Pharmacy Drug Policy Checklist

POLICY NAME	Adalimumab Products	POLICY #	1843P

Criteria

Exclusion Criteria – Any of the following prevents coverage

- ☐ **12.1** Allergic reaction to murine proteins or humanized monoclonal antibody
- ☐ **12.2** Inadequate response to initial or previous adalimumab therapy
- ☐ **12.3** Patients with active infections, latent tuberculosis, or symptomatic or deteriorating congestive heart failure
- ☐ **12.4** Health Alliance does not cover more than one immunomodulator at a time because of the possible increased risk for infections and potential drug interactions
- ☐ **12.5** Off-label (non-FDA-Approved) dosing frequencies
- ☐ **12.6** Only certain NDCs of adalimumab biosimilars will be considered for coverage, please reference statement of policy for covered NDCs

Coverage Criteria for Pediatric Crohn's Disease and Active Adult Crohn's Disease

- ☐ **1.1** See Crohn’s Disease Immunomodulator Therapies policy

Coverage Criteria for Rheumatoid Arthritis

- ☐ **2.1** See Rheumatoid Arthritis Immunomodulator Therapies policy

Coverage Criteria for Juvenile Idiopathic Arthritis

- ☐ **3.1** See Polyarticular Juvenile Idiopathic Arthritis Immunomodulator policy

Coverage Criteria for Plaque Psoriasis

- ☐ **4.1** See Plaque Psoriasis Immunomodulator Therapies policy

Coverage Criteria for Active Psoriatic Arthritis

- ☐ **5.1** See Psoriatic Arthritis Immunomodulator Therapies policy

Coverage Criteria for Ankylosing Spondylitis and Other Spondyloarthropathies

- ☐ **6.1** See Ankylosing Spondylitis Immunomodulator Therapies policy

Coverage Criteria for Ulcerative Colitis

- ☐ **7.1** See Ulcerative Colitis Immunomodulator Therapies policy

Coverage Criteria for Hidradenitis Suppurativa

- ☐ **8.1** See Hidradenitis Suppurativa Immunomodulator Therapies policy

Coverage Criteria for Arthritis Associated with Hidradenitis Suppurativa

- ☐ **9.1** Diagnosis of Arthritis associated with Hidradenitis Suppurativa
- ☐ **9.2** Prescribed by a rheumatologist (musculoskeletal doctor)
- ☐ **9.3** Documented failure to respond to a minimum 3 month trial, intolerance, or contraindication to a DMARD (Disease Modifying Anti-Rheumatic Drug): Methotrexate, Arava (leflunomide), Plaquenil (hydroxychloroquine), or sulfasalazine

Coverage Criteria for Uveitis

- ☐ **10.1** Diagnosis of Uveitis
- ☐ **10.2** Prescribed by an ophthalmologist (eye doctor) or a specialist in the treatment of uveitis
- ☐ **10.3** Documented failure to respond to topical glucocorticoids (such as prednisolone eye drops)
- ☐ **10.4** Documented failure to respond to systemic glucocorticoids or immunosuppressive agents (such as prednisone or methotrexate)

Coverage Criteria for Pyoderma Gangrenosum

- ☐ **11.1** Ordered by a specialist
- ☐ **11.2** Diagnosis of refractory pyoderma gangrenosum not responding to standard therapy (such as prednisone or cyclosporine)

Approval Time

- ☐ **14.1** Initial Authorization will be placed for 12 months
- ☐ **14.2** All subsequent authorizations will be placed for 12 months, based upon clinical response to therapy CPT Codes HCPCS Codes References