blue of california

adalimumab (HUMIRA)

Diagnoses Considered for Coverage:

- Ankylosing Spondylitis (AS)
- Crohn's disease (CD)
- Hidradenitis Suppurativa
- Polyarticular Juvenile Idiopathic Arthritis (pJIA)
- Psoriatic Arthritis (PsA)
- Rheumatoid Arthritis (RA)
- Plaque Psoriasis
- Ulcerative Colitis
- Uveitis-non-infectious

Coverage Criteria:

1. **For spondyloarthritis:**
   - Being prescribed by, or in consultation with, a rheumatologist, **and**
   - Not being used together with other targeted immunotherapies, **and**
   - Dose does not exceed FDA label maximum, **and**
   - One of the following:
     - For patient with no bleeding or ulcer risk factors: Either inadequate response or non-GI related intolerable side effect with TWO prescription-strength oral NSAIDs, OR intolerable GI side effect with ONE prescription-strength oral NSAID monotherapy not relieved with addition of concomitant proton pump inhibitor (PPI) therapy, **or**
     - For patient with high-risk potential for development of GI bleed or ulcer: Inadequate response or intolerable side effect to ONE prescription-strength oral NSAID in combination with a proton pump inhibitor (PPI), **or**
     - Patient unable to use NSAIDs due to history of GI bleed or ulcer

   Coverage Duration: one year

2. **For Crohn's disease:**
   - Not being used together with other targeted immunotherapies, **and**
   - Dose does not exceed FDA label maximum.

   Coverage Duration: one year

For a dose escalation request in moderate to severe Crohn's disease:

- Patient either flared or had a loss in response after at least one maintenance dose, **and**
- Not being used in combination with other targeted immunotherapies, **and**
- Dose does not exceed FDA label maximum.

Coverage Duration: one year

3. For hidradenitis suppurativa:

- Being prescribed by or in consultation with a dermatologist, **and**
- Patient has moderate to severe HS disease as evidenced by Hurley stage II or III disease, **and**
- Not being used in combination with other targeted immunotherapies, **and**
- Dose does not exceed FDA label maximum.

Coverage Duration: one year

4. For juvenile idiopathic rheumatoid arthritis:

- Being prescribed by or in consultation with a rheumatologist, **and**
- Inadequate response or intolerable side effect with one DMARD agent OR has a medical justification why methotrexate cannot be used, **and**
- Not being used together with other targeted, **and**
- Dose does not exceed FDA label maximum.

Coverage Duration: one year

5. For psoriatic arthritis:

- Being prescribed by or in consultation with a rheumatologist, **and**
- Inadequate response or intolerable side effect with one DMARD agent OR patient has a medical reason why methotrexate, leflunomide, and sulfasalazine cannot be used, **and**
- Not being used together with other targeted immunotherapies, **and**
- Dose does not exceed FDA label maximum.

Coverage Duration: one year

6. **For plaque psoriasis:**

Initial Authorization

• Patient is at least 18 years old, **and**
• Being prescribed by or in consultation with a rheumatologist or dermatologist, **and**
• Inadequate response, intolerable side effect, or contraindication to one of the following: methotrexate, cyclosporine (Neoral), acitretin (Soriatane), **or** PUVA/UVB, **and**
• Not being used in combination with another targeted biologic, **and**
• Dose does not exceed FDA label maximum, **and**
• One of the following:
  • Baseline PASI score is 10 or more prior to initiating biological therapy, **or**
  • Baseline BSA is 3% or more prior to initiating biological therapy, **or**
  • Sensitive area is involved (i.e. groin, face, etc.), **or**
  • Disease is otherwise debilitating.
 	
Coverage Duration: 24 weeks

Reauthorization
• Patient has shown improvement in the baseline PASI (or BSA if provided on initial request), **and** • Not being used together with other targeted immunotherapies, **and** • Dose does not exceed FDA label maximum. ***Coverage Duration:*** one year
Dose escalation beyond FDA maximum for maintenance
• Drug will be administered at home by the patient or the patient's caregiver, **and** • Not being used in combination with another targeted biologic, **and** • Dose does not exceed FDA label maximum. ***Coverage Duration:*** one year

7. **For rheumatoid arthritis:**

• Recommended by a rheumatologist, **and** • Inadequate response, intolerable side effect, or contraindication to

methotrexate, **and**

- Not being used in combination with another targeted immunomodulator, **and**
- Dose does not exceed FDA label maximum.

Coverage Duration: one year

8. **For ulcerative colitis:**

- Not being used in combination with other targeted immunotherapies, **and**
- Dose does not exceed FDA label maximum.

Coverage Duration: one year

9. **For non-infectious uveitis:**

- Being prescribed by or in consultation with an ophthalmologist, **and**
- Inadequate response, intolerable side effect, or contraindication to systemic corticosteroids, **and**
- Not being used together with other targeted immunotherapies, **and**
- Dose does not exceed FDA label maximum.

Coverage Duration: one year

Coverage Duration: see individual diagnoses

Effective Date: 01/03/2024