STATE OF WEST VIRGINIA
DEPARTMENT OF HUMAN SERVICES
BUREAU FOR MEDICAL SERVICES

Office of Pharmacy Services
Prior Authorization Criteria
Cytokine & CAM antagonist criteria
Effective 1/01/2022

Prior Authorization Request Form

Prior Authorization for any agent in this class requires the following criteria to be met. Additional criteria may be required for specific indications; off-label requests require an appeal:

- Diagnoses must accompany all requests
- Patient must meet the minimum age recommended by the manufacturer for the FDA-approved indication; **AND**
- Initial treatment plan must be done by, or in consultation with an appropriate specialist (such as a dermatologist, gastroenterologist or rheumatologist); **AND**
- A negative tuberculin skin test must be submitted prior to initiation of therapy.
- Off-label use must be appealed to the Medical Director and be accompanied by a letter from the prescriber detailing the clinical rationale for the request.
- *DMARD refers to a non-biologic disease-modifying anti-rheumatic drug and includes such agents as methotrexate (MTX), sulfasalazine, leflunomide, and cyclosporine among others.*
- Please refer to the table below for preferred agents (highlighted) and non-preferred agents with FDA-approved indications.

THE FOLLOWING INDICATION SPECIFIC CRITERIA MUST ALSO BE SATISFIED:

- **Ankylosing Spondylitis, Plaque Psoriasis, and Psoriatic Arthritis:**
  - **Plaque psoriasis**: Preferred agents require evidence of failure after at least 90 days of topical therapy* with two different agents classified as an emollient, corticosteroid, topical retinoid, or vitamin D analog. A 90-day trial of one DMARD (or a systemic retinoid such as acitretin) is also required.
    **Topical therapy requirement is waived for moderate-to-severe disease affecting at least 5% of the BSA or crucial body areas such as the hands, feet, face, neck, genitals/groin, or intertriginous areas.*
  - **Psoriatic Arthritis:** Preferred agents require a 90-day trial of one DMARD.
  - **Ankylosing Spondylitis:** Preferred agents require failure of two 30-day trials of NSAIDs.
  - Note: Taltz may be authorized only after a 90-day trial of one preferred ANTI-TNF agent.
  - Non-preferred agents require 90-day trials of all preferred agents that are indicated for the diagnosis.
- **Rheumatoid Arthritis:**
  - Preferred agents require a 90-day trial of a DMARD.

- Non-preferred agents require 90-day trials of each of the following: one DMARD and each preferred agent indicated for rheumatoid arthritis.

- **Juvenile Idiopathic Arthritis:**
  - Preferred agents require a 90-day trial of a DMARD.
  - Non-preferred agents each require 90-day trials of one DMARD and of each preferred agent indicated for juvenile idiopathic arthritis..

- **Crohn's Disease (Adult and Pediatric):**
  - Preferred agents may be authorized upon demonstration of an inadequate response to at least one 14-day trial of corticosteroids or an immunomodulator such as azathioprine, 6-mercaptopurine, or methotrexate.
  - In addition to the above criteria, non-preferred agents require a 90-day trial of each preferred agent indicated for Crohn's disease.

- **Ulcerative Colitis:**
  - Preferred agents may be authorized upon demonstration of an inadequate response to at least a 30-day course of aminosalicylates (e.g. sulfasalazine, mesalamine) requiring treatment for two (2) or more exacerbations using corticosteroids, such as prednisone.
  - In addition to the above criteria, non-preferred agents require a 90-day trial of each preferred agent indicated for ulcerative colitis.

- **Hidradenitis Suppurativa:**
  - Preferred agents may be authorized with documentation indicating that the patient has severe disease (Hurley stage III) OR moderate disease (Hurley stage II) despite treatment with an oral formulary tetracycline (i.e. doxycycline) OR topical clindamycin.

- **Uveitis:**
  - Preferred agents may be authorized for a diagnosis of non-infectious uveitis and failure to respond to an appropriate trial of oral/topical corticosteroid therapy, unless contraindicated.

FDA-approved indications – *(Preferred agents highlighted).* ***Current on 10/7/2025***
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		Ankylosing Spondylitis	Plaque Psoriasis	Psoriatic Arthritis	Polyarticular JIA	Rheumatoid Arthritis	Crohn's Disease	Pediatric Crohn's Disease	Ulcerative Colitis	Hidradenitis Suppurativa	Uveitis	Cytokine Release Syndrome	Giant Cell Arteritis	Systemic JIA	Periodic Fever Syndromes	Non-Radiographic Axial Spondyloarthritis	Mechanism of Action
Humira	adalinumab	þ	þ	þ	þ ≥ 2 y	þ	þ	þ ≥ 6 y	þ ≥ 5 y	þ ≥ 12 y	þ ≥ 2 y						Anti-TNF
Enbrel	etanercept	þ	þ ≥ 4 y	þ ≥ 2 y	þ ≥ 2 y	þ											Anti-TNF
Cosentyx	secukinumab	þ	þ ≥ 6 y	þ ≥ 2 y						þ						þ	Anti-IL-17A
Cimzia	certolizumab pegol		þ	þ	þ ≥ 2 y	þ	þ									þ	Anti-TNF
Remicade	infliximab	þ	þ	þ		þ	þ	þ ≥ 6 y	þ ≥ 6 y								Anti-TNF
Renflexis	infliximab-abda	þ	þ	þ		þ	þ	þ ≥ 6 y	þ ≥ 6 y								Anti-TNF
Avsola	infliximab-axxq	þ	þ	þ		þ	þ	þ ≥ 6 y	þ ≥ 6 y								Anti-TNF
Inflectra	infliximab-dyyb	þ	þ	þ		þ	þ	þ ≥ 6 y	þ ≥ 6 y								Anti-TNF
Simponi	golimumab	þ		þ		þ			þ								Anti-TNF
Simponi Aria	golimumab	þ		þ ≥ 2 y	þ ≥ 2 y	þ											Anti-TNF
Actemra	tocilizumab				þ ≥ 2 y	þ						þ ≥ 2 y	þ	þ ≥ 2 y			Anti-IL-6
Entyvio	vedolizumab						þ		þ								Select adhesion mol. inhib.
Kineret	anakinra					þ											IL-1 RA
Ilaris	canakinumab													þ ≥ 2 y	þ		IL-1 Beta Inhibitor
Kevzara	sarilumab				þ ≥ 63 kg	þ											Anti-IL-6
Orencia	abatacept			þ ≥ 2 y	þ ≥ 2 y	þ											Select. T-Cell costim. blocker
Otezla	apremilast		þ ≥ 6 y and ≥ 20 kg	þ ≥ 6 y and ≥ 20 kg													PDE-4 Enzyme Inhibitor
Siliq	brodalumab		þ														Anti-IL-17A
Stelara	ustekinumab		þ ≥ 6 y	þ ≥ 6 y			þ		þ								Anti-IL-12/23
Taltz	ixekizumab	þ	þ ≥ 6 y	þ												þ	Anti-IL-17A
Tremfya	guselkumab		þ ≥ 6 y and ≥ 40 kg	þ ≥ 6 y and ≥ 40 kg			þ		þ								Anti-IL-23
Skyrizi	risankizumab-rzaa		þ	þ			þ		þ								Anti-IL-23
Olumiant	baricitinib					þ											JAK inhibitor
Rinvoq ER	upadacitinib	þ		þ ≥ 2 y	þ ≥ 2 y	þ	þ		þ				þ			þ	JAK inhibitor
Ilumya	tildrakizumab-asmn		þ														Anti-IL-23
Xeljanz	tofacitinib	þ		þ	þ ≥ 2 y	þ			þ								JAK inhibitor
Pyzchiva	ustekinumab-ttwe		þ ≥ 6 y	þ ≥ 6 y			þ		þ								Anti-IL-12/23
Tyenne	tocilizumab-aazg				þ ≥ 2 y	þ						þ ≥ 2 y	þ	þ ≥ 2 y			Anti-IL-6
Infliximab	infliximab	þ	þ	þ		þ	þ	þ ≥ 6 y	þ ≥ 6 y								Anti-TNF

Updated: 1/1/22 PS
DUR Board approved: 11/20/2019, 11/17/2021

REFERENCES

1) Lexi-Comp drug monographs for all drugs listed reviewed on 2-22-2019, 11/2021
2) Package Inserts reviewed on 2-22-2019, 11/2021
3) 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis
4) The 2012 BSR and BHPR guideline for the treatment of psoriatic arthritis with biologics
5) American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network 2015 Recommendations for the Treatment of Ankylosing Spondylitis and Noradiographic Axial Spondyloarthritis
6) Crofford *Arthritis Research & Therapy* 2013, 15(Suppl 3):S2
7) J Braun *et al*. 2010 update of the ASAS/EULAR recommendations for the management of anykylosing spondylitis. Ann Rheum Dis 2011; 70:896-904
8) Scottish Intercollegiate Guidelines Network (SIGN). Diagnosis and management of psoriasis and psoriatic arthritis in adults. A national clinical guideline. Edinburgh (Scotland); Scottish Intercollegiate (SIGN), 2010 Oct (SIGN publication, no. 121 (217 references)
9) G Lichtenstein, S Hanauer *et al.* Management of Crohn's Disease in Adults. Am J Gastroenterol advance online publication, 6 January 2009
10) EDF Guideline for Hidradenitis Suppurativa / Acne Inversa (HS) - S1 Guideline – 2016-2017