

POLICY NAME	Adalimumab Products	POLICY #	1843P
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Criteria

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

- ☐ See Crohn's Disease Immunomodulator Therapies policy

Coverage Criteria for Rheumatoid Arthritis

- ☐ See Rheumatoid Arthritis Immunomodulator Therapies policy

Coverage Criteria for Juvenile Idiopathic Arthritis

- ☐ See Polyarticular Juvenile Idiopathic Arthritis Immunomodulator policy

Coverage Criteria for Plaque Psoriasis

- ☐ See Plaque Psoriasis Immunomodulator Therapies policy

Coverage Criteria for Active Psoriatic Arthritis

- ☐ See Psoriatic Arthritis Immunomodulator Therapies policy

Coverage Criteria for Ankylosing Spondylitis and Other Spondyloarthropathies

- ☐ See Ankylosing Spondylitis Immunomodulator Therapies policy

Coverage Criteria for Ulcerative Colitis

- ☐ See Ulcerative Colitis Immunomodulator Therapies policy

Coverage Criteria for Hidradenitis Suppurativa

- ☐ See Hidradenitis Suppurativa Immunomodulator Therapies policy

Coverage Criteria for Arthritis Associated with Hidradenitis Suppurativa

- ☐ Diagnosis of Arthritis associated with Hidradenitis Suppurativa
- ☐ Prescribed by a rheumatologist (musculoskeletal doctor)
- ☐ 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

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

Coverage Criteria for Pyoderma Gangrenosum

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

Exclusion Criteria – Any of the following prevents coverage

- ☐ Allergic reaction to murine proteins or humanized monoclonal antibody
- ☐ Inadequate response to initial or previous adalimumab therapy
- ☐ Patients with active infections, latent tuberculosis, or symptomatic or deteriorating congestive heart failure
- ☐ Health Alliance does not cover more than one immunomodulator at a time because of the possible increased risk for infections and potential drug interactions
- ☐ Off-label (non-FDA-Approved) dosing frequencies



Only certain NDCs of adalimumab biosimilars will be considered for coverage, please reference statement of policy for covered NDCs