

CRITERIA FOR PRIOR AUTHORIZATION

Humira® (adalimumab), Amjevita® (adalimumab-atto)

PROVIDER GROUP Pharmacy

MANUAL GUIDELINES The following drug requires prior authorization:
Adalimumab (Humira®, Amjevita®)

CRITERIA FOR RHEUMATOID ARTHRITIS (RA): (must meet all of the following)

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

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

- Patient must have a diagnosis of juvenile idiopathic arthritis
- Must be prescribed by a rheumatologist
- Evaluation for latent TB with TB skin test prior to initial prior authorization approval
- Patient must be 2 years of age or older
- 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
- Must be prescribed by a rheumatologist or dermatologist
- Evaluation for latent TB with TB skin test prior to initial prior authorization approval
- Patient must be 18 years of age or older
- Patient has not taken another biologic agent (see attached table) in the past 30 days

CRITERIA FOR ANKYLOSING SPONDYLITIS (AS): (must meet all of the following)

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

PA Criteria

Policy/Clarification Number: E2003-053

CRITERIA FOR CROHN'S DISEASE (CD): (must meet all of the following)

- Patient must have a diagnosis of Crohn's disease
- Must be prescribed by a gastroenterologist
- Evaluation for latent TB with TB skin test prior to initial prior authorization approval
- Patient must be 18 years of age or older
- Patient has not taken another biologic agent (see attached table) in the past 30 days
- The patient has used a conventional Crohn's disease therapy (see attached table) **OR** there is documentation of inadequate response, contraindication, allergy, or intolerable side effects to a conventional Crohn's disease therapy (see attached table)

CRITERIA FOR PEDIATRIC CROHN'S DISEASE (CD) (HUMIRA ONLY): (must meet all of the following)

- Patient must have a diagnosis of Crohn's disease
- Must be prescribed by a gastroenterologist
- Evaluation for latent TB with TB skin test prior to initial prior authorization approval
- Patient must be 6 years of age or older
- Patient has not taken another biologic agent (see attached table) in the past 30 days
- The patient has had an inadequate response to corticosteroids or immunomodulators such as azathioprine, 6-mercaptopurine, or methotrexate

CRITERIA FOR ULCERATIVE COLITIS (UC): (must meet all of the following)

- Patient must have a diagnosis of ulcerative colitis
- Must be prescribed by a gastroenterologist
- Evaluation for latent TB with TB skin test prior to initial prior authorization approval
- Patient must be 18 years of age or older
- Patient has not taken another biologic agent (see attached table) in the past 30 days
- The patient has used a conventional ulcerative colitis therapy (see attached table) **OR** there is documentation of inadequate response, contraindication, allergy, or intolerable side effects to a conventional ulcerative colitis therapy (see attached table)

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

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

CRITERIA FOR HIDRADENITIS SUPPURATIVA (HS) (HUMIRA ONLY): (must meet all of the following)

- Patient must have a diagnosis of moderate to severe hidradenitis suppurativa (Hurley Stage II or III or Acne Inversa Severity Index [AIS] score of ≥ 10)
- Must be prescribed by a rheumatologist or dermatologist
- Evaluation for latent TB with TB skin test prior to initial prior authorization approval
- Patient must be 18 years of age or older
- Patient has not taken another biologic agent (see attached table) in the past 30 days

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CRITERIA FOR UVEITIS (HUMIRA ONLY): (must meet all of the following)

- Patient must have a diagnosis of non-infectious intermediate uveitis, posterior uveitis, or panuveitis
- Must be prescribed by an ophthalmologist
- Evaluation for latent TB with TB skin test prior to initial prior authorization approval
- Patient must be 18 years of age or older
- Patient has not taken another biologic agent (see attached table) in the past 30 days

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®
Etanercept	Enbrel®, Erelzi®
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®

Conventional Crohn's Disease Therapies	
Generic Name	Brand Name
Azathioprine	Azasan®, Imuran®
Budesonide	Entocort®
Cortisone	Cortone®
Dexamethasone	Decadron®, Dexone®, Hexadrol®, Baycadron®, DexPak®, Zema-Pak®
Hydrocortisone	Hydrocortone®, Cortef®
Mercaptopurine	Purinethol®

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Mesalamine	Apriso [®] , Lialda [®] , Cariasa [®] , Pentasa [®] , Asacol [®] , Rowasa [®] , SF-Rowasa [®] , Fiv-Asa [®]
Methotrexate	Trexall [®] , Rheumatrex [®]
Methylprednisone	Medrol [®] , MethylPred [®] , Meprolone UniPak [®]
Prednisolone	Prelone [®] , MilliPred [®] , OraPred [®] , VeriPred [®] , Bubbli-Pred [®] , PediaPred [®]
Prednisolone/Peak Flow Meter	AsmaPred Plus [®]
Prednisone	Orasone [®] , Meticorten [®] , SteraPred [®] , Deltasone [®] , Prenicen-M [®]
Sulfasalazine	Azulfidine [®] , Sulfazine [®]

Conventional Ulcerative Colitis Therapies	
Generic Name	Brand Name
Balsalazide	Colazal [®]
Budesonide	Uceris [®]
Cortisone	Cortone [®]
Dexamethasone	Decadron [®] , Dexone [®] , Hexadrol [®] , Baycadron [®] , DexPak [®] , Zema-Pak [®]
Hydrocortisone	Hydrocortone [®] , Cortef [®]
Mesalamine	Apriso [®] , Lialda [®] , Canasa [®] , Pentasa [®] , Asacol [®] , Rowasa [®] , SF-Rowasa [®] , Fiv-Asa [®]
Methylprednisolone	Medrol [®] , Meprolone UniPak [®] , MethylPred [®]
Prednisolone	Prelone [®] , MilliPred [®] , OraPred [®] , VeriPred [®] , PediaPred [®] , Bubbli-Pred [®]
Prednisolone/Peak Flow Meter	AsmalPred Plus [®]
Prednisone	Orasone [®] , Meticorten [®] , SteraPred [®] , Deltasone [®] , Prednicen-M [®]
Sulfasalazine	Azulfidine [®] , Sulfazine [®]

Oral Plaque Psoriasis Therapy	
Generic Name	Brand Name
Acitretin	Soriatane [®]
Cyclosporine	Sandimmune [®]
Methotrexate	Trexall [®] , Rheumatrex [®]