

CRITERIA FOR PRIOR AUTHORIZATION

Enbrel® (etanercept), Erelzi® (etanercept-szszs)

PROVIDER GROUP Pharmacy
Professional

MANUAL GUIDELINES The following drug requires prior authorization:
Etanercept (Enbrel®, Erelzi®)

CRITERIA FOR JUVENILE IDIOPATHIC ARTHRITIS (JIA) (must meet all of the following):

- Patient must have a diagnosis of Juvenile idiopathic arthritis (JIA):
- Patient must be 2 years of age or older
- Evaluation for latent TB with TB skin test prior to initial prior authorization approval
- Must be prescribed by a rheumatologist
- Patient has not taken another biologic agent (see attached table) in the past 30 days

CRITERIA FOR RHEUMATOID ARTHRITIS (RA) OR ANKYLOSING SPONDYLITIS (AS) (must meet all of the following):

- Patient must have a diagnosis of Rheumatoid Arthritis (RA) or Ankylosing Spondylitis (AS)
- Patient must be 18 years of age or older
- Evaluation for latent TB with TB skin test prior to initial prior authorization approval
- Must be prescribed by a rheumatologist
- Patient has not taken another biologic agent (see attached table) in the past 30 days

CRITERIA FOR PSORIATIC ARTHRITIS (PSA) (must meet all of the following):

- Patient must have a diagnosis of Psoriatic Arthritis
- Patient must be 18 years of age or older
- Evaluation for latent TB with TB skin test prior to initial prior authorization approval
- Must be prescribed by a rheumatologist or dermatologist
- Patient has not taken another biologic agent (see attached table) in the past 30 days

PA Criteria

Policy/Clarification Number: E2003-053

CRITERIA FOR PLAQUE PSORIASIS (PsO) (must meet all of the following):

- Patient must have a diagnosis of Plaque psoriasis
- Patient must be 18 years of age or older for Erelzi **OR** 4 years of age or older for Enbrel
- Evaluation for latent TB with TB skin test prior to initial prior authorization approval
- Must be prescribed by a rheumatologist or dermatologist
- Patient has not taken another biologic agent (see attached table) in the past 30 days
- The patient has taken oral agents for the treatment of plaque psoriasis (see attached table) or patient is a candidate for systemic therapy or phototherapy

LENGTH OF APPROVAL 12 months

DRUG UTILIZATION REVIEW COMMITTEE CHAIR

PHARMACY PROGRAM MANAGER
DIVISION OF HEALTH CARE FINANCE
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

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| Biologic Agents | |
|-----------------|-----------------------|
| Generic Name | Brand Name |
| Abatacept | Orencia® |
| Adalimumab | Humira® |
| Alefacept | Amevive® |
| Anakinra | Kineret® |
| Certolizumab | Cimzia® |
| Golimumab | Simponi® |
| Infliximab | Remicade®, Inflectra® |
| Natalizumab | Tysabri® |
| Rituximab | Rituxan® |
| Tocilizumab | Actemra® |
| Ustekinumab | Stelara® |
| Secukinumab | Cosentyx® |
| Vedolizumab | Entyvio® |
| Canakinumab | Ilaris® |

Oral Plaque Psoriasis Therapy

| Generic Name | Brand Name |
|--------------|-----------------------|
| Acitretin | Soriatane® |
| Cyclosporine | Sandimmune® |
| Methotrexate | Trexall®, Rheumatrex® |