MASSACHUSETTS

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Pharmacy Medical Policy
Immune Modulating Drugs

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Policy Number: 004

BCBSA Reference Number: N/A

Related Policies

- Quality Care Dosing guidelines may apply and can be found in Medical Policy #**621B**

Prior Authorization Information

Policy	☒ Prior Authorization ☒ Step Therapy ☒ Quantity Limit	Reviewing Department	**Pharmacy Operations:** Tel: 1-800-366-7778 Fax: 1-800-583-6289
		Policy Effective Date	**1/2025**
Pharmacy (Rx) or Medical (MED) benefit coverage	☒ Rx ☐ MED	**To request for coverage:** Providers may call, fax, or mail the attached form (Formulary Exception/Prior Authorization form) to the address below. **Blue Cross Blue Shield of Massachusetts** **Pharmacy Operations Department** 25 Technology Place Hingham, MA 02043 Tel: 1-800-366-7778 Fax: 1-800-583-6289 **Individual Consideration for the atypical patient:** Policy for requests that do not meet clinical criteria of this policy, see section labeled Individual Consideration	
Policy applies to Commercial Members: • Managed Care (HMO and POS), • PPO and Indemnity • MEDEX with Rx plan • Managed Major Medical with Custom BCBSMA Formulary • Comprehensive Managed Major Medical with Custom BCBSMA Formulary • Managed Blue for Seniors with Custom BCBSMA Formulary **Policy does NOT apply to**: • Medicare Advantage			

Summary

This policy covers prior authorization, step therapy and quantity limit requirements for immune modulating drugs for some FDA-approved indications.

The FDA-approved indications covered in this policy:

The FDA-approved indications covered in this policy are listed below. You may select a condition by clicking on the name or if preferred, by scrolling down the document to the desired indication to see the formulary and prior authorization requirements.

Non-Preferred – Required to try and fail **ONE** (1) preferred prior to coverage.

Note: nothing after a diagnosis in the last column implies 18 years and older whereas an example of ≥ 6 YO means greater than or equal to 6 years of age.

QCD - Quality Care Dosing (quantity limits policy #621B); **SPBO** – Specialty Pharmacy benefit only coverage; **PA** – Prior Authorization; **ST** – Step Therapy; **NFNC** – Non-formulary, Non-Covered

Drug	Drug class	Coverage	Diag / Topic
Avsola (infliximab**)** (Remicade Biosimilar)	TNF	**Preferred**, PA	Ankylosing Spondylitis Crohn's Disease ≥ 6 YO Psoriasis Psoriatic Arthritis Rheumatoid Arthritis Ulcerative Colitis ≥ 6 YO
Cordavis Humira (adalimumab**)** (Humira Biosimilar)	TNF	**Preferred**, PA, QCD, SPBO	Ankylosing Spondylitis Crohn's Disease ≥ 6 YO Hidradenitis Suppurativa ≥ 12 YO Juvenile Idiopathic Arthritis ≥ 2 YO Panuveitis / Uveitis ≥ 2 YO Psoriasis Psoriatic Arthritis Rheumatoid Arthritis Ulcerative Colitis ≥ 5 YO
Enbrel (etanercept**)**	TNF	**Preferred**, PA, QCD, SPBO	Ankylosing Spondylitis Juvenile Idiopathic Arthritis ≥ 2 YO Psoriasis ≥ 4 YO Psoriatic Arthritis ≥ 2 YO Rheumatoid Arthritis

Drug	Drug class	Coverage	Diag / Topic
Hadlima (adalimumab**)** (Humira Biosimilar)	TNF	**Preferred**, PA, QCD	Ankylosing Spondylitis Crohn's Disease ≥ 6 YO Hidradenitis Suppurativa ≥ 12 YO Juvenile Idiopathic Arthritis ≥ 2 YO Panuveitis / Uveitis ≥ 2 YO Psoriasis Psoriatic Arthritis Rheumatoid Arthritis Ulcerative Colitis ≥ 5 YO
Humira (adalimumab**)**	TNF	**Preferred**, PA, QCD, SPBO	Ankylosing Spondylitis Crohn's Disease ≥ 6 YO Hidradenitis Suppurativa ≥ 12 YO Juvenile Idiopathic Arthritis ≥ 2 YO Panuveitis / Uveitis ≥ 2 YO Psoriasis Psoriatic Arthritis Rheumatoid Arthritis Ulcerative Colitis ≥ 5 YO
Inflectra (infliximab**)** (Remicade Biosimilar)	TNF	**Preferred**, PA	Ankylosing Spondylitis Crohn's Disease ≥ 6 YO Psoriasis Psoriatic Arthritis Rheumatoid Arthritis Ulcerative Colitis ≥ 6 YO

Drug	Drug class	Coverage	Diag / Topic
Simlandi (adalimumab**)** (Humira Biosimilar)	TNF	**Preferred**, PA, QCD	Ankylosing Spondylitis Crohn's Disease ≥ 6 YO Hidradenitis Suppurativa ≥ 12 YO Juvenile Idiopathic Arthritis ≥ 2 YO Panuveitis / Uveitis ≥ 2 YO Psoriasis Psoriatic Arthritis Rheumatoid Arthritis Ulcerative Colitis ≥ 5 YO
Ilaris (canakinumab**)**	IL1β	**Preferred**, PA, SPBO	Cryopyrin-associated Periodic Syndromes (CAPs) and Other FDA-approved Indications ≥ 4 YO Juvenile Idiopathic Arthritis ≥ 2 YO (Requires treatment failure with TWO (2) drugs on the preferred drug list)
Taltz (ixekizumab**)**	IL17a	**Preferred**, PA, QCD	Ankylosing Spondylitis Non-radiographic Axial Spondylarthritis Psoriasis ≥ 6 YO Psoriatic Arthritis
Skyrizi (risankizumab**)**	IL23	**Preferred**, PA, QCD, SPBO	Crohn's Disease Psoriasis Psoriatic Arthritis Ulcerative Colitis

Drug	Drug class	Coverage	Diag / Topic
Tremfya (guselkumab**)**	IL23	**Preferred**, PA, QCD, SPBO	Psoriasis Psoriatic Arthritis Ulcerative Colitis
Stelara (ustekinumab**)**	IL12/23	**Preferred**, PA, QCD, SPBO	Crohn's Disease Psoriasis ≥ 6 YO Psoriatic Arthritis ≥ 6 YO Ulcerative Colitis
Spevigo (spesolimab**)**	IL36	**Preferred**, PA	Generalized Pustular Psoriasis (GPP) ≥ 12 YO
Otezla (apremilast**)**	PDE4	**Preferred**, PA, QCD	Psoriasis ≥ 6 YO Psoriatic Arthritis
Velsipity (etrasimod)	S1PR	**Preferred,** PA, QCD, SPBO	Ulcerative Colitis
Adalimumab-aacf (Humira Biosimilar)	TNF	**Non-Preferred,** PA, QCD, SPBO	Ankylosing Spondylitis Crohn's Disease ≥ 6 YO Hidradenitis Suppurativa ≥ 12 YO Juvenile Idiopathic Arthritis ≥ 2 YO Panuveitis / Uveitis ≥ 2 YO Psoriasis Psoriatic Arthritis Rheumatoid Arthritis Ulcerative Colitis ≥ 5 YO

Drug	Drug class	Coverage	Diag / Topic
Adalimumab-aaty (Humira Biosimilar)	TNF	**Non-Preferred,** PA, QCD, SPBO	Ankylosing Spondylitis Crohn's Disease ≥ 6 YO Hidradenitis Suppurativa ≥ 12 YO Juvenile Idiopathic Arthritis ≥ 2 YO Panuveitis / Uveitis ≥ 2 YO Psoriasis Psoriatic Arthritis Rheumatoid Arthritis Ulcerative Colitis ≥ 5 YO
Adalimumab-adaz (Humira Biosimilar)	TNF	**Non-Preferred,** PA, QCD, SPBO	Ankylosing Spondylitis Crohn's Disease ≥ 6 YO Hidradenitis Suppurativa ≥ 12 YO Juvenile Idiopathic Arthritis ≥ 2 YO Panuveitis / Uveitis ≥ 2 YO Psoriasis Psoriatic Arthritis Rheumatoid Arthritis Ulcerative Colitis ≥ 5 YO
Adalimumab-adbm (Humira Biosimilar)	TNF	**Non-Preferred,** PA, QCD, SPBO	Ankylosing Spondylitis Crohn's Disease ≥ 6 YO Hidradenitis Suppurativa ≥ 12 YO Juvenile Idiopathic Arthritis ≥ 2 YO Panuveitis / Uveitis ≥ 2 YO Psoriasis Psoriatic Arthritis Rheumatoid Arthritis Ulcerative Colitis ≥ 5 YO

Drug	Drug class	Coverage	Diag / Topic
Adalimumab-fkjp (Humira Biosimilar)	TNF	**Non-Preferred,** PA, QCD, SPBO	Ankylosing Spondylitis Crohn's Disease ≥ 6 YO Hidradenitis Suppurativa ≥ 12 YO Juvenile Idiopathic Arthritis ≥ 2 YO Panuveitis / Uveitis ≥ 2 YO Psoriasis Psoriatic Arthritis Rheumatoid Arthritis Ulcerative Colitis ≥ 5 YO
Adalimumab-ryvk (Humira Biosimilar)	TNF	**Non-Preferred,** PA, QCD, SPBO	Ankylosing Spondylitis Crohn's Disease ≥ 6 YO Hidradenitis Suppurativa ≥ 12 YO Juvenile Idiopathic Arthritis ≥ 2 YO Panuveitis / Uveitis ≥ 2 YO Psoriasis Psoriatic Arthritis Rheumatoid Arthritis Ulcerative Colitis ≥ 5 YO
Infliximab [$] (Remicade Biosimilar)	TNF	**Non-Preferred,** PA [$=Must try either **ONE** (1) preferred infliximab]	Ankylosing Spondylitis Crohn's Disease ≥ 6 YO Psoriasis Psoriatic Arthritis Rheumatoid Arthritis Ulcerative Colitis ≥ 6 YO

Drug	Drug class	Coverage	Diag / Topic
Renflexis [$] **(**infliximab**)** (Remicade Biosimilar)	TNF	**Non-Preferred,** PA [$=Must try either **ONE** (1) preferred infliximab]	Ankylosing Spondylitis Crohn's Disease ≥ 6 YO Psoriasis Psoriatic Arthritis Rheumatoid Arthritis Ulcerative Colitis ≥ 6 YO
Zymfentra [$] **(**infliximab**)** (Remicade Biosimilar)	TNF	**Non-Preferred,** PA [$=Must try either **ONE** (1) preferred infliximab]	Ankylosing Spondylitis Crohn's Disease ≥ 6 YO Psoriasis Psoriatic Arthritis Rheumatoid Arthritis Ulcerative Colitis ≥ 6 YO
Rinvoq / LQ^ (upadacitinib**)**	JAK	**Non-Preferred**, PA, QCD (^ = must try a preferred TNF blocker prior to coverage)	Ankylosing Spondylitis Crohn's Disease Juvenile Idiopathic Arthritis ≥ 2 YO Non-radiographic Axial Spondylarthritis Psoriatic Arthritis ≥ 2 YO Rheumatoid Arthritis Ulcerative Colitis
Xeljanz ^ (tofacitinib**)**	JAK	**Non-Preferred,** PA (^ = must try a preferred TNF blocker prior to coverage)	Ankylosing Spondylitis Juvenile Idiopathic Arthritis ≥ 2 YO Psoriatic Arthritis Rheumatoid Arthritis Ulcerative Colitis

Drug	Drug class	Coverage	Diag / Topic
Xeljanz XR ^ (tofacitinib**)**	JAK	**Non-Preferred**, PA, QCD (^ = must try a preferred TNF blocker prior to coverage)	Ankylosing Spondylitis Juvenile Idiopathic Arthritis ≥ 2 YO Psoriatic Arthritis Rheumatoid Arthritis Ulcerative Colitis
Kevzara (sarilumab**)**	IL6	**Non-Preferred,** PA, QCD, SPBO	Juvenile Idiopathic Arthritis 63kG+ Rheumatoid Arthritis
Tofidence (tocilizumab**)** (Actemra Biosimilar)	IL6	**Non-Preferred,** PA	Juvenile Idiopathic Arthritis ≥ 2 YO Rheumatoid Arthritis
Tyenne (tocilizumab**)** (Actemra Biosimilar)	IL6	**Non-Preferred,** PA	Juvenile Idiopathic Arthritis ≥ 2 YO Rheumatoid Arthritis
Sotyktu (deucravacitinib)	TYK2	**Non-Preferred,** PA, QCD	Psoriasis
Abrilada (adalimumab**)** (Humira Biosimilar)	TNF	**NFNC**, PA, QCD, SPBO	Ankylosing Spondylitis Crohn's Disease ≥ 6 YO Hidradenitis Suppurativa ≥ 12 YO Juvenile Idiopathic Arthritis ≥ 2 YO Panuveitis / Uveitis ≥ 2 YO (Required to try and fail ONE (1) preferred prior to coverage.) Psoriasis Psoriatic Arthritis Rheumatoid Arthritis Ulcerative Colitis ≥ 5 YO

Drug	Drug class	Coverage	Diag / Topic
Amjevita (adalimumab**)** (Humira Biosimilar)	TNF	**NFNC**, PA, QCD, SPBO	Ankylosing Spondylitis Crohn's Disease ≥ 6 YO Hidradenitis Suppurativa ≥ 12 YO Juvenile Idiopathic Arthritis ≥ 2 YO Panuveitis / Uveitis ≥ 2 YO (Required to try and fail ONE (1) preferred prior to coverage.) Psoriasis Psoriatic Arthritis Rheumatoid Arthritis Ulcerative Colitis ≥ 5 YO
Cimzia (certolizumab**)**	TNF	**NFNC**, PA, QCD, SPBO	Ankylosing Spondylitis Crohn's Disease Non-radiographic Axial Spondylarthritis (Required to try and fail ONE (1) preferred prior to coverage.) Psoriasis Psoriatic Arthritis Rheumatoid Arthritis
Cyltezo (adalimumab**)** (Humira Biosimilar)	TNF	**NFNC**, PA, QCD, SPBO	Ankylosing Spondylitis Crohn's Disease ≥ 6 YO Hidradenitis Suppurativa ≥ 12 YO Juvenile Idiopathic Arthritis ≥ 2 YO Panuveitis / Uveitis ≥ 2 YO (Required to try and fail ONE (1) preferred prior to coverage.) Psoriasis Psoriatic Arthritis Rheumatoid Arthritis Ulcerative Colitis ≥ 5 YO

Drug	Drug class	Coverage	Diag / Topic
Hulio (adalimumab**)** (Humira Biosimilar)	TNF	**NFNC**, PA, QCD, SPBO	Ankylosing Spondylitis Crohn's Disease ≥ 6 YO Hidradenitis Suppurativa ≥ 12 YO Juvenile Idiopathic Arthritis ≥ 2 YO Panuveitis / Uveitis ≥ 2 YO (Required to try and fail ONE (1) preferred prior to coverage.) Psoriasis Psoriatic Arthritis Rheumatoid Arthritis Ulcerative Colitis ≥ 5 YO
Hyrimoz (adalimumab**)** (Humira Biosimilar)	TNF	**NFNC**, PA, QCD, SPBO	Ankylosing Spondylitis Crohn's Disease ≥ 6 YO Hidradenitis Suppurativa ≥ 12 YO Juvenile Idiopathic Arthritis ≥ 2 YO Panuveitis / Uveitis ≥ 2 YO (Required to try and fail ONE (1) preferred prior to coverage.) Psoriasis Psoriatic Arthritis Rheumatoid Arthritis Ulcerative Colitis ≥ 5 YO

Drug	Drug class	Coverage	Diag / Topic
Idacio (adalimumab**)** (Humira Biosimilar)	TNF	**NFNC**, PA, QCD, SPBO	Ankylosing Spondylitis Crohn's Disease ≥ 6 YO Hidradenitis Suppurativa ≥ 12 YO Juvenile Idiopathic Arthritis ≥ 2 YO Panuveitis / Uveitis ≥ 2 YO (Required to try and fail ONE (1) preferred prior to coverage.) Psoriasis Psoriatic Arthritis Rheumatoid Arthritis Ulcerative Colitis ≥ 5 YO
Remicade [$] **(**infliximab**)** (Remicade Biosimilar)	TNF	**NFNC**, PA, QCD, SPBO [$=Must try either **TWO** (2) preferred infliximabs]	Ankylosing Spondylitis Crohn's Disease ≥ 6 YO Psoriasis Psoriatic Arthritis Rheumatoid Arthritis Ulcerative Colitis ≥ 6 YO
Simponi / Aria **(**golimumab**)**	TNF	**NFNC**, PA, QCD, SPBO	Ankylosing Spondylitis Juvenile Idiopathic Arthritis ≥ 2 YO (Aria) Psoriatic Arthritis ≥ 2 YO (Aria) Rheumatoid Arthritis Ulcerative Colitis

Drug	Drug class	Coverage	Diag / Topic
Yuflyma (adalimumab**)** (Humira Biosimilar)	TNF	**NFNC**, PA, QCD, SPBO	Ankylosing Spondylitis Crohn's Disease ≥ 6 YO Hidradenitis Suppurativa ≥ 12 YO Juvenile Idiopathic Arthritis ≥ 2 YO Panuveitis / Uveitis ≥ 2 YO (Required to try and fail ONE (1) preferred prior to coverage.) Psoriasis Psoriatic Arthritis Rheumatoid Arthritis Ulcerative Colitis ≥ 5 YO
Yusimry (adalimumab**)** (Humira Biosimilar)	TNF	**NFNC**, PA, QCD	Ankylosing Spondylitis Crohn's Disease ≥ 6 YO Hidradenitis Suppurativa ≥ 12 YO Juvenile Idiopathic Arthritis ≥ 2 YO Panuveitis / Uveitis ≥ 2 YO (Required to try and fail ONE (1) preferred prior to coverage.) Psoriasis Psoriatic Arthritis Rheumatoid Arthritis Ulcerative Colitis ≥ 5 YO
Olumiant (baricitinib**)**	JAK	**NFNC**, PA, QCD	Rheumatoid Arthritis
Kineret (anakinra**)**	IL1	**NFNC**, PA, QCD, SPBO	Cryopyrin-associated Periodic Syndromes (CAPs) and Other FDA-approved Indications ≥ 2 YO Rheumatoid Arthritis
Actemra (tocilizumab**)**	IL6	**NFNC**, PA, QCD, SPBO	Juvenile Idiopathic Arthritis ≥ 2 YO Rheumatoid Arthritis

Drug	Drug class	Coverage	Diag / Topic
Cosentyx (secukinumab)	IL17a	**NFNC**, PA, QCD, SPBO	Ankylosing Spondylitis Enthesitis-Related Arthritis ≥ 4 YO (Requires Diag only) Hidradenitis Suppurativa ≥ 18 YO Non-radiographic Axial Spondylarthritis (Required to try and fail ONE (1) preferred prior to coverage) Psoriasis ≥ 6 YO Psoriatic Arthritis ≥ 2 YO
Bimzelx (bimekizumab)	IL17a & f	**NFNC**, PA, QCD, SPBO	Ankylosing Spondylitis Non-radiographic Axial Spondylarthritis (Required to try and fail ONE (1) preferred prior to coverage) Psoriasis Psoriatic Arthritis
Siliq (brodalumab)	IL17RA	**NFNC**, PA, QCD, SPBO	Psoriasis
Ilumya (tildrakizumab)	IL23	**NFNC**, PA, QCD, SPBO	Psoriasis
Omvoh (mirikizumab)	IL23	**NFNC**, PA, QCD, SPBO	Ulcerative Colitis
Orencia (abatacept)	T cell costimulation modulator	**NFNC**, PA, QCD	Juvenile Idiopathic Arthritis ≥ 2 YO Prophylaxis for Acute Graft versus Host Disease ≥ 2 YO (Requires diagnosis only) Psoriatic Arthritis ≥ 2 YO Rheumatoid Arthritis

Drug	Drug class	Coverage	Diag / Topic
Zeposia (ozanimod**)**	S1PR	**NF,** PA Non- formulary and requires **TWO** (2) preferred prior to coverage	Ulcerative Colitis

(This table is reproduced at the Top and Bottom of the table)

Non-Preferred – Required to try and fail **ONE** (1) preferred prior to coverage.

Note: nothing after a diagnosis in the last column implies 18 years and older whereas an example of > 6 YO means greater than or equal to 6 years of age.

QCD - Quality Care Dosing (quantity limits policy #621B); **SPBO** – Specialty Pharmacy benefit only coverage; **PA** – Prior Authorization; **ST** – Step Therapy; **NFNC** – Non-formulary, Non-Covered

Rheumatology Subsection Index with Preferred drug names included

Ankylosing Spondylitis (Avsola, Cordavis Humira, Enbrel, Hadlima, Humira, Inflectra, Simlandi, & Taltz)	Panuveitis / Uveitis (Cordavis Humira, Hadlima, Humira, & Simlandi)
Cryopyrin-associated Periodic Syndromes (CAPs) and Other FDA-approved Indications (Ilaris)	Psoriatic Arthritis Avsola, Cordavis Humira, Enbrel, Hadlima, Humira, Inflectra, Simlandi, Taltz, Skyrizi, Tremfya, & Otezla)
Juvenile Idiopathic Arthritis (Cordavis Humira, Enbrel, Hadlima, Humira, & Simlandi)	Rheumatoid Arthritis Avsola, Cordavis Humira, Enbrel, Hadlima, Humira, Inflectra, & Simlandi)
Non-radiographic Axial Spondylarthritis (Taltz)	

Dermatology Subsection Index with Preferred drug names included

Generalized Pustular Psoriasis (GPP) (Spevigo)
Hidradenitis Suppurativa (Cordavis Humira, Hadlima, Humira, & Simlandi)
Psoriasis

(Avsola, Cordavis Humira, Enbrel, Hadlima, Humira, Inflectra, Simlandi, Taltz, Skyrizi, Tremfya, Stelara & Otezla)

GI Subsection Index with Preferred drug names included

Crohn's Disease (Avsola, Cordavis Humira, Hadlima, Humira, Inflectra, Simlandi, Skyrizi, & Stelara)
Ulcerative Colitis (Avsola, Cordavis Humira, Hadlima, Humira, Inflectra, Simlandi, Skyrizi, Stelara & Tremfya

Policy

Rheumatology Subsection

Ankylosing Spondylitis

Length of Approval	12 months
Formulary Status	All requests must meet the preferred/non-preferred drug sequence and prior authorization requirements. For non-covered or non-formulary medications, the member **must** also have had a previous treatment failure with, or contraindication to, **at least two** covered formulary alternatives when available. See section on individual consideration for more information if you require an exception to any of these criteria requirements for an atypical patient.
Member cost share consideration	A higher non-preferred cost share may be applied if an exception request is approved for coverage of a non-preferred or a non-formulary/non-covered drug.

Prior Authorization Requirements for Ankylosing Spondylitis

Preferred drugs listed on the drug coverage table for ankylosing spondylitis, may be considered **MEDICALLY NECESSARY** and may be covered when **ALL** of the following criteria are met:

1. A documented diagnosis of active ankylosing spondylitis, **AND**
2. Age according to FDA approval, **AND**
3. The drug is prescribed by a board-certified or board eligible rheumatologist, **AND**
4. Treatment failure with, or contraindication to, one prescription NSAID **OR** Previous use and failure or clinical rationale for not using the preferred medication for ankylosing spondylitis, **AND**
5. Documented Dose and Frequency must be submitted and must be within the FDA approved Dosing and Frequency[%], **AND**

6. For a **Non-Preferred Drug or Non-Formulary, Non-Covered**, there has been previous use of preferred drugs and failure or clinical rationale for not using the preferred medication for Ankylosing Spondylitis (see table above for preferred drug failure requirements)

% - this criterion is only for Infliximab class.

Return to condition list

Ilaris for Cryopyrin-Associated Periodic Syndromes (CAPS) and Other FDA-approved Indications

Length of Approval	12 months
Formulary Status	All requests must meet the preferred/non-preferred drug sequence and prior authorization requirements. For non-covered or non-formulary medications, the member **must** also have had a previous treatment failure with, or contraindication to, **at least two** covered formulary alternatives when available. See section on individual consideration for more information if you require an exception to any of these criteria requirements for an atypical patient.
Member cost share consideration	A higher non-preferred cost share may be applied if an exception request is approved for coverage of a non-preferred or a non-formulary/non-covered drug.

Prior Authorization Requirements

Preferred drugs on the drug table for CAPs may be considered **MEDICALLY NECESSARY** and may be covered when **ALL** of the following criteria are met:

1. A documented diagnosis of:
    a. Cryopyrin-associated periodic syndrome (CAPS) which includes Familial Cold Autoinflammatory Syndrome (FCAS), Muckle-Wells Syndrome (MWS), and Neonatal-Onset Multisystem Inflammatory Disorder (NOMID, aka Chronic Infantile Neurologic Cutaneous & Articular Syndrome [CINCAS], **OR**
    b. Other FDA-approved indication for Ilaris (Gout, FMF, MKD, TRAPS, and HIDS), **AND**
2. The drug is prescribed by a board-certified or board-eligible rheumatologist or dermatologist, **AND**
3. For a **Non-Preferred Drug**, there has been previous use of preferred drugs and failure or clinical rationale for not using the preferred medication for CAPs (see drug coverage table for preferred drug failure requirements)

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Juvenile Idiopathic Arthritis (JIA)

Length of Approval	12 months
Formulary Status	All requests must meet the preferred/non-preferred drug sequence and prior authorization requirements. For non-covered or non-formulary medications, the member **must** also have had a previous treatment failure with, or contraindication to, **at least two** covered formulary alternatives when available. See section on individual consideration for more information if you require an exception to any of these criteria requirements for an atypical patient.

Member cost share consideration	A higher non-preferred cost share may be applied if an exception request is approved for coverage of a non-preferred or a non-formulary/non-covered drug.

Prior Authorization Criteria for Juvenile Idiopathic Arthritis (JIA)

Preferred drugs on the drug coverage table for JIA, may be considered **MEDICALLY NECESSARY** and may be covered when **ALL** of the following criteria are met:

1. A documented diagnosis of moderate to severely active JIA, **AND**
2. Age according to FDA approval

AND

3. The drug is prescribed by a board-certified or board-eligible rheumatologist, **AND**
4. Documented Dose and Frequency must be submitted and must be within the FDA approved Dosing and Frequency%%, **AND**
5. For a **Formulary Non-Preferred Drugs or Non-Formulary, Non-Covered**, there has been previous use of preferred drugs and failure or clinical rationale for not using the preferred medication for JIA (see drug table for JIA below for preferred drug failure requirements)

%% - this criterion is only for Actemra (including Biosimilars) and Orencia.

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Non-radiographic Axial Spondylarthritis

Length of Approval	12 months
Formulary Status	All requests must meet the preferred/non-preferred drug sequence and prior authorization requirements. For non-covered or non-formulary medications, the member **must** also have had a previous treatment failure with, or contraindication to, **at least two** covered formulary alternatives when available. See section on individual consideration for more information if you require an exception to any of these criteria requirements for an atypical patient.
Member cost share consideration	A higher non-preferred cost share may be applied if an exception request is approved for coverage of a non-preferred or a non-formulary/non-covered drug.

Prior Authorization Criteria for Non-radiographic Axial Spondylarthritis

Preferred drugs the drug table for Non-radiographic Axial Spondylarthritis may be considered **MEDICALLY NECESSARY** and may be covered for the treatment when **ALL** of the following criteria are met:

1. A documented diagnosis of non-radiographic axial spondylarthritis, **AND**
2. Age according to FDA approval, **AND**
3. The drug is prescribed by a board-certified or board-eligible rheumatologist, **AND**
4. Treatment failure or contraindication to a prescription NSAID **OR** Previous use and failure or clinical rationale for not using the preferred medication for non-radiographic axial spondylarthritis, **AND**
5. For a **Non-Preferred Drug**, there has been previous use of preferred drugs and failure or clinical rationale for not using the preferred medication for NAS (see drug coverage table for NAS for preferred drug failure requirements)

Return to condition list

Panuveitis/Uveitis

Length of Approval	12 months
Formulary Status	All requests must meet the preferred/non-preferred drug sequence and prior authorization requirements. For non-covered or non-formulary medications, the member **must** also have had a previous treatment failure with, or contraindication to, **at least two** covered formulary alternatives when available. See section on individual consideration for more information if you require an exception to any of these criteria requirements for an atypical patient.
Member cost share consideration	A higher non-preferred cost share may be applied if an exception request is approved for coverage of a non-preferred or a non-formulary/non-covered drug.

Prior Authorization Criteria for Panuveitis / Uveitis

Preferred drugs listed on the drug coverage table for Panuveitis/Uveitis may be considered **MEDICALLY NECESSARY** and may be covered when **ALL** of the following criteria are met:

1. A documented diagnosis of non-infectious intermediate, posterior Uveitis or Panuveitis, **AND**
2. Age according to FDA approval, **AND**

   Documentation of one (1) of the following:

   a. Topical Corticosteroids, **OR**

   b. Topical Cycloplegics, **OR**

   c. History of preferred drugs for Panuveitis / Uveitis, **OR**

   d. Severe disease with profoundly limited vision or risk of significant vision loss, including those with macular edema, **OR.**

   e. Bilateral posterior uveitis, **OR**

   f. Comorbid glaucoma precluding the use of local glucocorticoid injections, **OR**

   g. Certain systemic diseases including Behçet syndrome and serpiginous choroiditis

3. For a **Formulary Non-Preferred Drugs or Non-Formulary, Non-Covered**, there has been previous use of preferred drugs and failure or clinical rationale for not using the preferred medication for Panuveitis /Uveitis (see drug table for Panuveitis / Uveitis above for preferred drug failure requirements)

Return to condition list

Psoriatic Arthritis

Length of Approval	12 months
Formulary Status	All requests must meet the preferred/non-preferred drug sequence and prior authorization requirements. For non-covered or non-formulary medications, the member **must** also have had a previous treatment failure with, or contraindication to, **at least two** covered formulary alternatives when available. See section on individual consideration for more information if you require an exception to any of these criteria requirements for an atypical patient.
Member cost share consideration	A higher non-preferred cost share may be applied if an exception request is approved for coverage of a non-preferred or a non-formulary/non-covered drug.

Prior Authorization Criteria for Psoriatic Arthritis

Preferred drugs listed on the drug coverage table for psoriatic arthritis may be considered **MEDICALLY NECESSARY** and may be covered when **ALL** of the following criteria are met:

1. A documented diagnosis of active Psoriatic Arthritis, **AND**
2. Age according to FDA approval
3. Treatment failure with or contraindication to one oral or injectable DMARD **OR** Previous use of one of the preferred medications for psoriatic arthritis in the table, **AND**
4. The drug is prescribed by a board-certified or board-eligible rheumatologist, **AND**
5. Documented Dose and Frequency must be submitted and must be within the FDA approved Dosing and Frequency%%, **AND**
6. For a **Formulary Non-Preferred Drugs or Non-Formulary, Non-Covered**, there has been previous use of preferred drugs and failure or clinical rationale for not using the preferred medication for Psoriatic Arthritis

%% - this criterion is only for the Infliximab class and Orencia.

Return to condition list

Rheumatoid Arthritis

Length of Approval	12 months
Formulary Status	All requests must meet the preferred/non-preferred drug sequence and prior authorization requirements. For non-covered or non-formulary medications, the member **must** also have had a previous treatment failure with, or contraindication to, **at least two** covered formulary alternatives when available. See section on individual consideration for more information if you require an exception to any of these criteria requirements for an atypical patient.
Member cost share consideration	A higher non-preferred cost share may be applied if an exception request is approved for coverage of a non-preferred or a non-formulary/non-covered drug.

Prior Authorization Requirements for Rheumatoid Arthritis

Preferred drugs on the drug coverage table for rheumatoid arthritis may be considered **MEDICALLY NECESSARY** and may be covered when **ALL** of the following criteria are met:

1. A documented diagnosis of moderate to severely active rheumatoid arthritis, **AND**
2. Age ≥ 18 years, **AND**
3. The drug is prescribed by a board-certified or board eligible rheumatologist, **AND**
4. Treatment failure with or contraindication to one conventional DMARD (azathioprine, cyclophosphamide, cyclosporin, hydroxychloroquine, leflunomide, methotrexate, mycophenolate, sulfasalazine,) **OR** Previous use of one of the preferred medications for rheumatoid arthritis in the table, **AND**
5. Documented Dose and Frequency must be submitted and must be within the FDA approved Dosing and Frequency%%%, **AND**

6. For a **Formulary Non-Preferred Drugs or Non-Formulary, Non-Covered**, there has been previous treatment failure with a preferred drug (see drug coverage table for RA below for preferred drug failure requirements)

%%% - this criterion is only for the Infliximab class, Actemra (including Biosimilars) and Orencia.

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Dermatology Subsection

Generalized Pustular Psoriasis (GPP)

Length of Approval	3 months
Formulary Status	All requests must meet the preferred/non-preferred drug sequence and prior authorization requirements. For non-covered or non-formulary medications, the member **must** also have had a previous treatment failure with, or contraindication to, **at least two** covered formulary alternatives when available. See section on individual consideration for more information if you require an exception to any of these criteria requirements for an atypical patient.
Member cost share consideration	A higher non-preferred cost share may be applied if an exception request is approved for coverage of a non-preferred or a non-formulary/non-covered drug.

Prior Authorization Criteria for Generalized Pustular Psoriasis (GPP)

Preferred drugs listed on the drug coverage table for GPP, may be considered **MEDICALLY NECESSARY** and may be covered when **ALL** of the following criteria are met:

1. A documented diagnosis of Generalized Pustular Psoriasis, **AND**
2. Age according to FDA approval, **AND**
3. For a **Formulary Non-Preferred Drugs or Non-Formulary, Non-Covered**, there has been previous use of preferred drugs and failure or clinical rationale for not using the preferred medication for GPP (see drug table above for preferred drug failure requirements)

Return to condition list

Hidradenitis Suppurativa

Length of Approval	12 months
Formulary Status	All requests must meet the preferred/non-preferred drug sequence and prior authorization requirements. For non-covered or non-formulary medications, the member **must** also have had a previous treatment failure with, or contraindication to, **at least two** covered formulary alternatives when available. See section on individual consideration for more information if you require an exception to any of these criteria requirements for an atypical patient.
Member cost share consideration	A higher non-preferred cost share may be applied if an exception request is approved for coverage of a non-preferred or a non-formulary/non-covered drug.

Prior Authorization Criteria for Hidradenitis Suppurativa

Preferred drugs listed on the drug coverage table for hidradenitis suppurativa may be considered **MEDICALLY NECESSARY** and may be covered when **ALL** of the following criteria are met:

1. A documented diagnosis of moderate to severe hidradenitis suppurativa, **AND**
2. Age according to FDA approval.

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Psoriasis

Length of Approval	12 months
Formulary Status	All requests must meet the preferred/non-preferred drug sequence and prior authorization requirements. For non-covered or non-formulary medications, the member **must** also have had a previous treatment failure with, or contraindication to, **at least two** covered formulary alternatives when available. See section on individual consideration for more information if you require an exception to any of these criteria requirements for an atypical patient.
Member cost share consideration	A higher non-preferred cost share may be applied if an exception request is approved for coverage of a non-preferred or a non-formulary/non-covered drug.

Prior Authorization Criteria for Psoriasis

Preferred drugs on the drug coverage table for psoriasis may be considered **MEDICALLY NECESSARY** and covered when **ALL** of the following criteria are met:

1. A documented diagnosis of moderate-severe chronic plaque psoriasis, **AND**
2. Age according to FDA approval, **AND**
3. The drug is prescribed by a board-certified or board-eligible dermatologist, **AND**
4. Treatment failure with or contraindication to systemic therapy for Psoriasis (Methotrexate, Azathioprine, Acitretin, Tacrolimus, Cyclosporine, Mycophenolate, 6-thioguanine, Sulfasalazine, Hydroxyurea, Propylthiouracil, Narrow-band UVB, Oral methoxsalen) **OR** Previous use and failure or clinical rationale for not using the preferred medication for psoriasis, **AND**
5. Documented Dose and Frequency must be submitted and must be within the FDA approved Dosing and Frequency%, **AND**
6. For a **Formulary Non-Preferred Drugs or Non-Formulary, Non-Covered**, there has been previous use of preferred drugs and failure or clinical rationale for not using the preferred medication for Psoriasis (see drug table below for requirements and exceptions)

% - this criterion is only for the Infliximab class.

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GI Subsection

Crohn's Disease

Length of Approval	12 months
Formulary Status	All requests must meet the preferred/non-preferred drug sequence and prior authorization requirements. For non-covered or non-formulary medications, the member **must** also have had a previous treatment failure with, or contraindication to, **at least two** covered formulary alternatives when available. See section on individual consideration for more information if you require an exception to any of these criteria requirements for an atypical patient.
Member cost share consideration	A higher non-preferred cost share may be applied if an exception request is approved for coverage of a non-preferred or a non-formulary/non-covered drug.

Prior Authorization Criteria for Crohn's Disease

Preferred drugs listed on the drug coverage table for Crohn's Disease, may be considered **MEDICALLY NECESSARY** and may be covered when **ALL** of the following criteria are met:

1. A documented diagnosis of moderate to severe Crohn's Disease, **AND**
2. Age according to FDA approval, **AND**
3. The drug is prescribed by a board-certified or eligible gastroenterologist, **AND**
4. Not receiving in combination with any of the following:
    a. Potent Immunosuppressives (JAK inhibitors, TNF inhibitors, IL-1 inhibitor, IL-6 inhibitor, any other applicable categories), **OR**
    b. Integrin inhibitors (Vedolizumab, Natalizumab), **AND**
5. Documented Dose and Frequency must be submitted and must be within the FDA approved Dosing and Frequency%, **AND**
6. For a **Formulary Non-Preferred Drugs or Non-Formulary, Non-Covered**, there has been previous use of preferred drugs and failure or clinical rationale for not using the preferred medication for Crohn's Disease (see the drug table above for preferred drug failure requirements)

% - this criterion is only for Infliximab class.

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Ulcerative Colitis

Length of Approval	12 months
Formulary Status	All requests must meet the preferred/non-preferred drug sequence and prior authorization requirements. For non-covered or non-formulary medications, the member **must** also have had a previous treatment failure with, or contraindication to, **at least two** covered formulary alternatives when available. See section on individual consideration for more information if you require an exception to any of these criteria requirements for an atypical patient.
Member cost share consideration	A higher non-preferred cost share may be applied if an exception request is approved for coverage of a non-preferred or a non-formulary/non-covered drug.

Prior Authorization Criteria for Ulcerative Colitis (UC)

Preferred drugs on the drug coverage table for UC, may be considered **MEDICALLY NECESSARY** and may be covered when **ALL** of the following criteria are met:

1. A documented diagnosis of moderate to severe Ulcerative Colitis, **AND**
2. Age according to FDA approval, **AND**
3. The drug is prescribed by a board-certified or eligible gastroenterologist, **AND**
4. Documented history of failure, contraindication, or intolerance to at least one of the following therapies:
    a. Tumor necrosis factor (TNF) blocker (adalimumab, certolizumab, etanercept, infliximab or golimumab), **OR**
    b. DMARD (azathioprine, cyclophosphamide, cyclosporin, hydroxychloroquine, leflunomide, methotrexate, mycophenolate, sulfasalazine), **OR**
    c. Systemic Corticosteroid(s), **OR**
    d. Documented history of previous use and failure or clinical rationale for not using the **preferred medication** for ulcerative colitis.

AND

5. Documented Dose and Frequency must be submitted and must be within the FDA approved Dosing and Frequency%, **AND**
6. Not receiving in combination with any of the following:
    a. Potent Immunosuppressives (JAK inhibitors, TNF inhibitors, IL-1 inhibitor, IL-6 inhibitor, any other applicable categories), **OR**
    b. Integrin inhibitors (Vedolizumab, Natalizumab), **AND**
7. For a **Formulary Non-Preferred Drugs^ or Non-Formulary, Non-Covered Drugs,** there has been previous use of preferred drugs and failure or clinical rationale for not using the preferred medication for UC.

% - this criterion is only for the Infliximab class.

^ -- must try a preferred TNF blockers prior to coverage.

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Provider Documentation Requirements

Documentation from the provider to support a reason preventing trial of formulary alternative(s) must include the name and strength of alternatives tried and failed (if alternatives were tried, including dates if available) and specifics regarding the treatment failure. Documentation to support clinical basis preventing switch to formulary alternative should also provide specifics around clinical reason.

Individual Consideration (For Atypical Patients)

Our medical policies are written for most people with a given condition. Each policy is based on peer reviewed clinical evidence. We also take into consideration the needs of atypical patient populations and diagnoses.

If the coverage criteria outlined is unlikely to be clinically effective for the prescribed purpose, the health care provider may request an exception to cover the requested medication based on an individual's unique clinical circumstances. This is also referred to as "individual consideration" or an "exception request."

Some reasons why you may need us to make an exception include: therapeutic contraindications; history of adverse effects; expected to be ineffective or likely to cause harm (physical, mental, or adverse reaction).

To facilitate a thorough and prompt review of an exception request, we encourage the provider to include additional supporting clinical documentation with their request. This may include:

- Clinical notes or supporting clinical statements;
- The name and strength of formulary alternatives tried and failed (if alternatives were tried) and specifics regarding the treatment failure, if applicable;
- Clinical literature from reputable peer reviewed journals.
- References from nationally recognized and approved drug compendia such as American Hospital Formulary Service® Drug Information (AHFS-DI), Lexi-Drug, Clinical Pharmacology, Micromedex or Drugdex ®; and
- References from consensus documents and/or nationally sanctioned guidelines.

Providers may call, fax or mail relevant clinical information, including clinical references for individual patient consideration, to:

Blue Cross Blue Shield of Massachusetts
Pharmacy Operations Department
25 Technology Place
Hingham, MA 02043
Phone: 1-800-366-7778
Fax: 1-800-583-6289

We may also use prescription claims records to establish prior use of formulary alternatives or to show if step therapy criteria has been met. We will require the provider to share additional information when prescription claims data is either not available or the medication fill history fails to establish use of preferred formulary medications or that step therapy criteria has been met.

Policy History

Date	Action
1/2025	Updated to add Tremfya's new indication add FDA ages into the criteria and drug table and add Adalimumab-aacf to the policy as Non-Preferred.
11/2024	Reformatted Drug table and added Velsipity to preferred.
8/2024	Updated Spevigo change in age indication and Otezla's age in Psoriasis section, to add Zymfentra to the policy as non-preferred in Remicade table, to add Adalimumab-aaty & Adalimumab-ryvk to the non-preferred section, to add Tofidence & Tyenne to the non-preferred section, and to Clarify coverage for JAK inhibitors and include Rinvoq new liquid plus its JIA indication along with Kevzara's JIA indication.
5/2024	Updated to include Simlandi and Cordavis Humira to the policy.
4/2024	Updated to make Remicade and Amjevita non preferred and clarified age requirements for non-preferred drugs and covered indications of CAPs.
3/2024	Updated Dose and Frequency requirements to coincide with Medical claim edits and to add Omvoh, Bimzelx, and Velsipity to the policy as non-preferred.
1/2024	Updated to add Humira (adalimumab) biosimilars to the policy and to add new indication for Cosentyx.
12/2023	Reformatted policy. Updated IC to align with 118E MGL § 51A. Updated criteria for Ulcerative Colitis and Crohn's Disease. Updated policy format
9/2023	Updated to add new Rinvoq UC indication to the policy and updated IC to align with 118E MGL § 51A.
4/2023	Updated to add Amjevita and Sotyktu to the policy and add Age for Cosentyx for Psoriasis.
3/2023	Announced Skyrizi and Ilumya are joining Policy 071 on 7/1/2023.
1/2023	Updated to move Actemra, Cimzia, Ilumya, Kineret, Olumiant, Orencia, Siliq, and Simponi to non-covered. Also, to add Spevigo to the policy.
11/2022	Updated to add clarifying Footnote to Remicade and Olumiant.

8/2022	Updated to include new indication of CD for Skyrizi ® and update the criteria for UC and Crohn's.
7/2022	Clarified Age for Psoriasis and added Indication for Simponi Aria (pJIA).
5/2022	Updated to include Rinvoq and additional clarity to RA criteria.
4/2022	Updated to add Avsola in the Infliximab table as Preferred.
2/2022	Updated to add AG biosimilar Infliximab as nonpreferred in the infliximab table and updated to separate Severe types or Ulcerative Colitis and Crohns disease. Lastly, Moved Xeljanz and Rinvoq to non-preferred in line with FDA label update.
1/2022	Updated to include 3rd row for Ulcerative Colitis in the table at the top.
8/2021	Updated criteria for Crohn's Disease and clarified criteria for Psoriasis.
7/2021	Updated to add nonpreferred language to Cosentyx, also new age for Humira in UC and a new indication for Actemra.
1/1/2021	Updated to move Cosentyx and Actemra to non-preferred. Plus Tremfya, Taltz, Enbrel, Stelara, Xeljanz to preferred. A new indication was added to the policy with Cimzia as preferred.
11/2020	Updated to add new diagnosis for Xeljanz to first non-preferred grouping and to move Rituxan to policy 123.
10/2020	Updated to prefer Inflectra as preferred infliximab.
9/2020	Updated to add Avsola to the Infliximab table and Stelara' s new age for psoriasis.
6/2020	Updated to move Otezla to preferred for psoriatic arthritis.
2/2020	Updated to move Stelara to move to non-preferred for UC.
1/2020	Updated to move Taltz in all indications and Xeljanz in UC indication to non-preferred.
10/2019	Updated to add Rinvoq to preferred RA and to add expanded indications for Inflectra, Renflexis & Otezla.
7/2019	Updated to add Skyrizi & Tremfya to preferred in Psoriasis and to add Humira first step to Cimzia for Crohn's disease.
1/1/2019	Updated to Add an Infliximab table and make Inflectra a Preferred drug for its indications. Moved Xeljanz /XR to preferred status for all indications. Clarified coding information
10/2018	Updated to add Ilumya and Olumiant to a non-preferred position in the policy.
7/2018	Update to include additional Criteria for Remicade.
2/2018	Update to add Stelara to Preferred in Crohn's, Xeljanz to Psoriatic Arthritis non-preferred and added Tremfya to requiring Humira first instead of two covered alternatives.
1/2018	Clarified coding information and updated to include Tremfya & Siliq as Non-Preferred medications to the policy.
11/2017	Updated to add Kevzara to this policy and add new indications plus update Walgreens specialty.
Date	**Action**
10/2017	Updated to include Renflexis.
7/2017	Update to include new indications for Actemra and Orencia.
6/2017	Update Address for Pharmacy Operations.
5/2017	Updated to Add hyperlinks for disease states in the medication table to link to specific criteria in the policy.
1/1/2017	Updated criteria to be arranged by diagnosis instead by drug.
10/2016	Updated to add Taltz and to add new Q code for Infliximab.
4/2016	Updated to include new diagnosis and coding for Humira & Cosentyx.
1/2016	Clarified coding information.
10/2015	Updated to included revised language for Pharmacy only medications.
7/2015	Updated to clarify Cosentyx placement and Rituxan® IC criteria. Clarified coding information.
4/2015	Updated to include Cosentyx.
1/2015	Update Criteria for Orencia For PJIA.
10/2014	Updated to include Otezla (apremilast) and updated to include Entyvio(vedolizumab)
7/2014	Updated to include ICD-10.
2/2014	Added some already coded ICD9s.(i.e. 556.0). Diagnoses codes: 555.3, 555.4, 555.5, 555.6, 555.7 and 555.8 were previously listed in error as covered diagnoses and have

	been removed to coincide with system edits that remain unchanged.
1/2014	Updated to include new UC indication for Simponi, Stelara and add Xeljanz criteria. Removed Blue Value Formulary information. Added Enbrel and Humira where indication appropriate. Updated ExpressPAth language. Updated Reference 1.
1/2013	Updated 1/2013 to include new FDA approved indication for Actemra® of systemic juvenile idiopathic arthritis.
4/2012	Updated with specialty pharmacy contact information.
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
1/2012	Updated with specialty pharmacy contact information.
11/2011	Reviewed - Medical Policy Group - Plastic Surgery and Dermatology. No changes to policy statements.
11/2010	Reviewed - Medical Policy Group - Gastroenterology, Nutrition and Organ Transplantation. No changes to policy statements.
9/2010	Updated to include coverage criteria for new FDA approved products based on P&T Committee recommendations: Actemra, Ilaris, and Stelara and update of specialty pharmacy contact information.
7/2010	Reviewed - Medical Policy Group - Orthopedics, Rehabilitation Medicine and Rheumatology. No changes to policy statements.
1/2010	Policy updated to include coverage criteria for new drug Simponi®, add new PDA approved diagnosis of rheumatoid arthritis to coverage criteria for Cimzia®, and to add additional coverage criteria to certain Remicade diagnoses®.
12/2009	Reviewed - Medical Policy Group - Plastic Surgery and Dermatology. No changes to policy statements.
10/2009	Policy updated to reflect UM requirements and remove Raptiva from medical policy.
9/2009	Policy updated to change 180 day look back period to 130 days and to remove Medicare Part D criteria from Medical Policy.
7/2009	Reviewed - Medical Policy Group - Orthopedics, Rehabilitation Medicine and Rheumatology. No changes to policy statements.
1/2009	Updated to include coverage criteria for Rituxan® for rheumatoid arthritis and to combine coverage criteria for plaque psoriasis diagnoses for Amevive® , Enbrel ®, Humira®, Raptiva™ and Remicade® (Taken from Medical Policy #020 which will be retired on 1/1/09.)
10/2008	Updated to include covered indication for Cimzia®.
7/2008	Reviewed - Medical Policy Group - Orthopedics, Rehabilitation Medicine and Rheumatology. No changes to policy statements.
5/2008	Updated to include new indication for Orencia® for juvenile idiopathic arthritis.
3/2008	Updated to include new indication for Humira™ for juvenile idiopathic arthritis.
2/2008	Updated to include additional retail specialty pharmacy network information.
11/2007	Reviewed - Medical Policy Group - Gastroenterology, Nutrition and Organ Transplantation. No changes to policy statements.
7/2007	Reviewed - Medical Policy Group - Orthopedics, Rehabilitation Medicine and Rheumatology. No changes to policy statements.
5/2007	Updated to include FDA-approved indication for Humira (adalimumab) for Crohn's Disease and Ankylosing Spondylitis.
1/2007	Updated to include coverage for FDA-approved indication for Remicade for Pediatric Crohn's Disease and retail specialty pharmacy network information.
10/2004	New policy, effective 10/2004, describing covered and non-covered indications.

Forms

To request prior authorization using the Massachusetts Standard Form for Medication Prior Authorization Requests (eForm), click the link below:

https://www.bluecrossma.org/medical-policies/sites/g/files/csphws2091/files/acquiadam-assets/023%20E%20Form%20medication%20prior%20auth%20instruction%20prn.pdf

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