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Subject: Anakinra (Kineret[®]) Injection

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DESCRIPTION:

Anakinra (Kineret) is a recombinant, non-glycosylated form of the human Interleukin-1 receptor antagonist (IL-1Ra) that differs from the naturally occurring human interleukin-1 (IL-1) receptor antagonist by the addition of one N-terminal methionine. IL-1, a dominant cytokine associated with [rheumatoid arthritis](#), is produced in response to inflammatory stimuli and mediates inflammatory and immunological responses. IL-1 causes cartilage degradation by its induction of the rapid loss of proteoglycans, stimulation of bone resorption, and inflammation due to prostaglandin and cyclooxygenase-2 production. In normal joints, endogenous IL-1Ra adheres to the IL-1 receptor on target cells and blocks the binding of IL-1 thus inhibiting the effects of IL-1. In joints effected by rheumatoid arthritis (RA), there is an over-expression of IL-1 that cannot be sufficiently countered by endogenous IL-1Ra. Anakinra exerts its action in the same manner as endogenous IL-1Ra by blocking the biologic activity of interleukin-1 (IL-1) due to competitive inhibition of IL-1 binding to the IL-1 type I receptor (IL-1RI).

Anakinra was approved by the US Food and Drug Administration (FDA) in 2001 for treatment of RA in persons 18 years of age or older who have failed one or more disease-modifying anti-rheumatic drugs ([DMARDs](#)). While anakinra can be used in combination with DMARDs, it should not be used concomitantly with tumor necrosis factor (TNF) antagonists. The 2015 American College of Rheumatology (ACR) RA guidelines do not discuss the role of anakinra due to infrequent use and/or lack of new data for this agent. The next update to the guideline is expected in late 2019 or early 2020. In 2012, the FDA expanded the approval of anakinra to include treatment of cryopyrin-associated periodic syndromes (CAPS), specifically neonatal-onset multisystem inflammatory disease (NOMID). NOMID was previously designated by the FDA as an orphan indication in 2010. Anakinra, as sponsored by the innovator drug company, also has an orphan drug designation for “treatment of Still's disease including systemic juvenile idiopathic arthritis and adult-onset Still's disease” (2015).

RHEUMATOID DISORDERS

Rheumatoid arthritis (RA)

Rheumatoid arthritis (RA) is the most common inflammatory autoimmune arthritis in adults. The main goal of therapy is to achieve remission, but additional goals include decrease inflammation, relieve symptoms, prevent joint and organ damage, improve physical function/overall well-being, and reduce long term complications. The choice of therapy depends on several factors, including the severity of disease activity when therapy is initiated and the response of the patient to prior therapeutic interventions.

American College of Rheumatology (ACR) guidelines recommend a treat-to-target approach in therapy, regardless of disease activity. ACR guidelines categorize therapy for those with early RA (disease duration <6 months) or established RA (disease duration ≥6 months) as follows:

- In general, MTX is the preferred initial DMARD therapy for most patients with RA with active disease.
- For early RA patients, the ACR recommends the following:
 - Naïve to therapy: DMARDs, methotrexate (MTX) preferred, as initial, monotherapy therapy unless contraindicated. Other DMARD monotherapy options include sulfasalazine, hydroxychloroquine, and leflunomide.
 - Moderate or high disease activity despite DMARD monotherapy: treatment with combination DMARDs or a TNF-inhibitor (e.g., adalimumab, certolizumab pegol, etanercept, golimumab, or infliximab) or a non-TNF inhibitor (abatacept, rituximab, or tocilizumab [excludes anakinra]), with or without MTX.
 - Moderate or high disease activity despite the previous DMARD or biologic therapy: addition of low-dose glucocorticoid (≤10 mg/day of prednisone or equivalent) to bridge therapy until therapeutic effects of DMARD is reached. ACR also recommends short-term (<3 months) with lowest dose of glucocorticoids for flares.
- For established RA patients, the ACR recommends the following:
 - Low disease activity and is DMARD naïve: DMARD monotherapy, MTX preferred, is recommended over a TNF-inhibitor.
 - Moderate or high disease and is DMARD naïve: DMARD monotherapy, MTX preferred, is recommended over double or triple DMARD therapy and tofacitinib.
 - Moderate-high disease activity despite DMARD monotherapy: combination DMARD therapy OR the addition of TNF inhibitor, non-TNF biologic, or tofacitinib with or without MTX is recommended rather than continuing DMARD monotherapy. Combination biologic therapy and MTX is recommended over biologic monotherapy.
 - Moderate or high disease despite TNF-inhibitor and not on DMARD: addition of one or two DMARD, rather than TNF-inhibitor monotherapy

Early use of DMARD, particularly MTX, is recommended as soon as possible following diagnosis of RA. Dosing of MTX for RA is once weekly dosing with starting doses at 7.5 mg or 15 mg once weekly.²⁶⁻²⁸ MTX dose is increased as tolerated and as needed to control symptoms and signs of RA disease. The usual target dose is at least 15 mg weekly and the usual maximum dose is 25 mg weekly.^{27,28} ACR defines optimal dosing for RA treatments as 1) dosing to achieve a therapeutic target derived from mutual patient-clinician consideration of patient priorities and 2) given for at least 3 months before therapy escalation or switching. For patients who are unable to take MTX, hydroxychloroquine, sulfasalazine, or leflunomide are other DMARD options. In patients resistant to initial MTX treatment, combination DMARD (e.g., MTX plus sulfasalazine or hydroxychloroquine or a TNF-inhibitor) is recommended.

For patients who are resistant to MTX after 3 months of treatment at optimal doses (usually 25 mg per week), it is recommended to either use DMARD triple therapy with MTX plus sulfasalazine and hydroxychloroquine or combination of MTX with TNF inhibitor. Triple therapy regimen has been found to be of similar clinical efficacy to MTX with biologics in several randomized trials, including in patients with high level of disease activity or with adverse prognostic features. The use of triple therapy has been shown to be highly cost-effective compared with combining a biologic with MTX, providing comparable or near comparable clinical benefit. The use of biologic with MTX combination is preferred when patients have high disease activity and clinical benefit from a more rapid response is needed and when patients who do not achieve satisfactory response within 3 months with non-biologic triple therapy following an inadequate response to MTX therapy.

OTHER DISORDERS

Cryopyrin-Associated Periodic Syndromes (CAPS)/Neonatal-Onset Multisystem Inflammatory Disease

Cryopyrin-associated periodic syndrome (CAPS) is a rare autosomal dominant hereditary autoimmune disorder associated with a defect in the cryopyrin protein. There are three distinct phenotypes related to a defect in the same gene, but differ in the organs involved and disease severity. Familial cold autoinflammatory syndrome (FCAS) is the mildest form and more common in the United States. Muckle-Wells syndrome (MWS) is the intermediate phenotype and more common in Europe. Neonatal-onset multisystem inflammatory disease (NOMID) is the least common disease and is the most severe form.

FCAS is characterized by a hive-like rash that is associated with exposure to cold and other environmental triggers and with symptoms lasting up to 24 hours. Patients experience urticaria, arthralgia, fever with chills, severe thirst, red-eyes, and headache after a general cold exposure, including air conditioning. In MWS, inflammation can occur spontaneously as well as from triggers, such as stress, cold, or exercise, with episodes lasting from one to three days. MWS shares the same characteristics as FCAS, but is also characterized by renal amyloidosis, sensorineural hearing loss, and conjunctivitis. Hearing loss, partial or complete, often develop by teenage years.

NOMID is characterized by neonatal onset of cutaneous symptoms along with fever with inflammation in multiple organ systems. NOMID shares most of the same characteristics with FCAS and MWS, but also has more severe arthropathy, chronic urticaria, and CNS involvement. CNS manifestations range from hearing loss to aseptic meningitis and mental disabilities. Arthropathy typically affects the large joints, resulting in joint enlargement and functional disability.

Interleukin (IL)-1-beta inhibitors (e.g., anakinra, riloncept, and canakinumab) have shown effectiveness in preventing and alleviating symptoms of CAPS and reducing levels of inflammatory indices, including serum amyloid A. Treatment with non-steroidal anti-inflammatory drugs, disease modifying antirheumatic drugs, and glucocorticoids offered only some patients partial symptom control.

POSITION STATEMENT:

Comparative Effectiveness

The Food and Drug Administration has deemed the drug(s) or biological product(s) in this coverage policy to be appropriate for self-administration or administration by a caregiver (i.e., not a healthcare professional). Therefore, coverage (i.e., administration) in a provider-administered setting such as an

outpatient hospital, ambulatory surgical suite, physician office, or emergency facility is not considered medically necessary.

NOTE: The preferred and non-preferred, self-administered products for certain indications are as follows:

Table 1

Disease State	Step 1 (Preferred)	Step 2 (Non-preferred directed to ONE step 1 agent)	Step 3a (Non- preferred directed to TWO step 1 agents)	Step 3b (Non-preferred directed to TWO agents from step 1 and/or step 2)	Step 3c (Non-preferred directed to THREE step 1 agents)
Rheumatoid Disorders					
Ankylosing Spondylitis (AS)	SQ: Cosentyx, Enbrel, Humira	N/A	SQ: Cimzia, Simponi, Taltz	N/A	N/A
Nonradiographic Axial Spondyloarthritis (nr-axSpA)	SQ: Cimzia, Cosentyx	N/A	SQ: Taltz	N/A	N/A
Polyarticular Juvenile Idiopathic Arthritis (PJIA)	SQ: Enbrel, Humira Oral: Xeljanz	SQ: Actemra (Humira is required Step 1 agent)	N/A	SQ: Orencia	N/A
Psoriatic Arthritis (PsA)	SQ: Cosentyx, Enbrel, Humira, Stelara, Tremfya Oral: Otezla, Xeljanz, Xeljanz XR	N/A	SQ: Cimzia, Orencia, Simponi, Taltz	N/A	N/A
Rheumatoid Arthritis	SQ: Enbrel, Humira, Oral: Rinvoq, Xeljanz, Xeljanz XR	SQ: Actemra (Humira is required Step 1 agent)	Oral: Olumiant SQ: Cimzia, Kevzara, Kineret , Orencia, Simponi	N/A	N/A
Dermatological Disorders					
Hidradenitis Suppurativa (HS)	SQ: Humira	N/A	N/A	N/A	N/A
Psoriasis (PS)	SQ: Cosentyx, Enbrel, Humira, Skyrizi, Stelara, Tremfya Oral: Otezla	N/A	SQ: Cimzia, Ilumya, Siliq	N/A	SQ: Taltz
Inflammatory Bowel Disease					
Crohn's Disease	SQ: Humira, Stelara	SQ: Cimzia (Humira is required Step 1 agent)	N/A	N/A	N/A
Ulcerative Colitis	SQ: Humira, Stelara	SQ: Simponi Oral: Xeljanz, Xeljanz XR	N/A	N/A	N/A
Other					
Uveitis	SQ: Humira	N/A	N/A	N/A	N/A
Indications Without Preferred Agents Required					
Giant Cell Arteritis	N/A	N/A	N/A	N/A	N/A

(GCA)					
Neonatal-Onset Multisystem Inflammatory Disease (NOMID)					
Systemic Juvenile Idiopathic Arthritis (SJIA)					

*Note: A trial of either or both Xeljanz products (Xeljanz and Xeljanz XR) collectively counts as **ONE** product

Initiation of anakinra (Kineret) meets the definition of medical necessity when **ALL** of the following are met (“1” to “6”):

1. **ONE** of the following (“a”, “b”, or “c”):
 - a. Information has been provided that indicates the member has been treated with anakinra (starting on samples is not approvable) within the past 90 days
 - b. The prescriber states the member has been treated with anakinra (starting on samples is not approvable) within the past 90 days **AND** is at risk if therapy is changed
 - c. **BOTH** of the following (“i” and “ii”):
 - i. Anakinra will be used for the treatment of an indication listed in Table 2, and **ALL** of the indication-specific criteria are met
 - ii. **EITHER** of the following (“I” or “II”)
 - I. The member’s age is within FDA labeling for the requested indication for anakinra
 - II. The prescriber has provided information in support of using anakinra for the member’s age
2. The prescriber is a specialist in the area of the member’s diagnosis (e.g., rheumatologist for RA) or the prescriber has consulted with a specialist in the area of the member’s diagnosis
3. Member does **NOT** have any FDA labeled contraindications to anakinra
4. Member has been tested for latent tuberculosis (TB) **AND**, if positive, the member has begun therapy for latent TB
5. Member will **NOT** be using anakinra in combination with another biologic immunomodulator agent or Otezla
6. **ANY** of the following (“a”, “b”, or “c”):
 - a. The dosage does not exceed 100 mg once daily
 - QL: 100 mg syringe - 28 syringes (18.76 mL)/28 days
 - b. The requested quantity (dose) is greater than program’s quantity limit but does **NOT** exceed the maximum FDA labeled dose **OR** the maximum compendia-supported dose (i.e. DrugDex with 1 or 2a level of evidence, AHFS, or NCCN compendium recommended use 1 or 2a) for the requested indication, **AND** the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength and/or package size that does not exceed the program quantity limit
 - c. The requested quantity (dose) is greater than the program’s quantity limit and greater than the maximum FDA labeled dose **AND** the maximum compendia-supported dose (i.e. with 1 or 2a level of evidence, AHFS, or NCCN compendium recommended use 1 or 2a) for the requested indication, **AND** the prescriber has provided information in support of therapy with a higher dose

for the requested indication (submitted copy required; e.g., clinical trials, phase III studies, guidelines required)

Approval duration: 12 months

Table 2

Diagnosis	Criteria
Moderately to severely active rheumatoid arthritis (RA)	<p>BOTH of the following:</p> <ol style="list-style-type: none"> 1. ONE of the following: <ol style="list-style-type: none"> a. The member has tried and had an inadequate response to maximally tolerated methotrexate (e.g., titrated to 25 mg weekly) for at least 3 months <li style="text-align: center;">OR b. The member has tried and had an inadequate response to another conventional agent (i.e., hydroxychloroquine, leflunomide, sulfasalazine) used in the treatment of RA for at least 3 months <li style="text-align: center;">OR c. The member has an intolerance or hypersensitivity to ONE of the following conventional agents (i.e., maximally tolerated methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) used in the treatment of RA <li style="text-align: center;">OR d. The member has an FDA labeled contraindication to ALL of the following conventional agents (i.e., methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) used in the treatment of RA <li style="text-align: center;">OR e. The member's medication history indicates use of another biologic immunomodulator agent that is FDA labeled or supported in DrugDex with 1 or 2a level of evidence, AHFS, or NCCN compendium recommended use 1 or 2a for the treatment of RA <li style="text-align: center;">AND 2. ANY of the following: <ol style="list-style-type: none"> a. The member has tried and had an inadequate response to at least TWO of the following for at least 3 months: <ul style="list-style-type: none"> • Enbrel (etanercept) • Humira (adalimumab) • Rinvoq (upadacitinib) • Xeljanz/Xeljanz XR (tofacitinib)

	<p>b. The member has an intolerance (defined as an intolerance to the drug or its excipients, not to the route of administration) or hypersensitivity to TWO of the following:</p> <ul style="list-style-type: none"> • Enbrel (etanercept) • Humira (adalimumab) • Rinvoq (upadacitinib) • Xeljanz/Xeljanz XR (tofacitinib) <p>OR</p> <p>c. The member has an FDA labeled contraindication to ALL of the following:</p> <ul style="list-style-type: none"> • Enbrel (etanercept) • Humira (adalimumab) • Rinvoq (upadacitinib) • Xeljanz/Xeljanz XR (tofacitinib) <p>OR</p> <p>d. The prescriber has provided information indicating why ALL of the following are not clinically appropriate for the member, AND the prescriber has provided a complete list of previously tried agents for the requested indication:</p> <ul style="list-style-type: none"> • Enbrel (etanercept) • Humira (adalimumab) • Rinvoq (upadacitinib) • Xeljanz/Xeljanz XR (tofacitinib)
Neonatal-Onset Multisystem Inflammatory Disease (NOMID)	Diagnosis only
Other indications	The member has another FDA labeled indication or an indication supported in DrugDex with 1 or 2a level of evidence, AHFS, or NCCN compendium recommended use 1 or 2a

Continuation of anakinra **meets the definition of medical necessity** when **ALL** of the following are met (“1” to “6”):

1. An authorization or reauthorization for anakinra has been previously approved by Florida Blue
2. Member has had clinical benefit with anakinra therapy
3. The prescriber is a specialist in the area of the member’s diagnosis (e.g., rheumatologist for RA) or the prescriber has consulted with a specialist in the area of the member’s diagnosis
4. Member does **NOT** have any FDA labeled contraindications to anakinra

5. Member will **NOT** be using anakinra in combination with another biologic immunomodulator agent or Otezla
6. **ANY** of the following (“a”, “b”, or “c”):
 - a. The dosage does not exceed 100 mg once daily
 - QL: 100 mg syringe - 28 syringes (18.76 mL)/28 days
 - b. The requested quantity (dose) is greater than program’s quantity limit but does **NOT** exceed the maximum FDA labeled dose **OR** the maximum compendia-supported dose (i.e. DrugDex with 1 or 2a level of evidence, AHFS, or NCCN compendium recommended use 1 or 2a) for the requested indication, **AND** the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength and/or package size that does not exceed the program quantity limit
 - c. The requested quantity (dose) is greater than the program’s quantity limit and greater than the maximum FDA labeled dose **AND** the maximum compendia-supported dose (i.e. DrugDex with 1 or 2a level of evidence, AHFS, or NCCN compendium recommended use 1 or 2a) for the requested indication, **AND** the prescriber has provided information in support of therapy with a higher dose for the requested indication (submitted copy required; e.g., clinical trials, phase III studies, guidelines required)

Approval duration: 12 months

DOSAGE/ADMINISTRATION:

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FDA-approved: anakinra is indicated for reduction in signs and symptoms and slowing the progression of structural damage in moderately to severely active rheumatoid arthritis in persons 18 years of age and older who have failed 1 or more disease-modifying anti-rheumatic drugs (DMARDs). The recommended dose of anakinra is 100 mg/day administered as subcutaneous (SQ) injection. The dose should be administered at approximately the same time every day.

Dose Adjustments

- **Renal Impairment:** a dose of 100 mg every other day should be used in persons with severe renal insufficiency or end stage renal disease (defined as creatinine clearance [CrCl] less than 30 ml/min)

Drug Availability: anakinra is available as a 100 mg/0.67 mL solution for injection.

PRECAUTIONS:

Contraindication

Persons with a known hypersensitivity to E. coli-derived proteins or in those known to have a hypersensitivity to the active or inactive ingredients

Warnings/Precautions

- **Serious infections:** discontinue if serious infection develops and do not initiate therapy in persons with active infections.

- **Concomitant TNF-antagonist therapy:** do not use in combination with TNF-antagonist therapy (e.g., adalimumab, etanercept, infliximab, certolizumab, golimumab).
- **Hypersensitivity:** hypersensitivity reactions, including anaphylactic reactions and angioedema, have been reported.
- **Immunosuppression:** the impact of treatment with anakinra on active and/or chronic infections and the development of malignancies is unknown.
- **Neutrophil count:** assess neutrophil counts prior to therapy initiation, monthly for 3 months following initiation, and quarterly thereafter for a period up to 1 year.
- **Vaccinations:** do not administer live vaccines in members receiving anakinra.

BILLING/CODING INFORMATION:

HCPSC Coding:

J3590	Unclassified biologics
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ICD-10 Diagnosis Codes That Support Medical Necessity:

D47.2	Monoclonal gammopathy [for Schnitzler syndrome only]
D47.Z2	Castleman disease
G03.1	Chronic meningitis [for neonatal-onset multisystem inflammatory disease (NOMID) only]
L50.8	Other urticaria [for NOMID and Schnitzler syndrome only]
M05.00 – M05.09	Felty's syndrome
M05.10 – M05.19	Rheumatoid lung disease with rheumatoid arthritis
M05.20 – M05.29	Rheumatoid vasculitis with rheumatoid arthritis
M05.30 – M05.39	Rheumatoid heart disease with rheumatoid arthritis
M05.40 – M05.49	Rheumatoid myopathy with rheumatoid arthritis
M05.50 – M05.59	Rheumatoid polyneuropathy with rheumatoid arthritis
M05.60 – M05.69	Rheumatoid arthritis with involvement of other organs and systems
M05.70 – M05.79	Rheumatoid arthritis with rheumatoid factor without organ or systems involvement
M05.80 – M05.89	Other rheumatoid arthritis with rheumatoid factor
M05.9	Rheumatoid arthritis with rheumatoid factor, unspecified
M06.00 – M06.09	Rheumatoid arthritis without rheumatoid factor
M06.1	Adult-onset Still's disease
M06.20 – M06.29	Rheumatoid bursitis
M06.30 – M06.39	Rheumatoid nodule
M06.80 – M06.89	Other specified rheumatoid arthritis
M06.9	Rheumatoid arthritis, unspecified
M08.20 – M08.29	Juvenile rheumatoid arthritis with systemic onset
Q87.89	Other specified congenital malformation syndromes, not elsewhere classified [for NOMID only]

REIMBURSEMENT INFORMATION:

Refer to section entitled **POSITION STATEMENT**.

PROGRAM EXCEPTIONS:

Federal Employee Program (FEP): Follow FEP guidelines.

State Account Organization (SAO): Follow SAO guidelines.

Medicare Advantage Products: No National Coverage Determination (NCD) and/or Local Coverage Determination (LCD) were found at the time of the last guideline review date.

Medicare Part D: Florida Blue has delegated to Prime Therapeutics authority to make coverage determinations for the Medicare Part D services referenced in this guideline.

DEFINITIONS:

DMARDs: An acronym for disease-modifying antirheumatic drugs. These are drugs that modify the rheumatic disease processes, and slow or inhibit structural damage to cartilage and bone. These drugs are unlike symptomatic treatments such as NSAIDs that do not alter disease progression. DMARDs can be further subcategorized. With the release of biologic agents (e.g., anti-TNF drugs), DMARDs were divided into either: (1) conventional, traditional, synthetic, or non-biological DMARDs; or as (2) biological DMARDs. However, with the release of newer targeted non-biologic drugs and biosimilars, DMARDs are now best categorized as: (1) conventional synthetic DMARDs (csDMARD) (e.g., MTX, sulfasalazine), (2) targeted synthetic DMARDs (tsDMARD) (e.g., tofacitinib, apremilast), and (3) biological DMARDs (bDMARD), which can be either a biosimilar DMARD (bsDMARD) or biological originator DMARD (boDMARD).

Neonatal-onset multisystem inflammatory disease (NOMID): also known as chronic infantile neurologic cutaneous articular (CINCA) syndrome, is a rare, congenital, systemic, inflammatory condition distinguished by fever, rash, joint disease, and central nervous system (CNS) disease. The hallmark of NOMID is onset during infancy or early childhood. NOMID is the most severe form of the cryopyrin associated periodic syndromes (CAPS) caused by mutations in the CIAS1/NLRP3 gene.

Rheumatoid arthritis: An inflammatory disease of the synovium, or lining of the joint which results in pain, stiffness, and swelling of multiple joints. The inflammation may extend to other joints and cause bone and cartilage erosion, joint deformities, movement problems, and activity limitations.

RELATED GUIDELINES:

[Abatacept \(Orencia\), 09-J0000-67](#)

[Adalimumab \(Humira\), 09-J0000-46](#)

[Apremilast \(Otezla\) Tablet, 09-J2000-19](#)

[Baricitinib \(Olumiant\), 09-J3000-10](#)

[Canakinumab \(Ilaris\) Injection, 09-J1000-14](#)

[Certolizumab Pegol \(Cimzia\), 09-J0000-77](#)

[Etanercept \(Enbrel\), 09-J0000-38](#)

[Golimumab \(Simponi, Simponi Aria\), 09-J1000-11](#)

[Infliximab Products \(Infliximab \(Remicade\), infliximab-dyyb \(Inflectra\), and infliximab-abda \(Renflexis\)\), 09-J0000-39](#)

[Rilonacept \(Arcalyst\), 09-J0000-89](#)

[Rituximab \(Rituxan\), 09-J0000-59](#)

[Sarilumab \(Kevzara\), 09-J2000-87](#)

[Tocilizumab \(Actemra\) Injection, 09-J1000-21](#)

[Tofacitinib \(Xeljanz, Xeljanz XR\) Tablets, 09-J1000-86](#)

[Vedolizumab \(Entyvio\) Injection, 09-J2000-18](#)

OTHER:

Table 3: Conventional Systemic DMARDs

Generic Name	Brand Name
Auranofin (oral gold)	Ridaura
Azathioprine	Imuran
Cyclosporine	Neoral, Sandimmune
Hydroxychloroquine	Plaquenil
Leflunomide	Arava
Methotrexate	Rheumatrex, Trexall
Sulfasalazine	Azulfidine, Azulfidine EN-Tabs

Table 4: Grading of Severity of Rheumatoid Arthritis

Severity	Criteria
Mild	Joint pain Inflammation of at least 3 joints No inflammation in tissues other than the joints Usually, a negative result on a rheumatoid factor test An elevated erythrocyte sedimentation rate (ESR) or C reactive protein (CRP) level No evidence of bone or cartilage damage on x-rays
Moderate	Between 6 and 20 inflamed joints Usually no inflammation in tissues other than the joints An elevated ESR or CRP levels A positive rheumatoid factor test or anti-cyclic citrullinated peptide (anti-CCP) antibodies Evidence of inflammation but no evidence of bone damage on x-rays
Severe	More than 20 persistently inflamed joints or a rapid loss of functional abilities Elevated ESR or CRP levels Anemia related to chronic illness Low blood albumin level A positive rheumatoid factor test, often with a high level Evidence of bone and cartilage damage on x-ray Inflammation in tissues other than joints

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COMMITTEE APPROVAL:

This Medical Coverage Guideline (MCG) was approved by the Florida Blue Pharmacy Policy Committee on 10/14/20.

GUIDELINE UPDATE INFORMATION:

01/01/05	New Medical Coverage Guideline.
08/15/05	Revised and Updated: added description, when services are covered, dose/administration, deleted precautions, updated when services are not covered, other, references, and related internet links.
01/01/06	CPT code update: deleted expired code 90782, and added new code 90772.
09/15/06	Biennial review; updated references and added related guidelines.
01/01/07	MCG revised to include Medicare Part D as a program exception.
07/15/07	Reviewed: maintain current coverage and limitations. Reformatted guideline, updated internet links and references.
07/15/08	Reviewed with no changes in coverage. Added related MCG and updated references and links.
01/01/09	Annual HCPCS coding update: deleted code 90772; added code 96372.
07/15/09	Review and revision; consisting of review of product information, added PRECAUTIONS section and updated the references.
08/15/10	Review and revision; consisting of rewording description, updating precautions and references.
01/15/11	Revision; consisting of adding ICD-10 codes.
04/01/11	Revision; consisting of adding dosage limitations.
08/15/11	Review and revision to guideline; consisting of updating references.
08/15/12	Review and revision to guideline; consisting of reformatting the position statement, updating coding and references.
09/15/12	Revision to guideline; consisting of modifying continuation criteria.
04/15/13	Revision to guideline; consisting of revising and reformatting position statement to include treatment of chronic infantile neurological cutaneous articular syndrome and orphan drug indications; reformatted and revised description, dosage/administration, and precautions sections; updated references and coding; added pertinent definitions.
09/15/13	Review and revision to guideline; consisting of updating position statement, description, program exceptions, and references.
01/01/14	Revision to guideline; consisting of updating position statement.
04/15/14	Revision to guideline; consisting of updating and reformatting position statement.
09/15/14	Review and revision to guideline; consisting of updating position statement, references, and related guidelines.
09/15/15	Review and revision to guideline; consisting of updating description section, position statement, billing/coding, and references.
12/15/15	Revision to guideline consisting of updating description and position statement based on a new orphan indication.
09/15/16	Review and revision to guideline consisting of updating description, position statement, coding/billing, definitions, and references.
10/01/16	Revision: ICD-10 code updates
10/15/17	Review and revision to guideline consisting of updating description, position statement, coding/billing, definitions, related guidelines, and references

01/01/18	Revision to guideline consisting of updating the preferred self-administered biologic products according to indication for use. Tofacitinib (Xeljanz, Xeljanz XR) added as prerequisite therapy for rheumatoid arthritis indication.
07/01/18	Revision to guideline consisting of updating the position statement.
10/15/18	Review and revision to guideline consisting of updating the position statement, related guidelines, and references.
10/15/19	Review and revision to guideline consisting of updating the description, position statement, billing/coding, and references.
01/01/20	Revision to guideline consisting of updating the position statement due to changes in preferred and non-preferred products.
07/01/20	Revision to guideline consisting of updating the description, position statement, and billing/coding.
01/01/21	Review and revision to guideline consisting of updating the position statement and references.