

POLICY NAME	Hidradenitis Suppurativa Immunomodulator	POLICY #	3375P
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Criteria

Coverage Criteria of Preferred Products (Covered adalimumab biosimilars)

- ☐ 1.1 Diagnosis of moderate to severe Hidradenitis Suppurativa
- ☐ 1.2 Prescribed by or in consultation with a Dermatologist (skin doctor)
- ☐ 1.3 Documented failure, intolerance, or contraindication to topical (applied to the skin) clindamycin therapy
- ☐ 1.4 Documented failure, intolerance, or contraindication to oral (taken by mouth) doxycycline, minocycline, or clindamycin therapy

Coverage Criteria of Non-Preferred Products (Cosentyx, Bimzelx)

- ☐ 2.1 Diagnosis of moderate to severe Hidradenitis Suppurativa
- ☐ 2.2 Prescribed by or in consultation with a Dermatologist (skin doctor)
- ☐ 2.3 Documented failure, intolerance, or contraindication to topical (applied to the skin) clindamycin therapy
- ☐ 2.4 Documented failure, intolerance, or contraindication to oral (taken by mouth) doxycycline, minocycline, or clindamycin therapy
- ☐ 2.5 Previous trial and failure, contraindication or intolerance to a covered adalimumab biosimilar

Exclusion Criteria – Any of the following prevents coverage

- ☐ 3.1 Patients with active infections, latent tuberculosis, or symptomatic or deteriorating congestive heart failure
- ☐ 3.2 Off-label (non-FDA approved) dosing frequencies
- ☐ 3.3 Health Alliance Does not cover concurrent therapy with other immunomodulators based upon the possible increased risk for infections and other potential pharmacological interactions
- ☐ 3.4 Only certain NDCs of adalimumab biosimilars will be considered for coverage, please reference most recent formulary file for covered NDCs