved alternative for COVID-19; for Renflexis, removed "re-administration to patients who have experienced severe hypersensitivity reaction to infliximab products" in contraindications section; for Cosentyx, Rinvoq, Avsola, Inflectra, Remicade, and Renflexis, added "maximum dose escalation allowed per prescriber information with documentation of inadequate response" in criteria and section V; added Bimzelx, Zymfentra, Omvoh, Sotyktu, Tofidence, and Velsipity to section III.B; references reviewed and updated. Per March SDC: for Rinvoq in Atopic Dermatitis, modified requirement of two topical corticosteroids to require only one, removed requirement for use of one systemic agent. RT4: added newly approved Humira biosimilar Simlandi to criteria; RT4: added newly approved Actemra biosimilar Tyenne to RA, GCA, pJIA, and sJIA criteria; added Sotyktu to description section and "medically necessary" section.		
Per SDC: for PsO, added redirection to Enbrel and Otezla as alternative option with "or" instead of "and" language to list of preferred redirected agents. Added branded Cyltezo 40 mg/0.4 mL specific NDCs [0597-0495-40, 0597-0495-50, 0597-0495-60, 0597-0485-20] to list of preferred adalimumab products; for PsA and pJIA, added redirection to preferred agent Rinvoq LQ. RT4: for Entyvio, added new dosage form (subcutaneous injection) and removed "request is for IV formulation" for CD criteria; RT4: for PsA and PsO, added newly approved biosimilar Selarsdi to criteria; for PsO, updated Wezlana age requirement from $\geq$ 18 years to $\geq$ 6 years; RT4: for Otezla, added newly approved pediatric extension to 6 years and older for PsO criteria; RT4: for Rinvoq, updated criteria to reflect pediatric extension to 2 years and older for PsA; for Rinvoq, added new FDA approved pJIA indication and added redirection to preferred agent Rinvoq LQ; for PsA and pJIA, added new oral solution dosage form [Rinvoq LQ] to criteria; for PsA, added redirection to preferred agent Stelara for pediatric Orencia requests; RT4: for Omvoh, added new dosage form [single-dose prefilled syringe 100 mg/mL]; RT4: for Cyltezo, added new 40 mg/0.4 mL dosage strengths for single-dose pen and single-dose prefilled syringe; for Appendix D, removed supplemental information on DIRA indication and PHOENIX 2 trial for Stelara.	05.09.24	06.24

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Added HCPCS codes [J3247, Q5137, Q5138, J2267] and removed HCPCS codes [C9166, C9168].		
Per June SDC: modified Remicade stepwise redirection by adding if member has failed Inflectra, Renflexis, and Avsola, member must use unbranded Remicade; for unbranded Remicade, member must use Inflectra and Renflexis, then if member has failed Inflectra and Renflexis, member must use Avsola; for CD and UC, added additional requirement for Zymfentra requests requiring provider attestation that "member is unable to receive continued therapy with IV infliximab due to lack of caregiver or support system for assistance with administration and/or inadequate access to healthcare facility or home care interventions and/or lack of transportation to healthcare facility." RT4: for Kevzara, added newly approved polyarticular juvenile idiopathic arthritis indication to criteria; RT4: for Skyrizi, added newly approved Ulcerative Colitis indication to criteria; RT4: for CD, UC, PsO, PsA: added newly approved biosimilar Pyzchiva to criteria. For PsA: added Rinvoq to list of agents for ages ≥ 2 years and older; for Orencia requests for ages 2 to 17 years and Selarsdi/Wezlana requests for ages 6 to 17 years, added Rinvoq to list of redirected agents.	07.15.24	08.24
RT4: for Simlandi, added new prefilled syringe formulation and strengths [20 mg/0.2 mL, 40 mg/0.4 mL, 80 mg/0.8 mL]; for section V, added Simlandi pediatric dose for pJIA [15 kg to less than 30 kg: 20 mg every other week] and pediatric dose for CD [17 kg to less than 40 kg: 80 mg SC on Day 1, 40 mg SC on Day 15, then 20 mg SC every other week starting on Day 29]; RT4: for Tofidence, added coverage for COVID-19 and GCA; for section V, added Tofidence dosing for GCA; for Appendix M, added supplemental information for Tofidence; added HCPCS code [Q5135] for Tyenne; RT4: for Taltz: added new strengths for single-dose prefilled syringe [20 mg/0.25 mL, 40 mg/0.5 mL].	08.13.24	
RT4: for Tremfya, added criteria for newly approved indication for UC; added new subcutaneous formulations [single-dose prefilled syringe 200 mg/2 mL; single-dose prefilled pen (Tremfya Pen) 200 mg/2 mL] and intravenous formulation [single-dose vial 200 mg/20 mL]; RT4: for Cimzia, added criteria for newly approved indication for PJIA; RT4: for Bimzelx, added criteria for newly approved indications for PsA, AS, and nr-axSpA; RT4: added newly approved biosimilar Otulfi to criteria.	09.19.24	11.24
Per August SDC, added Yuflyma with specific NDCs to list of preferred adalimumab products; removed Hadlima and adalimumab-adaz from list of preferred adalimumab products.	11.04.24	12.24

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RT4: for Bimzelx, added new strength [320 mg/2 mL] for single-dose prefilled syringe and single-dose prefilled autoinjector; RT4: added newly approved biosimilar Imuldosa to criteria; RT4: for Selarsdi, added newly approved indications for CD and UC; added new dosage formulation [single-dose vial for IV infusion 130 mg/26 mL]; for continued therapy, removed redirection to Stelara for Stelara biosimilars. Added HCPCS codes [J0139, Q5140, Q5141, Q5142, Q5143, Q5144, Q5145, Q9996, Q9997, Q9998] and removed [J0135, Q5131, Q5132]. For Stelara, added "#" superscript to include IV induction for CD and UC indications in FDA Approved Indications table.		
Per December SDC: for RA and pJIA, revised Actemra redirection to require only a single step through preferred formulary products. RT4: for Bimzelx, added criteria for newly approved indication for HS; RT4: added newly approved biosimilar Yesintek to criteria; RT4: for Pyzchiva, added new dosage formulation [single-dose vial for SC injection 45 mg/0.5 mL]; added Pyzchiva to "weight < 60 kg: 0.75 mg/kg per dose" pediatric dosing for PsO and PsA; RT4: for Wezlana, added new dosage formulation [single-dose prefilled autoinjector (ConfiPen) 45 mg/0.5 mL, 90 mg/mL]; RT4: added newly approved biosimilar Steqeyma to criteria; for AS, CD, HS, PsO, pJIA, PsA, RA, UC, and UV, added adalimumab-aacf, adalimumab-aaty, adalimumab-bwwd, and adalimumab-ryvk to criteria; per SDC: for GCA, removed criteria for failure of "≥ 3 consecutive month trial" of a systemic corticosteroid and "in conjunction with methotrexate or azathioprine"; for pJIA: removed criteria for minimum cJADAS-10 score ≥ 8.5 for documentation of high disease activity and "baseline 10-joint clinical juvenile arthritis disease activity score" in initial criteria; removed criteria for "member is responding positively to therapy as evidenced by a decrease in cJADAS-10 from baseline" in continued therapy; for Appendix K, added pJIA disease activity information per 2019 ACR guidelines.	01.13.25	02.25
2Q 2025 annual review: for UC initial criteria, added option for documentation of modified Mayo Score ≥ 5; removed redirection to preferred adalimumab products as adalimumab is not recommended due to low efficacy per 2024 AGA guidelines; for Appendix F, added supplemental information on modified Mayo Score; RT4: for Omvoh, added criteria for newly approved indication for CD and added new dosage forms [single-dose prefilled pen 200 mg/2 mL and single-dose syringe 200 mg/2 mL]; RT4: added newly approved biosimilar Avtozma to criteria; RT4: for Simlandi, added new single-dose autoinjector strength [80 mg/0.8 mL]; for sJIA, added redirection to NSAID as an option per clinical practice guidelines and competitor	04.07.25	05.25

Reviews, Revisions, and Approvals	Date	P&T Approval Date
analysis; for CD, allowed redirection to preferred agent Rinvoq after TNF blocker per FDA labeling; for CRS, revised criteria from "member has developed refractory CRS related to blinatumomab therapy" to "used as supportive care in severe CRS related to blinatumomab therapy" and added criteria "used as prophylaxis to reduce the risk of CRS when administering teclistamab-cqyv" per NCCN compendium; added HCPCS code [Q9999]; for Appendix D, removed supplemental information on Enbrel in HS; updated section III.B with Spevigo and biosimilar verbiage; ; for Kawasaki disease, updated dose in section V from 5 mg/kg given over 2 hours to 10 mg/kg given over 2 hours; for Appendix M, removed supplemental information on COVID-19 therapeutic alternatives; references reviewed and updated. RT4: for Tyenne, added newly approved CRS and COVID-19 indications to criteria; for Appendix D, removed PsA and PsO supplemental information on Otezla; RT4: for Tremfya, added criteria for newly approved indication for CD; RT: for Tremfya, added new strength [100 mg/mL] for single-dose prefilled pen (Tremfya Pen); RT4: for Otulfi, added new dosage formulation [single-dose vial for SC injection: 45 mg/0.5 mL]; added Otulfi to "weight < 60 kg: 0.75 mg/kg per dose" pediatric dosing in section V for PsA and PsO; per SDC: for UC, revised redirection to include adalimumab product in criteria for "three of the following: Stelara, Skyrizi, Tremfya, adalimumab product [Humira/Cyltezo/Yuflyma]"; added step therapy bypass for IL HIM per IL HB 5395.		
RT4: for Rinvoq, added newly approved GCA indication to criteria. Added HCPCS codes [Q5098, Q5099, and Q5100]. Extended initial approval duration for all indications to 12 months for HIM Texas.	05.29.25	06.25
RT4: added newly approved biosimilar Starjemza to criteria; RT4: for Steqeyma, added new dosage formulation [single-dose vial for SC injection: 45 mg/0.5 mL] and updated pediatric dosing for PsO and PsA in section V; added step therapy bypass for non-formulary agents per IL HIM per IL HB 5395.	06.12.25	
For section V, updated column for "maximum dose" to "maximum maintenance dose."	08.06.25	
RT4: for Otezla, added newly approved pediatric extension to 6 years and older for PsA; added redirection to Otezla for pediatric agents indicated for PsA; RT4: for Avtozma, added newly approved CRS indication to criteria; for UC, added option for Mayo Endoscopic Score $\geq$ 2 to define moderate-to-severe UC; added Mayo Endoscopic Score descriptions for each numerical scoring to Appendix F; added bypass of conventional therapies if a member has failed a biologic	10.15.25	11.25

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agent to clarify intention of not stepping back from biologic agent to conventional therapy; RT4: for Skyrizi, added new 180 mg/1.2 mL single-dose prefilled syringe dosage form and strength; for Skyrizi CD and UC criteria, added "if request is for vials/cartridges" to clarify quantity limit applies to vial/cartridge requests; added HCPCS code [Q5156] for Avtozma. RT4: for Tremfya, added newly approved pediatric age extension to 6 years and older for PsO and PsA and updated UC induction dosing per PI. RT4: for Rinvoq, reflected place in therapy for UC and CD per PI. RT4: for Simponi, reflected pediatric age extension for UC per PI. Extended initial approval durations to 12 months for chronic conditions. RT4: for Xeljanz, applied pediatric age extension for PsA per PI. RT4: for Amjevita, applied pediatric age extensions for HS and uveitis per PI. RT4: added newly FDA-approved formulation, Otezla XR.		
Per August SDC: for PsO, PsA, CD, and UC initial approval criteria, added redirection to additional preferred ustekinumab products (Pyzchiva, Steqeyma, and Yesintek) and applied to continuation of therapy requests, and for members initiating therapy with Stelara added a single step through preferred agents; for RA, pJIA, PsA, AS, CD, UC, PsO, HS, UV initial therapy, added redirection to preferred adalimumab products (adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, Simlandi) and removed redirection to Cyltezo; for members initiating therapy with Humira initial approval criteria, added single step through preferred agents; extended initial approval durations from 6 months to 12 months for chronic indications.	08.20.25	12.25

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.

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