NC Division of Medical Assistance | **Medicaid and Health Choice**
Outpatient Pharmacy | **Effective Date: August 15, 2014**
Prior Approval Criteria | **Amended Date:**
Systemic Immunomodulators

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Therapeutic Class Code: D6A, S2J, S2M, S2Q, Z2U, Z2Z, S2Z, L1A, S2V, Z2V, D6K
Therapeutic Class Description: Injectable Immunomodulators

Medication	Generic Code Number(s)	NDC Number(s)
Actemra SQ	35486	
Arcalyst	99473	
Cimzia	23471, 99615	
Cosentyx	37788, 37789	
Enbrel	23574, 52651, 97724, 98398	
Humira	18924, 97005, 99439, 37262	
Ilaris	27445	
Kineret	14867	
Orencia SQ	30289, 41656	
Otezla	36172, 36173, 37765	
Simponi	22533, 22536, 34697, 35001	
Stelara	28158, 28159	
Taltz	40848, 48049	
Xeljanz and Xeljanz XR	33617, 38086	
Kevzara	43223, 43224	
Actemra Infusion	27366, 27367, 27368	
Entyvio Infusion	36544	
Inflectra Infusion	40977	
Orencia Infusion	26306	
Remicade Infusion	61501	
Simponi Aria Infusion	34983	
Renflexis	43638	
Tremfya	43612	
Olumiant	43468	

Eligible Beneficiaries
NC Medicaid (Medicaid) beneficiaries shall be enrolled on the date of service and may have service restrictions due to their eligibility category that would make them ineligible for this service.

NC Health Choice (NCHC) beneficiaries, ages 6 through 18 years of age, shall be enrolled on the date of service to be eligible, and must meet policy coverage criteria, unless otherwise specified. **EPSDT does not apply to NCHC beneficiaries**.

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EPSDT Special Provision: Exception to Policy Limitations for Beneficiaries under 21

Years of Age 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiaries under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

a. that is unsafe, ineffective, or experimental/investigational.
b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate fora health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR
APPROVAL IS REQUIRED. Additional information on EPSDT guidelines may be accessed at https://medicaid.ncdhhs.gov/.

Criteria

1. Ankylosing Spondylitis: For Enbrel, Humira, Simponi, Simponi Aria, Cosentyx, Cimzia, Remicade, Inflectra, and Renflexis ONLY.

- Beneficiary has a diagnosis of Ankylosing Spondylitis.

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AND
- Beneficiary is not on another injectable biologic immunomodulator.
AND
- Beneficiary has been considered and screened for the presence of latent tuberculosis infection. AND
- Beneficiary has been tested with Hep B SAG and Core Ab
AND
- Beneficiary has experienced inadequate symptom relief from treatment with at least two NSAIDS OR
- Beneficiary is unable to receive treatment with NSAIDS due to contraindications.
OR
- Beneficiary has clinical evidence of severe or rapidly progressing disease
AND
- Coverage of non-preferred medications require a trial and failure of Enbrel or Humira or a clinical reason beneficiary cannot try Enbrel or Humira.

2. Crohn's disease (Adult): For Cimzia, Stelara, and Humira, Entyvio, Inflectra, Remicade, Renflexis ONLY.
- Beneficiary has a diagnosis of moderate to severe Crohn's Disease. AND
- Beneficiary is not on another injectable biologic immunomodulator. AND
- Beneficiary has been considered and screened for the presence of latent tuberculosis infection. AND
- Beneficiary has been tested with Hep B SAG and Core Ab
AND
- Coverage of non-preferred medications require a trial and failure of Humira or a clinical reason beneficiary cannot try Humira

3. Crohn's disease (Pediatric): For Inflectra, Remicade, Renflexis and Humira ONLY

- Beneficiary has a diagnosis of moderate to severe Crohn's Disease. AND
- Beneficiary is not on another injectable biologic immunomodulator. AND
- Beneficiary has been considered and screened for the presence of latent tuberculosis infection. AND
- Beneficiary has been tested with Hep B SAG and Core Ab
AND
- Coverage of non-preferred medications require a trial and failure of Humira or a clinical reason beneficiary cannot try Humira

4. Polyarticular Juvenile Idiopathic Arthritis (PJIA): For Enbrel, Humira, Actemra SQ, Actemra Infusion, and Orencia SQ, Orencia Infusion ONLY.

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- Beneficiary has a diagnosis of Polyarticular Juvenile Idiopathic Arthritis
  AND
- Beneficiary is not on another injectable biologic immunomodulator.
  AND
- Beneficiary has been considered and screened for the presence of latent tuberculosis infection.

  AND
- Beneficiary has been tested with Hep B SAG and Core Ab
  AND
- Beneficiary has tried one systemic corticosteroid (e.g. prednisone, methylprednisolone) or methotrexate, leflunomide or sulfasalazine with inadequate response or is unable to take these therapies due to contraindications.
- OR

Beneficiary has PJIA subtype enthesitis related arthritis

AND

- Coverage of non-preferred medications require a trial and failure of Embrel or Humira or a clinical reason beneficiary cannot try Enbrel or Humira.

5. Systemic Onset Juvenile Idiopathic Arthritis.(SJIA): For ~~Enbrel~~, Ilaris, and Actemra SQ, and-Actemra Infusion ONLY.

Beneficiary has a diagnosis of Systemic Juvenile Idiopathic arthritis.
AND

- Beneficiary is not on another injectable biologic immunomodulator.
  AND
- Beneficiary has been considered and screened for the presence of latent tuberculosis infection. AND

Beneficiary has been tested with Hep B SAG and Core Ab
OR

- Beneficiary has systemic arthritis with active systemic features and features of poor prognosis, as determined by the prescribing physician (e.g. arthritis of the hip, radiographic damage)
  AND
- ~~Coverage of non-preferred medications require a trial and failure of Enbrel or a clinical reason beneficiary cannot try Enbrel.~~

6. Neonatal Onset Multisystem Inflammatory Disease (NOMID): For Kineret ONLY.

- Beneficiary has a diagnosis of neonatal-onset multisystem inflammatory disease
  AND
- Beneficiary is not on another injectable biologic immunomodulator. AND
- Beneficiary has been considered and screened for the presence of latent tuberculosis

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infection. AND
- Beneficiary has been tested with Hep B SAG and Core Ab

7. Cryopyrin-Associated Periodic Syndromes (CAPS) including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS): For Ilaris and Arcalyst ONLY.
- Beneficiary has a diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS) including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS)
  AND
- Beneficiary is not on another injectable biologic immunomodulator. AND
- Beneficiary has been considered and screened for the presence of latent tuberculosis infection.
  AND
- Beneficiary has been tested with Hep B SAG and Core Ab

8. Plaque psoriasis (Pediatric): For Enbrel and Stelara (ages 12 and up) ONLY.
- Beneficiary has a diagnosis of plaque psoriasis and is a candidate for systemic therapy or phototherapy
  AND
- Beneficiary is not on another injectable biologic immunomodulator. AND
- Beneficiary has been considered and screened for the presence of latent tuberculosis infection. AND
- Beneficiary has been tested with Hep B SAG and Core Ab
  AND
- Beneficiary has experienced a therapeutic failure/inadequate response with methotrexate.
  AND
- Beneficiary has body surface area (BSA) involvement of at least 3%.
  OR
- Beneficiary has involvement of the palms, soles, head and neck, or genitalia, causing disruption in normal daily activities and/or employment.
- For ages 12 and up, coverage of non-preferred medications requires a trial and failure of Enbrel or a clinical reason beneficiary cannot try Enbrel.

9. Plaque psoriasis (adult): For Enbrel, Humira, Otezla, Cimzia, Cosentyx, Stelara, Inflectra, Remicade, Renflexis ~~and~~ Taltz, and Tremfya ONLY.
- Beneficiary has a documented definitive diagnosis of moderate-to-severe chronic plaque psoriasis
  AND
- Beneficiary is 18 years of age or older
  AND

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- Beneficiary is not on another injectable biologic immunomodulator. AND
- Beneficiary has been considered and screened for the presence of latent tuberculosis infection. AND
- Beneficiary has been tested with Hep B SAG and Core Ab
  AND
- Beneficiary has experienced a therapeutic failure/inadequate response with methotrexate
  AND
- Beneficiary has body surface area (BSA) involvement of at least 3%.
  OR
- Beneficiary has involvement of the palms, soles, head and neck, or genitalia, causing disruption in normal daily activities and/or employment.
  AND
- Beneficiary has failed to respond to, or has been unable to tolerate phototherapy and **ONE** of the following medications or beneficiary has contraindications to these treatments:

  - Soriatane (acitretin)
  - Methotrexate
  - Cyclosporine

  AND
- Coverage of non-preferred medications require a trial and failure of Enbrel or Humira or a clinical reason beneficiary cannot try either Enbrel or Humira.

10. Psoriatic arthritis: For Enbrel, Humira, Cimzia, Simponi, Simponi Aria, Cosentyx, Inflectra, Remicade, Taltz Renflexis, Xeljanz, Xeljanz XR and Stelara, Orencia SQ, Orencia Infusion, Otezla ONLY

- Beneficiary has a documented definitive diagnosis of psoriatic arthritis
  AND
- Beneficiary is 18 years of age or older
  AND
- Beneficiary is not on another injectable biologic immunomodulator. AND
- Beneficiary has been considered and screened for the presence of latent tuberculosis infection. AND
- Beneficiary has been tested with Hep B SAG and Core Ab
  AND
- Beneficiary has a documented inadequate response or inability to take methotrexate
  AND
- Coverage of non-preferred medications require a trial and failure of Enbrel or Humira or a clinical reason beneficiary cannot try either Enbrel or Humira.

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11. Rheumatoid arthritis: For Cimzia, Enbrel, Humira, Kineret, Orencia SQ, Simponi and Xeljanz, Xeljanz XR, Actemra SQ, Actrema Infusion, Inflectra, Orencia, Remicade, Simponi Aria, and Renflexis, Kevzara ONLY

- Beneficiary has a diagnosis of rheumatoid arthritis.
  AND
- Beneficiary is not on another injectable biologic immunomodulator. AND
- Beneficiary has been considered and screened for the presence of latent tuberculosis infection. AND
- Beneficiary has been tested with Hep B SAG and Core Ab
  AND
- Beneficiary has experienced a therapeutic failure/inadequate response with methotrexate or at least one disease modifying antirheumatic drug (e.g. leflunomide, hydroxychloroquine, minocycline, sulfasalazine). ~~For Renflexis Beneficiary should be receiving methotrexate with Renflexis~~ OR
- Beneficiary is unable to receive methotrexate or disease modifying antirheumatic drug due to contraindications or intolerabilities. ~~For Renflexis Beneficiary should be receiving methotrexate with Renflexis~~

OR

- Beneficiary has clinical evidence of severe or rapidly progressing disease
  AND
- Coverage of non-preferred medications require a trial and failure of Enbrel or Humira or a clinical reason beneficiary cannot try either Enbrel or Humira.

12. Ulcerative colitis (Adult): For Humira, Entyvio, Inflectra, Remicade, Renflexis, ~~and~~ Simponi, Xeljanz and Xeljanz XR ONLY.

- Beneficiary has a diagnosis of ulcerative colitis. AND
- Beneficiary is not on another injectable biologic immunomodulator. AND
- Beneficiary has been considered and screened for the presence of latent tuberculosis infection. AND
- Beneficiary has been tested with Hep B SAG and Core Ab
  AND
- Coverage of non-preferred medications require a trial and failure of Humira or a clinical reason beneficiary cannot try Humira

13. Ulcerative colitis (Pediatric): For Remicade ONLY

- Beneficiary has a diagnosis of ulcerative colitis. AND
- Beneficiary is not on another injectable biologic immunomodulator. AND
- Beneficiary has been considered and screened for the presence of latent tuberculosis infection. AND
- Beneficiary has been tested with Hep B SAG and Core Ab

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14. Hidradenitis Suppurativa: For Humira ONLY

- Beneficiary has a diagnosis of Hidradenitis Suppurativa (moderate to severe).
  AND
- Beneficiary is not on another injectable biologic immunomodulator. AND
- Beneficiary has been considered and screened for the presence of latent tuberculosis infection. AND
- Beneficiary has been tested with Hep B SAG and Core Ab

15. Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS); Ilaris ONLY

- Beneficiary has a diagnosis of Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS)
  AND
- Beneficiary is not on another injectable biologic immunomodulator. AND
- Beneficiary has been considered and screened for the presence of latent tuberculosis infection. AND
- Beneficiary has been tested with Hep B SAG and Core Ab

16. Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD): Ilaris ONLY

- Beneficiary has a diagnosis of Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD)
  AND
- Beneficiary is not on another injectable biologic immunomodulator. AND
- Beneficiary has been considered and screened for the presence of latent tuberculosis infection. AND
- Beneficiary has been tested with Hep B SAG and Core Ab

17. Familial Mediterranean Fever (FMF): Ilaris ONLY

- Beneficiary has a diagnosis of Familial Mediterranean Fever (FMF)
  AND
- Beneficiary is not on another injectable biologic immunomodulator. AND
- Beneficiary has been considered and screened for the presence of latent tuberculosis infection. AND
- Beneficiary has been tested with Hep B SAG and Core Ab

18. Non-infectious Intermediate Posterior Panuveitis: Humira ONLY

- Beneficiary has a diagnosis of Non-infectious Intermediate Posterior Panuveitis
  AND
- Beneficiary is not on another injectable biologic

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immunomodulator. AND
- Beneficiary has been considered and screened for the presence of latent tuberculosis infection. AND
- Beneficiary has been tested with Hep B SAG and Core Ab

19. Giant Cell Arteritis: Actemra and Actemra SQ ONLY
- Beneficiary has a diagnosis of Giant Cell Arteritis
- AND
- Beneficiary is not on another injectable biologic immunomodulator. AND
- Beneficiary has been considered and screened for the presence of latent tuberculosis infection. AND
- Beneficiary has been tested with Hep B SAG and Core Ab

20. Cytokine Release Syndrome: Actemra and Actemra SQ ONLY
- Beneficiary has a diagnosis of Cytokine Release Syndrome
- AND
- Beneficiary is not on another injectable biologic immunomodulator. AND
- Beneficiary has been considered and screened for the presence of latent tuberculosis infection. AND
- Beneficiary has been tested with Hep B SAG and Core Ab

Procedures

- Approve for up to 12 months.
- Coverage of one injectable immunomodulator at a time.

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Medicaid and Health Choice
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Amended Date:

Summary of Indications of Immunomodulators:

	Enbrel (P)	**Humira (P)**	Actemra Infusion/ Actemra SQ	Arcalyst	Cimzia	Cosentyx	Entyvio	Ilaris	Inflectra	Kineret	Orencia/ Orencia SQ	Otezla	Remicade	Simponi	Simponi Aria	Stelara	Taltz	Xeljanz/ Xeljanz XR	Kevzara	Renflexis
Anklyosing Spondylitis	**X**	**X**			X***	X***			X***				X***	X***	X***					X***
Crohn's Disease (adult)		**X**			X**		X**		X**				X**			X**				X**
Crohn's Disease (pediatric)		**X**							X**				X**							X**
Polyarticular Juvenile Idiopathic Arthritis (PJIA)	**X**	**X**	X***								X***									
Systemic Onset Juvenile Idiopathic Arthritis (SJIA)			X					X												
Neonatal Onset Multisystem Inflammatory Disease (NOMID)										X										
Cryoprin Associated Periodic Syndromes (CAPS) including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS)				X				X												
Plaque Psoriasis (pediatric)	**X**																X* (ages 12 and up)			
Plaque Psoriasis (adult)	**X**	**X**			X***	X***			X***			X***	X***			X***	X***			X***

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	Enbrel (P)	**Humira (P)**	Actemra Infusion/ Actemra SQ	Arcalyst	Cimzia	Cosentyx	Entyvio	Ilaris	Inflectra	Kineret	Orencia/ Orencia SQ	Otezla	Remicade	Simponi	Simponi Aria	Stelara	Taltz	Xeljanz/ Xeljanz XR	Kevzara	Renflexis
Psoriatic Arthritis	**X**	**X**			X***	X***			X***		X***	X***	X***	X***	X***	X***	X***	X***		X***
Rheumatoid Arthritis	**X**	**X**	X***		X***				X***	X***	X***		X***	X***	X***			X***	X***	X***
Ulcerative Colitis (adult)		**X**					X**		X**				X**	X**				X**		X**
Ulcerative Colitis (pediatric)													X							
Hidradenitis Suppurativa		**X**																		
Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS)								X												
Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD)								X												
Familial Mediterranean Fever (FMF)								X												
Non-Infectious Intermediate Posterior Panuveitis		**X**																		
Giant Cell Arteritis			X																	
Cytokine Release Syndrome			X																	

*Trial and failure of Enbrel before coverage of non-preferred agent

**Trial and failure of Humira before coverage of non-preferred agent

*** Trial and failure of either Enbrel or Humira before coverage of non-preferred agent

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4. Swedish Orphan Biovitrum AB. Kineret package insert. Stockholm, Sweden: 2001.
5. Bristol-Myers Squibb Company. Orencia package insert. Princeton, NJ: July 2013. Revised March 2017. Revised June 2017.
6. Janssen Biotech, Inc. Simponi package insert. Horsham, PA: May 2013.
7. Janssen Biotech, Inc. Stelara package insert. Horsham, PA: May 2013.
8. Pfizer. Xeljanz package insert. New York: September 2013. Revised December 2017.
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10. Ellis C, Krueger GG. Treatment of chronic plaque psoriasis by selective targeting of memory effector T lymphocytes. N Engl J Med 2001; 345:248-255.
11. Fredriksson T, Pettersson U. Severe psoriasis--oral therapy with a new retinoid. Dermatologica 1978; 157:238-244.
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13. Novartis Pharmaceuticals Corporation. Ilaris prescribing information. East Hanover, NJ: October 2014.
14. Novartis Pharmaceuticals Corporation. Cosentyx prescribing information. East Hanover, NJ; January 2015.
15. Eli Lilly and Company. Taltz prescribing information. Indianapolis, IN 46285: March 2016. Updated 12/2017
16. Novartis Pharmaceuticals Corporation. Ilaris prescribing information. East Hanover, NJ: September 2016.
17. AbbVie Inc. Humira package insert. North Chicago, IL: updated June 2016 (Uveitis).
18. Regeneron Pharmaceuticals, INC. Arcalyst prescribing information. Tarrytown, NY; September 2016.
19. Genentech Inc. Actemra Prescribing Information. San Fransisco CA: revised ~~May 2017~~ May 2018.
20. Takeda Pharmaceuticals America. Entyvio Prescribing Information. Deerfield IL: May 2014.
21. Pfizer Labs, Inc. Inflectra Prescribing Information. New York, NY: August 2016.
22. Janssen Biotech, Inc. Remicade Prescribing Information. Horsham, PA: October 2015.
23. Janssen Biotech, Inc. Simponi Aria Prescribing Information. Horsham, PA: January 2017.
24. Sanofi-Aventis, US, LLC, Kevzara Prescribing information. Bridgewater, NJ: May 2017.
25. Merck Sharp and Dohme, Corporation, Renflexis Prescribing Information. Whitehouse Station, NJ: April 2017.
26. Janssen Biotech, INC., Tremfya Prescribing Information. Horsham, PA: July 2017.
27. Lilly, USA, LLC., Olumiant Prescribing Information. Indianapolis, IN: May 2018.

Criteria Change Log

08/15/2014	Criteria effective date
06/10/2015	add Otezla and add gcn 37262 for Humira
01/21/2016	add Cosentyx
06/13/2016	add dx Hidradenitis Suppurativa for Humira
10/03/2016	add Xeljanz XR
10/19/2016	add Taltz
06/27/2018	add diagnosis for Ilaris- Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS), Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD), and Familial Mediterranean Fever (FMF) add diagnosis for Humira-Uveitis add Arcalyst to criteria coverage add infusion products to clinical coverage criteria- Actemra Infusion, Entyvio Infusion, Orencia Infusion, Remicade Infusion, Simponi Aria Infusion add new dx for Orencia- PHIA, Psoriatic Arthritis add Kevzara to criteria add diagnosis chart add Renflexis add Psoriatic Arthritis DX for coverage-Taltz add Psoriatic Arthritis DX for Xeljanz and Xeljanz XR
	update chart add Simponi Aria for DX Ankylosing Spondylitis, add Enbrel PJIA add Stelara Plaque Psoriasis (12 and up) add Cimzia Plaque Psoriasis adult add Otezla Psoriatic Arthritis remove Renflexis exception add Xeljanz/Xeljanx XR and Renflexis UC adults add Actemra and Actemra SQ to Giant Cell Arteritis and Cytokine Release Syndrome add Tremfya add Olumiant