**Immunomodulator Agents for Systemic Inflammatory Disease**

|  |  |
| --- | --- |
| Criteria 1 | Preferred with PA- Adbry, Enbrel, Humira, Kineret, Otezla, Xeljanz IR |
| Criteria 2 | Preferred with ST- Taltz |
| Criteria 3 | Non-Preferred- Actemra, Amjevita, Cibinqo, Cimzia, Cosentyx, Ilumya, Kevzara, Olumiant, Orencia, Rinvoq, Siliq, Simponi, Skyrizi, Sotyktu, Stelara, Tremfya, Xeljanz Sol, Xeljanz XR |
| Criteria 4 | Dupixent PA |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Criteria Title** | | | Immunomodulator Agents: Systemic Inflammatory Disease | | | | | | |
| **Criteria Subtitle** | | | Preferred Products with PA | | | | | | |
| **Approval Level** | | | GCNSeqNo | | | | | | |
| **Products**   |  |  | | --- | --- | | Preferred | X | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | | | Drug Name | | Corresponding Code (s) | | Type of Code (GCNSeqNo, HICL, NDC) | | |
| ADBRY | | 082945 | | GCNSeqNo | | |
| ENBREL | | 040869 | | GCNSeqNo | | |
| ENBREL | | 058214 | | GCNSeqNo | | |
| ENBREL | | 061938 | | GCNSeqNo | | |
| ENBREL | | 062624 | | GCNSeqNo | | |
| ENBREL | | 077783 | | GCNSeqNo | | |
| ENBREL | | 081339 | | GCNSeqNo | | |
| HUMIRA | | 051599 | | GCNSeqNo | | |
| HUMIRA | | 061205 | | GCNSeqNo | | |
| HUMIRA | | 077469 | | GCNSeqNo | | |
| HUMIRA | | 077470 | | GCNSeqNo | | |
| HUMIRA | | 077767 | | GCNSeqNo | | |
| HUMIRA | | 077870 | | GCNSeqNo | | |
| HUMIRA | | 078347 | | GCNSeqNo | | |
| HUMIRA | | 078348 | | GCNSeqNo | | |
| HUMIRA | | 078360 | | GCNSeqNo | | |
| HUMIRA | | 078672 | | GCNSeqNo | | |
| KINERET | | 048899 | | GCNSeqNo | | |
| OTEZLA | | 072075 | | GCNSeqNo | | |
| OTEZLA | | 073370 | | GCNSeqNo | | |
| XELJANZ IR | | 070233 | | GCNSeqNo | | |
| XELJANZ IR | | 078538 | | GCNSeqNo | | |
| **Sequence Number** | **Question ID** | **Default Next Question ID** | | **Question Type** | | **Question Text** | | **Choice Text** | **Next Question ID** |
| 1 | 0998 |  | | Select | | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | | New Start (initial authorization request) | 0999 |
| Continuation (re-authorization request) | 1234 |
| 2 | 0999 |  | | Select | | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | | Y | 1000 |
| N | 1235 |
| 3 | 1000 |  | | Select and Free Text | | Has the patient had an inadequate clinical response of at least 90 days with at least two applicable first-line drugs indicated for diagnosis?  If yes, please submit documentation of the trialed drugs, dosages, dates, and durations. | | Y | 1001 |
| N | 1235 |
| 4 | 1001 |  | | Select and Free Text | | Has the provider submitted documentation of the requested loading and maintenance dosing, if applicable?  Please note: Authorization of dosing regimens (loading/maintenance) will be based upon diagnosis. | | Y | 1002 |
| N | 1235 |
| 5 | 1002 |  | | Select | | Does the patient have a current, active infection? | | Y | 1235 |
| N | 1003 |
| 6 | 1003 |  | | Select | | Is a negative tuberculosis (TB) test prior to initiation of biologic therapy required for the requested agent? | | Y | 1004 |
| N | 1005 |
| 7 | 1004 |  | | Select and Free Text | | Has the provider submitted documentation of a negative tuberculosis (TB) test prior to initiation of biologic therapy? | | Y | 1005 |
| N | 1235 |
| 8 | 1005 |  | | Select | | What is the patient’s diagnosis? | | Alopecia areata | 4000 |
| Atopic dermatitis | 5000 |
| Plaque psoriasis | 6000 |
| Ulcerative colitis | 7000 |
| Other | 1006 |
| 9 | 1006 |  | | Free Text | | Please provide the patient’s diagnosis. | | END (Pending Manual Review) | |
| 10 | 4000 |  | | Select | | Is the medication being prescribed by or in consultation with a specialist (i.e., dermatologist, rheumatologist)? | | Y | 4001 |
| N | 1235 |
| 11 | 4001 |  | | Select and Free Text | | Has the provider submitted documentation of an inadequate clinical response of at least 90 days with a topical steroid?  If yes, please submit the medication trials and dates. | | Y | END (Pending Manual Review) |
| N | 1235 |
| 12 | 5000 |  | | Select  and Free Text | | Does the patient have at least 10% body surface area (BSA) involvement with two of the following: topical corticosteroids or topical calcineurin inhibitors [e.g., Elidel]?  If yes, please submit the medication trials and dates. | | Y | END (Pending Manual Review) |
| N | 5001 |
| 13 | 5001 |  | | Select | | Is the patient’s atopic dermatitis severe and involves greater than 25% BSA? | | Y | END (Pending Manual Review) |
| N | 1235 |
| 14 | 6000 |  | | Select | | Has the patient had an inadequate clinical response to at least 90 days of phototherapy? | | Y | END (Pending Manual Review) |
| N | 1235 |
| 15 | 7000 |  | | Select | | Has the patient had an inadequate clinical response after 90 days with one TNF inhibitor?  Please note: further TNF inhibitors will not be authorized. | | Y | 1235 |
| N | END (Pending Manual Review) |
| 16 | 1234 |  | | Select and Free Text | | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | | Y | END (Pending Manual Review) |
| N | 1235 |
| 17 | 1235 |  | | Free Text | | Please provide the rationale for the medication being requested. | | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: Initial: 90 days; Subsequent: 365 days

|  |  |
| --- | --- |
| **Last Approved** | 8/11/2023 |
| **Other** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Criteria Title** | Immunomodulator Agents: Systemic Inflammatory Disease | | |
| **Criteria Subtitle** | Preferred Step Therapy Products | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred | X | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| TALTZ | 075731 | GCNSeqNo |
| TALTZ | 075732 | GCNSeqNo |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0998 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0999 |
| Continuation (re-authorization request) | 1234 |
| 2 | 0999 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1000 |
| N | 1235 |
| 3 | 1000 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 90 days with at least two applicable first-line drugs indicated for diagnosis?  If yes, please submit documentation of the trialed drugs, dosages, dates, and durations. | Y | 1001 |
| N | 1235 |
| 4 | 1001 |  | Select and Free Text | Has the provider submitted documentation of the requested loading and maintenance dosing, if applicable?  Please note: Authorization of dosing regimens (loading/maintenance) will be based upon diagnosis. | Y | 1002 |
| N | 1235 |
| 5 | 1002 |  | Select | Does the patient have a current, active infection? | Y | 1235 |
| N | 1003 |
| 6 | 1003 |  | Select | Is a negative tuberculosis (TB) test prior to initiation of biologic therapy required for the requested agent? | Y | 1004 |
| N | 1005 |
| 7 | 1004 |  | Select and Free Text | Has the provider submitted documentation of a negative tuberculosis (TB) test prior to initiation of biologic therapy? | Y | 1005 |
| N | 1235 |
| 8 | 1005 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 90 days with at least one preferred TNF inhibitor indicated for diagnosis?  If yes, please submit the medication trials and dates. | Y | 1007 |
| N | 1006 |
| 9 | 1006 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 1007 |
| N | 1236 |
| 10 | 1007 |  | Select | What is the patient’s diagnosis? | Alopecia areata | 4000 |
| Atopic dermatitis | 5000 |
| Plaque psoriasis | 6000 |
| Ulcerative colitis | 7000 |
| Other | 1008 |
| 11 | 1008 |  | Free Text | Please provide the patient’s diagnosis. | END (Pending Manual Review) | |
| 12 | 4000 |  | Select | Is the medication being prescribed by or in consultation with a specialist (i.e., dermatologist, rheumatologist)? | Y | 4001 |
| N | 1235 |
| 13 | 4001 |  | Select and Free Text | Has the provider submitted documentation of an inadequate clinical response of at least 90 days with a topical steroid?  If yes, please submit the medication trials and dates. | Y | END (Pending Manual Review) |
| N | 1235 |
| 14 | 5000 |  | Select and Free Text | Does the patient have at least 10% body surface area (BSA) involvement with two of the following: topical corticosteroids or topical calcineurin inhibitors [e.g., Elidel]?  If yes, please submit the medication trials and dates. | Y | END (Pending Manual Review) |
| N | 5001 |
| 15 | 5001 |  | Select | Is the patient’s atopic dermatitis severe and involves greater than 25% BSA? | Y | END (Pending Manual Review) |
| N | 1235 |
| 16 | 6000 |  | Select | Has the patient had an inadequate clinical response to at least 90 days of phototherapy? | Y | END (Pending Manual Review) |
| N | 1235 |
| 17 | 7000 |  | Select | Has the patient had an inadequate clinical response after 90 days with one TNF inhibitor?  Please note: further TNF inhibitors will not be authorized. | Y | 1235 |
| N | END (Pending Manual Review) |
| 18 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) |
| N | 1235 |
| 19 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 20 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: Initial: 90 days; Subsequent: 365 days

|  |  |
| --- | --- |
| **Last Approved** | 8/11/2023 |
| **Other** |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Criteria Title** | | | Immunomodulator Agents: Systemic Inflammatory Disease | | | | | | | |
| **Criteria Subtitle** | | | Non-Preferred Products | | | | | | | |
| **Approval Level** | | | GCNSeqNo | | | | | | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | | | Drug Name | | Corresponding Code (s) | | Type of Code (GCNSeqNo, HICL, NDC) | | | |
| ACTEMRA | | 071590 | | GCNSeqNo | | | |
| ACTEMRA | | 078707 | | GCNSeqNo | | | |
| AMJEVITA | | 076794 | | GCNSeqNo | | | |
| AMJEVITA | | 076834 | | GCNSeqNo | | | |
| AMJEVITA | | 076836 | | GCNSeqNo | | | |
| AMJEVITA | | 084656 | | GCNSeqNo | | | |
| CIBINQO | | 082989 | | GCNSeqNo | | | |
| CIBINQO | | 082990 | | GCNSeqNo | | | |
| CIBINQO | | 082991 | | GCNSeqNo | | | |
| CIMZIA | | 063903 | | GCNSeqNo | | | |
| CIMZIA | | 065189 | | GCNSeqNo | | | |
| COSENTYX | | 073394 | | GCNSeqNo | | | |
| COSENTYX | | 073395 | | GCNSeqNo | | | |
| COSETNYX | | 082340 | | GCNSeqNo | | | |
| ILUMYA | | 078258 | | GCNSeqNo | | | |
| KEVZARA | | 077264 | | GCNSeqNo | | | |
| KEVZARA | | 077265 | | GCNSeqNo | | | |
| KEVZARA | | 078046 | | GCNSeqNo | | | |
| KEVZARA | | 078047 | | GCNSeqNo | | | |
| OLUMIANT | | 077445 | | GCNSeqNo | | | |
| OLUMIANT | | 077446 | | GCNSeqNo | | | |
| OLUMIANT | | 080389 | | GCNSeqNo | | | |
| ORENCIA | | 067681 | | GCNSeqNo | | | |
| ORENCIA | | 076265 | | GCNSeqNo | | | |
| ORENCIA | | 077399 | | GCNSeqNo | | | |
| ORENCIA | | 077400 | | GCNSeqNo | | | |
| RINVOQ | | 080125 | | GCNSeqNo | | | |
| RINVOQ | | 082927 | | GCNSeqNo | | | |
| RINVOQ | | 083196 | | GCNSeqNo | | | |
| SILIQ | | 077139 | | GCNSeqNo | | | |
| SIMPONI | | 065113 | | GCNSeqNo | | | |
| SIMPONI | | 065114 | | GCNSeqNo | | | |
| SIMPONI | | 071017 | | GCNSeqNo | | | |
| SIMPONI | | 071262 | | GCNSeqNo | | | |
| SOTYKTU | | 083817 | | GCNSeqNo | | | |
| SKYRIZI | | 079675 | | GCNSeqNo | | | |
| SKYRIZI | | 082261 | | GCNSeqNo | | | |
| SKYRIZI | | 082262 | | GCNSeqNo | | | |
| SKYRIZI | | 083492 | | GCNSeqNo | | | |
| STELARA | | 064967 | | GCNSeqNo | | | |
| STELARA | | 065993 | | GCNSeqNo | | | |
| STELARA | | 065994 | | GCNSeqNo | | | |
| TREMFYA | | 077565 | | GCNSeqNo | | | |
| TREMFYA | | 079520 | | GCNSeqNo | | | |
| XELJANZ SOL, XR | | 075641 | | GCNSeqNo | | | |
| XELJANZ SOL, XR | | 080628 | | GCNSeqNo | | | |
| XELJANZ SOL, XR | | 081537 | | GCNSeqNo | | | |
| **Sequence Number** | **Question ID** | **Default Next Question ID** | | **Question Type** | | **Question Text** | | **Choice Text** | **Next Question ID** |
| 1 | 0998 |  | | Select | | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | | New Start (initial authorization request) | 0999 |
| Continuation (re-authorization request) | 1234 |
| 2 | 0999 |  | | Select | | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | | Y | 1000 |
| N | 1235 |
| 3 | 1000 |  | | Select and Free Text | | Has the patient had an inadequate clinical response of at least 90 days with at least two applicable first-line drugs indicated for diagnosis?  If yes, please submit documentation of the trialed drugs, dosages, dates, and durations. | | Y | 1001 |
| N | 1235 |
| 4 | 1001 |  | | Select and Free Text | | Has the provider submitted documentation of the requested loading and maintenance dosing, if applicable?  Please note: Authorization of dosing regimens (loading/maintenance) will be based upon diagnosis. | | Y | 1002 |
| N | 1235 |
| 5 | 1002 |  | | Select | | Does the patient have a current, active infection? | | Y | 1235 |
| N | 1003 |
| 6 | 1003 |  | | Select | | Is a negative tuberculosis (TB) test prior to initiation of biologic therapy required for the requested agent? | | Y | 1004 |
| N | 1005 |
| 7 | 1004 |  | | Select and Free Text | | Has the provider submitted documentation of a negative tuberculosis (TB) test prior to initiation of biologic therapy? | | Y | 1005 |
| N | 1235 |
| 8 | 1005 |  | | Select and Free Text | | Has the patient had an inadequate clinical response of at least 90 days with at least two preferred drugs, if indicated for diagnosis?  If yes, please submit the medication trials and dates. | | Y | 1007 |
| N | 1006 |
| 9 | 1006 |  | | Select and Free Text | | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | | Y | 1007 |
| N | 1236 |
| 10 | 1007 |  | | Select | | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | | Y | 1008 |
| N | 1009 |
| 11 | 1008 |  | | Select and Free Text | | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | | Y | 1009 |
| N | 1235 |
| 12 | 1009 |  | | Select | | What is the patient’s diagnosis? | | Alopecia areata | 4000 |
| Atopic dermatitis | 5000 |
| Plaque psoriasis | 6000 |
| Ulcerative colitis | 7000 |
| Other | 1010 |
| 13 | 1010 |  | | Free Text | | Please provide the patient’s diagnosis. | | END (Pending Manual Review) | |
| 14 | 4000 |  | | Select | | Is the medication being prescribed by or in consultation with a specialist (i.e., dermatologist, rheumatologist)? | | Y | 4001 |
| N | 1235 |
| 15 | 4001 |  | | Select and Free Text | | Has the provider submitted documentation of an inadequate clinical response of at least 90 days with a topical steroid?  If yes, please submit the medication trials and dates. | | Y | END (Pending Manual Review) |
| N | 1235 |
| 16 | 5000 |  | | Select  and Free Text | | Does the patient have at least 10% body surface area (BSA) involvement with two of the following: topical corticosteroids or topical calcineurin inhibitors [e.g., Elidel]?  If yes, please submit the medication trials and dates. | | Y | END (Pending Manual Review) |
| N | 5001 |
| 17 | 5001 |  | | Select | | Is the patient’s atopic dermatitis severe and involves greater than 25% BSA? | | Y | END (Pending Manual Review) |
| N | 1235 |
| 18 | 6000 |  | | Select | | Has the patient had an inadequate clinical response to at least 90 days of phototherapy? | | Y | END (Pending Manual Review) |
| N | 1235 |
| 19 | 7000 |  | | Select | | Has the patient had an inadequate clinical response after 90 days with one TNF inhibitor?  Please note: further TNF inhibitors will not be authorized. | | Y | 1235 |
| N | END (Pending Manual Review) |
| 20 | 1234 |  | | Select and Free Text | | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | | Y | END (Pendng Manual Review) |
| N | 1235 |
| 21 | 1235 |  | | Free Text | | Please provide the rationale for the medication being requested. | | END (Pending Manual Review) | |
| 22 | 1236 |  | | Free Text | | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: Initial: 90 days; Subsequent: 365 days

|  |  |
| --- | --- |
| **Last Approved** | 8/11/2023 |
| **Other** |  |