Pharmacy Drug Policy Checklist

POLICY NAME	Psoriatic Arthritis Immunomodulator Therapies	POLICY #	2751P

Criteria

Coverage Criteria of Preferred Products (Cimzia, covered adalimumab biosimilars, Enbrel, Otezla, Simponi, Simponi Aria, Skyrizi, covered ustekinumab biosimilars, Tremfya)

- ☐ **1.1** Diagnosis of Psoriatic Arthritis
- ☐ **1.2** Ordered by a rheumatologist (musculoskeletal doctor) or dermatologist (skin doctor)
- ☐ **1.3** Age 18 years or older (age 2 years or older for Simponi Aria or Enbrel, age 6 years or older for ustekinumab)

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

- ☐ **2.1** Diagnosis of Psoriatic Arthritis
- ☐ **2.2** Ordered by a rheumatologist (musculoskeletal doctor) or dermatologist (skin doctor)
- ☐ **2.3** Age 18 years or older (age 2 years or older for Rinvoq)
- ☐ **2.4** Documented failure to respond to a minimum 3 month trial or intolerance to one or more TNF inhibitors (such as Cimzia, Simponi, Enbrel)

Coverage Criteria of Non-Preferred Products with Single Step-Edit (Taltz)

- ☐ **3.1** Diagnosis of Psoriatic Arthritis
- ☐ **3.2** Ordered by a rheumatologist (musculoskeletal doctor) or dermatologist (skin doctor)
- ☐ **3.3** Age 18 years or older
- ☐ **3.4** Documented failure to respond to a minimum 3 month trial, intolerance, or contraindication to any ONE of the following:
  - Cimzia
  - Covered adalimumab biosimilars
  - Enbrel
  - Simponi
  - Covered ustekinumab biosimilars
  - Tremfya

- Skyrizi
- Rinvoq
- Xeljanz/XR Pharmacy Drug Policy & Procedure

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

- ☐ **4.1** Diagnosis of Psoriatic Arthritis
- ☐ **4.2** Ordered by a rheumatologist (musculoskeletal doctor) or dermatologist (skin doctor)
- ☐ **4.3** Age 2 years or older
- ☐ **4.4** Documented failure to respond to a minimum 3 month trial, intolerance, or contraindication to any TWO of the following:
  - Cimzia
  - Covered adalimumab biosimilars
  - Enbrel
  - Simponi
  - Covered ustekinumab biosimilars
  - Tremfya
  - Skyrizi
  - Rinvoq
  - Xeljanz/XR

Coverage Criteria of Non-Preferred Products with Quadruple Step-Edit (Bimzelx, Cosentyx IV or Sub-Q)

- ☐ **5.1** Diagnosis of Psoriatic Arthritis
- ☐ **5.2** Ordered by a rheumatologist (musculoskeletal doctor) or dermatologist (skin doctor)
- ☐ **5.3** Age 2 years or older
- ☐ **5.4** Documented failure to respond to a minimum 3 month trial, intolerance, or contraindication to any TWO of the following:
  - Cimzia
  - Covered adalimumab biosimilars
  - Enbrel
  - Simponi
  - Skyrizi
  - Covered ustekinumab biosimilars
  - Tremfya
  - Xeljanz/XR
  - Rinvoq
- ☐ **5.5** Documented failure to respond to a minimum 3 month trial, intolerance, or contraindication to BOTH of the following:
  - Taltz

- Orencia

Exclusion Criteria – Any of the following prevents coverage

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