Pharmacy Drug Policy Checklist

POLICY NAME	Polyarticular Juvenile Idiopathic Arthritis	POLICY #	2746P

Criteria

Exclusion Criteria – Any of the following prevents coverage

- ☐ **5.1** Allergic reaction to murine proteins or humanized monoclonal antibody
- ☐ **5.2** Inadequate response to initial or previous therapy with requested immunomodulator
- ☐ **5.3** Patients with active infections, latent tuberculosis, or symptomatic or deteriorating congestive heart failure
- ☐ **5.4** Off-label (non-FDA approved) dosing frequencies
- ☐ **5.5** Health Alliance does not cover more than one immunomodulator at a time because of the possible increased risk for infections and other potential drug interactions
- ☐ **5.6** Only certain NDCs of adalimumab biosimilars will be considered for coverage, please reference most recent formulary file for covered NDCs

Coverage Criteria of Preferred Products (covered adalimumab biosimilars, Simponi Aria, Enbrel, Cimzia)

- ☐ **1.1** Diagnosis of Polyarticular Juvenile Idiopathic Arthritis
- ☐ **1.2** Ordered by a Rheumatologist (musculoskeletal doctor)
- ☐ **1.3** Age 2 years or older
- ☐ **1.4** Documented failure to respond to a minimum 3-month trial, intolerance, or contraindication to methotrexate

Coverage Criteria of Preferred Products with Single Step Edit (Xeljanz, Rinvoq)

- ☐ **2.1** Diagnosis of Polyarticular Juvenile Idiopathic Arthritis
- ☐ **2.2** Ordered by a Rheumatologist (musculoskeletal doctor)
- ☐ **2.3** Age 2 years or older
- ☐ **2.4** Documented failure to respond to a minimum 3-month trial, intolerance, or contraindication to methotrexate
- ☐ **2.5** Documented failure to respond to a minimum 3-month trial, intolerance, or contraindication to one or more TNF inhibitors (e.g. Enbrel)

Coverage Criteria of Non-Preferred Products with Double Step Edit (Actemra Sub-Q, Orencia IV or Sub-Q)

- ☐ **3.1** Diagnosis of Polyarticular Juvenile Idiopathic Arthritis
- ☐ **3.2** Ordered by a Rheumatologist (musculoskeletal doctor)
- ☐ **3.3** Age 2 years or older
- ☐ **3.4** Documented failure to respond to a minimum 3-month trial, intolerance, or contraindication to methotrexate
- ☐ **3.5** Documented failure to respond to a minimum 3-month trial, intolerance, or contraindication to any TWO of the following:
  - Covered adalimumab biosimilars
  - Enbrel
  - Cimzia
  - Xeljanz
  - Rinvoq Pharmacy Drug Policy & Procedure Statement of the Policy Criteria References

Coverage Criteria of Non-Preferred Products with Quadruple Step Edit (Kineret, Kevzara)

- ☐ **4.1** Diagnosis of Polyarticular Juvenile Idiopathic Arthritis
- ☐ **4.2** Ordered by a Rheumatologist (musculoskeletal doctor)
- ☐ **4.3** Age 2 years or older
- ☐ **4.4** Documented failure to respond to a minimum 3-month trial, intolerance, or contraindication to methotrexate
- ☐ **4.5** Documented failure to respond to a minimum 3-month trial, intolerance, or contraindication to Actemra and Orencia and TWO of the following:
  - Covered adalimumab biosimilars
  - Enbrel
  - Cimzia
  - Xeljanz
  - Rinvoq