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Subject: Certolizumab Pegol (Cimzia®) Injection

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DESCRIPTION:

Certolizumab pegol (Cimzia) is one of five commercially available tumor necrosis factor (TNF) alpha inhibitors available, not counting biosimilars as separate products, in the United States. It was FDA approved for Crohn's disease in April 2008, for rheumatoid arthritis (RA) in May 2009, for psoriatic arthritis (PsA) in September 2013, for ankylosing spondylitis (AS) in October 2013, for plaque psoriasis in May 2018, for non-radiographic axial spondyloarthritis (nr-AxSp) in March 2019, and for polyarticular juvenile idiopathic arthritis (PJIA) in September 2024. Tumor necrosis factor, a proinflammatory cytokine, initiates the body's defense response to local injury by stimulating the production of inflammatory mediators and signaling immune cells. TNF may augment host defense mechanisms when in low concentration, but large amounts of TNF can lead to excessive inflammation and tissue deterioration. In rheumatoid arthritis, activated T-cells migrate into the synovial lining of the joint where TNF is released and joint destruction begins. The intestinal mucosa from patients with Crohn's disease or ulcerative colitis has been associated with high levels of TNF as compared to healthy individuals; a similar elevation in TNF has been demonstrated in patients with psoriasis. The National Comprehensive Cancer Network (NCCN) guidelines on the Management of Immune Checkpoint Inhibitor-Related-Toxicities now include all TNF alpha inhibitors as options to be considered for the management of moderate or severe immunotherapy-related inflammatory arthritis if unable to taper corticosteroids after 1 week.

RHEUMATOID DISORDERS

Ankylosing spondylitis (AS)

Ankylosing spondylitis (AS) is a form of chronic inflammatory arthritis characterized by sacroiliitis, enthesitis, and a marked propensity for sacroiliac joint and spinal fusion. AS is distinguished by universal involvement with sacroiliac joint inflammation or fusion and more prevalent spinal ankylosis. Goals of treatment for AS are to reduce symptoms, maintain spinal flexibility and normal posture, reduce functional limitations, maintain work ability, and decrease disease complications. The mainstays of treatment have been nonsteroidal anti-inflammatory drugs (NSAIDs) and exercise/physical therapy.

NSAIDs are used as first line therapy for patients with active AS, with continuous treatment with NSAIDs being preferred. In patients with stable disease, NSAIDs may be used on-demand to decrease the risk of adverse effects with long term use. No particular NSAID is recommended as a preferred option. Biologics should be used in patients who continue to have persistently high disease activity despite NSAIDs. Failure of standard treatment with NSAIDs can be defined as a lack of response (or intolerance) to at least 2 NSAIDs after at least a 4-week duration of therapy in total.

Tumor necrosis factor (TNF) inhibitors or interleukin (IL)-17 inhibitors are recommended as initial biologic therapy. Other present comorbidities (e.g., inflammatory bowel disease, psoriasis, uveitis) can help guide selection of the initial biologic agent/drug class. Patients who have an inadequate response to a TNF inhibitor or IL-17 inhibitor may switch to a biologic of the other drug class, or switch to a Janus kinase (JAK) inhibitor. Patients with secondary failure to a biologic (presence of antidrug antibodies) may switch to another biologic of the same or different mode of action.

Systemic glucocorticoids should generally not be used in the treatment of AS. Short-term glucocorticoid injections may be used in select patients with peripheral signs and symptoms. Conventional disease-modifying antirheumatic drugs (cDMARDs) (e.g., methotrexate, sulfasalazine, leflunomide) are not recommended as treatment due to their lack of efficacy. However, sulfasalazine may be considered in patients with peripheral arthritis.

Polyarticular Juvenile Idiopathic Arthritis (PJIA)

Psoriatic arthritis (PsA) is a chronic inflammatory musculoskeletal disease associated with psoriasis (PS), most commonly presenting with peripheral arthritis, dactylitis, enthesitis, and spondylitis. Active PsA is defined as symptoms at an unacceptably bothersome level as reported by the patient due to one of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, active skin and/or nail involvement, and/or extraarticular manifestations such as uveitis or inflammatory bowel disease (IBD). Disease severity is based on the assessment of the level of disease activity at a given point in time, and the presence/absence of poor prognostic factors and long-term damage. Severe PsA is defined in the American College of Rheumatology (ACR) and the National Psoriasis Foundation (NPF) guidelines for PsA and includes the presence of one or more of the following:

- Erosive disease
- Elevated markers of inflammation (e.g., erythrocyte sedimentation rate [ESR], C-reactive protein [CRP]) attributable to PsA
- Long-term damage that interferes with function (e.g., joint deformities, vision loss)
- Highly active disease that causes a major impairment in quality of life, such as:
    - Active PsA at many sites including dactylitis and enthesitis

- Function-limiting PsA at a few sites
- Rapidly progressive disease

Treatment involves the use of a variety of interventions, including many agents used for the treatment of other inflammatory arthritis disorders, particularly spondyloarthritis and rheumatoid arthritis, and other management strategies of the cutaneous manifestations of psoriasis. Symptomatic treatments include nonsteroidal anti-inflammatory drugs (NSAIDs), glucocorticoids, and local glucocorticoid injections. Only patients with very mild peripheral disease may sufficiently benefit from NSAIDs as monotherapy, and instead patients are typically treated with disease-modifying antirheumatic drugs (DMARDs) and/or biologics. Efficacy of DMARD and biologic therapies should be assessed 3 months after initiation, and if adequate improvement is not seen then the treatment regimen should be updated or changed. The ACR-NPF guidelines for PsA recommend a treat-to-target approach in therapy, regardless of disease activity, and treatment recommendations for active disease are as follows:

- Treatment naïve patients:
  - First line options include oral small molecules (OSM), tumor necrosis factor (TNF) inhibitors, interleukin (IL)-17 inhibitors, and IL-12/23 inhibitors
    - OSM (i.e., methotrexate [MTX], sulfasalazine, cyclosporine, leflunomide, apremilast) should be considered if the patient does not have severe PsA, does not have severe PS, prefers oral therapy, has concern over starting a biologic, or has contraindications to TNF inhibitors
    - Biologics (e.g., TNF inhibitor, IL-17 inhibitor, IL-12/23 inhibitor) are recommended as a first line option in patients with severe PsA and/or severe PS
- Previous treatment with OSM and continued active disease:
  - Switch to a biologic (i.e., TNF inhibitor, IL-17 inhibitor, IL-12/23 inhibitor); recommended over switching to a different OSM
    - Biologic monotherapy is conditionally recommended over biologic plus MTX combination therapy
  - Switch to a different OSM (except apremilast) OR add on apremilast to current OSM therapy; recommended over adding another OSM
  - Add another OSM (except apremilast) to current OSM therapy; may consider for patients that have exhibited partial response to current OSM
  - Switch to apremilast monotherapy; may be considered instead of adding apremilast to current OSM therapy if the patient has intolerable side effects with the current OSM
- Previous treatment with a biologic and continued active disease:
  - Switch to another biologic (e.g., TNF inhibitor, IL-17 inhibitor, IL-12/23 inhibitor, abatacept, or tofacitinib) as monotherapy
  - Add MTX to the current biologic; may consider adding MTX in patients with a partial response to current biologic therapy

The European Alliance of Associations for Rheumatology (EULAR) guidelines for PsA (2023 update) also recommend a treat-to-target approach in therapy. MTX (preferred) or another conventional synthetic disease-modifying antirheumatic drug (csDMARD) (e.g., sulfasalazine, leflunomide) should be used for

initial therapy. If the treatment target is not achieved with a csDMARD, a biologic should be initiated with preference of product being based on patient specific disease characteristics. Biologics include TNF inhibitors, IL-12/23 inhibitors, IL-17A inhibitors, IL-17A/F inhibitors, IL-23 inhibitors, and cytotoxic T-lymphocyte–associated antigen 4 (CTLA4) analogs. No order of preference of biologics is provided since none have demonstrated superiority for joint involvement, however, CTLA4 analogs are least preferred due to limited efficacy in clinical trials. The use of a Janus kinase (JAK) inhibitor (e.g., tofacitinib, upadacitinib) may be used after failure of a biologic or if biologics are not clinically appropriate for the patient. However, careful consideration should be applied prior to using a JAK inhibitor due to the increased risk of cardiovascular and malignancy events in older patients with RA and cardiovascular risk factors. A phosphodiesterase-4 (PDE4) inhibitor (i.e., apremilast) may be considered in patients with mild disease and an inadequate response to at least one csDMARD, in whom neither a biologic nor a JAK inhibitor is appropriate. Patients with an inadequate response to a biologic or JAK inhibitor may switch to a different drug within the same class or switch to a different mode of action. Adding MTX to a biologic may increase drug survival by limiting the development of antidrug antibodies, especially for TNF inhibitors.

Nonradiographic Axial Spondyloarthritis (nr-axSpA)

Nonradiographic axial spondyloarthritis (nr-axSpA) falls under the same spondyloarthritis family as ankylosing spondylitis (AS). Nr-axSpA is characterized by chronic back pain and features suggestive of spondyloarthritis (SpA), although advanced sacroiliac joint damage and spine ankylosis are absent. The goals of treatment are to reduce symptoms, maintain spinal flexibility and normal posture, reduce functional limitations, maintain work ability, and decrease disease complications. The mainstays of treatment have been NSAIDs and exercise/physical therapy.

NSAIDs are used as first line therapy for patients with active nr-axSpA, with continuous treatment with NSAIDs being preferred. In patients with stable disease, NSAIDs may be used on-demand to decrease the risk of adverse effects with long term use. No particular NSAID is recommended as a preferred option.(64) Biologics should be used in patients who continue to have persistently high disease activity despite NSAIDs. Failure of standard treatment with NSAIDs can be defined as a lack of response (or intolerance) to at least 2 NSAIDs after at least a 4-week duration of therapy in total.

Tumor necrosis factor (TNF) inhibitors or interleukin (IL)-17 inhibitors are recommended as initial biologic therapy. Other present comorbidities (e.g., inflammatory bowel disease, psoriasis, uveitis) can help guide selection of the initial biologic agent/drug class. Patients who have an inadequate response to a TNF inhibitor or IL-17 inhibitor may switch to a biologic of the other drug class, or switch to a Janus kinase (JAK) inhibitor. Patients with secondary failure to a biologic (presence of antidrug antibodies) may switch to another biologic of the same or different mode of action.

Systemic glucocorticoids should generally not be used in the treatment of nr-axSpA. Short-term glucocorticoid injections may be used in select patients with peripheral signs and symptoms. Conventional disease-modifying antirheumatic drugs (cDMARDs) (e.g., methotrexate, sulfasalazine, leflunomide) are not recommended as treatment due to their lack of efficacy. However, sulfasalazine may be considered in patients with peripheral arthritis.

Rheumatoid arthritis (RA)

Rheumatoid arthritis (RA) is an inflammatory autoimmune disease that primarily affects the joints but can also damage extra-articular organs. The main goal of therapy is to achieve remission, but additional goals include decreased disease activity, prevention of systemic complications, and improved physical functioning. 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 list the following guiding principles in the treatment of RA:

- RA requires early evaluation, diagnosis, and management
- Treatment decisions should follow a shared decision-making process
- Treatment decisions should be reevaluated within a minimum of 3 months based on efficacy and tolerability of the disease-modifying antirheumatic drug(s) (DMARDs) chosen
- Recommendations are limited to DMARDs approved by the US FDA for treatment of RA:
    - Conventional synthetic DMARDs (csDMARDs): hydroxychloroquine, sulfasalazine, methotrexate (MTX), leflunomide
    - Biologic DMARDs (bDMARDs): Tumor necrosis factor (TNF) inhibitors (e.g., etanercept, adalimumab, infliximab, golimumab, certolizumab pegol), T cell costimulatory inhibitor (e.g., abatacept), Interleukin (IL)-6 receptor inhibitors (e.g., tocilizumab, sarilumab), anti-CD20 antibody* (e.g., rituximab)

        *Recommendations referring to bDMARDs exclude rituximab unless patients have had an inadequate response to TNF inhibitors (in order to be consistent with FDA approval) or have a history of lymphoproliferative disorder for which rituximab is an approved therapy

    - Targeted synthetic DMARDs (tsDMARDs): Janus kinase (JAK) inhibitors (e.g., tofacitinib, baricitinib, upadacitinib)
- Triple therapy refers to hydroxychloroquine, sulfasalazine, and either methotrexate or leflunomide
- Biosimilars are considered equivalent to FDA-approved originator bDMARDs
- Treat-to-target refers to a systematic approach involving frequent monitoring of disease activity using validated instruments and modifications of treatment to minimize disease activity with the goal of reaching a predefined target (low disease activity or remission)

ACR guidelines (2021) are broken down by previous treatment and disease activity:

- DMARD-naïve patients with moderate-to-high disease activity initial treatment:
    - MTX monotherapy is strongly recommended over hydroxychloroquine, sulfasalazine, bDMARDs monotherapy, tsDMARD monotherapy, or combination of MTX plus a non-TNF bDMARD or tsDMARD
    - MTX monotherapy is conditionally recommended over leflunomide, dual or triple csDMARD therapy, or combination MTX plus a TNF inhibitor
- DMARD-naïve patients with low disease activity initial treatment
    - Hydroxychloroquine is conditionally recommended over other csDMARDs
    - Sulfasalazine is conditionally recommended over MTX

    - MTX is conditionally recommended over leflunomide
- Initial therapy in csDMARD-treated patients, but MTX naïve, with moderate-to high disease activity:
    - MTX monotherapy is conditionally recommended over combination MTX and a bDMARD or tsDMARD
- Treatment modifications in patients treated with DMARDs who are not at target:
    - Addition of a bDMARD or tsDMARD is conditionally recommended over triple therapy for patients taking maximally tolerated doses of MTX who are not at target
    - Switching to a bDMARD or tsDMARD of a different class is conditionally recommended over switching to a bDMARD or tsDMARD belonging to the same class for patients taking a bDMARD or tsDMARD who are not at target.

The European Alliance of Associations for Rheumatology (EULAR) guidelines for RA (2022 update) also recommend a treat-to-target approach in therapy. MTX is recommended as first line therapy and should be initiated as soon as the diagnosis of RA is made. If MTX is not clinically appropriate, then an alternative csDMARD should be used as part of the (first) treatment strategy. If initial csDMARD therapy does not produce adequate improvement after 3 months, another csDMARD may be added or switched to as long as poor prognosis factors are absent. In the presence of poor prognosis factors, a bDMARD or JAK inhibitor should be added to csDMARD therapy. If treatment failure occurs with the initial bDMARD or JAK inhibitor, another bDMARD or JAK inhibitor should be considered. If a TNF- or IL-6 receptor inhibitor therapy was initially failed, patients may receive an agent with another mode of action or a second TNF- or IL-6 receptor inhibitor.

Initial dosing of MTX for RA should optimally be 15 mg once weekly, with the dose increased as tolerated and as needed to control signs and symptoms. A fast dose escalation of 5 mg/month to 25-30 mg/week has been associated with higher efficacy, but toxicity with this dosing regimen is a limiting factor. In the presence of sufficient folic acid supplementation, the MTX dose can be rapidly escalated to 25 mg once weekly. The MTX target dose is 25 mg weekly, or the highest tolerable dose.

Psoriatic Arthritis (PsA)

Psoriatic arthritis (PsA) is a chronic inflammatory musculoskeletal disease associated with psoriasis (PS), most commonly presenting with peripheral arthritis, dactylitis, enthesitis, and spondylitis. Active PsA is defined as symptoms at an unacceptably bothersome level as reported by the patient due to one of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, active skin and/or nail involvement, and/or extraarticular manifestations such as uveitis or inflammatory bowel disease (IBD). Disease severity is based on the assessment of the level of disease activity at a given point in time, and the presence/absence of poor prognostic factors and long-term damage. Severe PsA is defined in the American College of Rheumatology (ACR) and the National Psoriasis Foundation (NPF) guidelines for PsA and includes the presence of one or more of the following:

- Erosive disease
- Elevated markers of inflammation (e.g., erythrocyte sedimentation rate [ESR], C-reactive protein [CRP]) attributable to PsA
- Long-term damage that interferes with function (e.g., joint deformities, vision loss)

- Highly active disease that causes a major impairment in quality of life, such as:
  - Active PsA at many sites including dactylitis and enthesitis
  - Function-limiting PsA at a few sites
- Rapidly progressive disease

Treatment involves the use of a variety of interventions, including many agents used for the treatment of other inflammatory arthritis disorders, particularly spondyloarthritis and rheumatoid arthritis, and other management strategies of the cutaneous manifestations of psoriasis. Symptomatic treatments include nonsteroidal anti-inflammatory drugs (NSAIDs), glucocorticoids, and local glucocorticoid injections. Only patients with very mild peripheral disease may sufficiently benefit from NSAIDs as monotherapy, and instead patients are typically treated with disease-modifying antirheumatic drugs (DMARDs) and/or biologics. Efficacy of DMARD and biologic therapies should be assessed 3 months after initiation, and if adequate improvement is not seen then the treatment regimen should be updated or changed. The ACR-NPF guidelines for PsA recommend a treat-to-target approach in therapy, regardless of disease activity, and treatment recommendations for active disease are as follows:

- Treatment naïve patients:
  - First line options include oral small molecules (OSM), tumor necrosis factor (TNF) inhibitors, interleukin (IL)-17 inhibitors, and IL-12/23 inhibitors
    - OSM (i.e., methotrexate [MTX], sulfasalazine, cyclosporine, leflunomide, apremilast) should be considered if the patient does not have severe PsA, does not have severe PS, prefers oral therapy, has concern over starting a biologic, or has contraindications to TNF inhibitors
    - Biologics (e.g., TNF inhibitor, IL-17 inhibitor, IL-12/23 inhibitor) are recommended as a first line option in patients with severe PsA and/or severe PS
- Previous treatment with OSM and continued active disease:
  - Switch to a biologic (i.e., TNF inhibitor, IL-17 inhibitor, IL-12/23 inhibitor); recommended over switching to a different OSM
    - Biologic monotherapy is conditionally recommended over biologic plus MTX combination therapy
  - Switch to a different OSM (except apremilast) OR add on apremilast to current OSM therapy; recommended over adding another OSM
  - Add another OSM (except apremilast) to current OSM therapy; may consider for patients that have exhibited partial response to current OSM
  - Switch to apremilast monotherapy; may be considered instead of adding apremilast to current OSM therapy if the patient has intolerable side effects with the current OSM
- Previous treatment with a biologic and continued active disease:
  - Switch to another biologic (e.g., TNF inhibitor, IL-17 inhibitor, IL-12/23 inhibitor, abatacept, or tofacitinib) as monotherapy
  - Add MTX to the current biologic; may consider adding MTX in patients with a partial response to current biologic therapy

The European Alliance of Associations for Rheumatology (EULAR) guidelines for PsA (2023 update) also recommend a treat-to-target approach in therapy. MTX (preferred) or another conventional synthetic disease-modifying antirheumatic drug (csDMARD) (e.g., sulfasalazine, leflunomide) should be used for initial therapy. If the treatment target is not achieved with a csDMARD, a biologic should be initiated with preference of product being based on patient specific disease characteristics. Biologics include TNF inhibitors, IL-12/23 inhibitors, IL-17A inhibitors, IL-17A/F inhibitors, IL-23 inhibitors, and cytotoxic T-lymphocyte–associated antigen 4 (CTLA4) analogs. No order of preference of biologics is provided since none have demonstrated superiority for joint involvement, however, CTLA4 analogs are least preferred due to limited efficacy in clinical trials. The use of a Janus kinase (JAK) inhibitor (e.g., tofacitinib, upadacitinib) may be used after failure of a biologic or if biologics are not clinically appropriate for the patient. However, careful consideration should be applied prior to using a JAK inhibitor due to the increased risk of cardiovascular and malignancy events in older patients with RA and cardiovascular risk factors. A phosphodiesterase-4 (PDE4) inhibitor (i.e., apremilast) may be considered in patients with mild disease and an inadequate response to at least one csDMARD, in whom neither a biologic nor a JAK inhibitor is appropriate. Patients with an inadequate response to a biologic or JAK inhibitor may switch to a different drug within the same class or switch to a different mode of action. Adding MTX to a biologic may increase drug survival by limiting the development of antidrug antibodies, especially for TNF inhibitors.

DERMATOLOGICAL DISORDERS

Psoriasis (PS)

Psoriasis (PS) is a chronic inflammatory skin and systemic disorder. It is a complex disease that affects the skin and joints and is associated with numerous comorbidities, including obesity and inflammatory bowel disease. Psoriasis vulgaris, or plaque psoriasis, is a cutaneous form that often presents with pink plaques with silvery scale on the scalp, elbows, knees, or presacral region, but any area of the skin may be involved. Plaque psoriasis is the most common form (affecting 90% of adults with psoriasis), but others include guttate, erythrodermic, pustular, inverse, nail, and psoriatic arthritis (PsA). PS is clinically diagnosed based on the presence of cutaneous and systemic symptoms, and treatment is similar for most forms but is guided by the body surface area (BSA) involved. The American Academy of Dermatology (AAD) and National Psoriasis Foundation (NPF) categorize psoriasis severity as mild (less than 3% of BSA), moderate (3% to 10% of BSA), or severe (greater than 10% of BSA). The AAD/NPF guidelines also note that psoriasis can be considered severe irrespective of BSA when it causes serious emotional consequences, occurs in select locations (e.g., hands, feet, scalp, face, or genital area), or when it causes intractable pruritus.

Topical therapies are most commonly used to treat mild to moderate PS, but they may be used in combination with phototherapy, systemic, or biologic therapies for the treatment of moderate to severe PS. Topical therapies alone can be sufficient for managing limited disease and also have fewer significant adverse effects compared to systemic treatment options. However, topical therapies may be inadequate to obtain and maintain skin clearance, and systemic therapies may be warranted. Conventional systemic agents are widely used as monotherapy or in combination with biologics for moderate to severe disease, and they are beneficial for widespread disease and ease of administration. Biologics are routinely used when one or more conventional agents fail to produce an adequate response but are considered first

line in patients with severe PS or patients with concomitant severe PsA. The NPF medical board recommends a treat-to-target approach to therapy for psoriasis that includes the following:

- The preferred assessment instrument for determining treatment response is BSA
- The preferred time to perform initial evaluation of treatment response is after 3 months
- Target response after treatment initiation should be BSA less than or equal to 1% after 3 months
- Acceptable response is either a BSA less than or equal to 3% or a BSA improvement greater than or equal to 75% from baseline at 3 months after treatment initiation

Selection of treatment is based on several factors including benefit-risk assessment, clinical presentation, disease severity, and comorbidities. The AAD/NPF psoriasis treatment guidelines support the following treatment options:

- Topical therapies:
    - Topical corticosteroids (TCS)
    - Topical calcineurin inhibitors (TCIs), such as tacrolimus and pimecrolimus
    - Vitamin D analogues (e.g., calcipotriene and calcitriol)
    - Tazarotene (topical retinoid)
    - Coal tar preparations
    - Topical anthralin
- Psoralen plus ultraviolet light (PUVA) phototherapy
- Systemic non-biologic therapies:
    - Methotrexate (MTX)
    - Cyclosporine
    - Acitretin
    - Apremilast
- Biologic therapies:
    - Tumor necrosis factor (TNF)-α inhibitors (e.g., adalimumab, certolizumab, etanercept, infliximab)
    - Interleukin (IL)-17 inhibitors (e.g., brodalumab, ixekizumab, secukinumab)
    - IL-23 inhibitors (e.g., guselkumab, risankizumab, tildrakizumab)
    - IL-12/IL-23 Inhibitors (e.g., ustekinumab)

      *Note: Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics was published in 2019. No specific biologic drug/class is recommended as first-line for all patients with psoriasis, and instead choice of therapy should be individualized based on patient specific factors. Additional biologic drugs have since received FDA approval for psoriasis that are not discussed.

Primary failure for biologics is defined as initial nonresponse to treatment. Primary failure to a tumor necrosis factor (TNF)-α inhibitor does not preclude successful response to a different TNF-α inhibitor, and failure of another biologic therapy does not preclude successful response to ustekinumab. All biologics may lose efficacy in a patient who initially responds favorably to the medication (secondary failure), and loss of efficacy may be attributed to the presence of antidrug antibodies. The concomitant use of MTX with a biologic may increase drug survival by limiting antibody formation.

For the treatment of PS in the pediatric patient population, topical corticosteroids are the mainstay option based on extensive clinical experience that supports efficacy. Topical calcineurin inhibitors are also a treatment option and may be preferred for psoriasis of the face, genitalia, and body folds. Vitamin D analogues are recommended as a treatment option for childhood plaque psoriasis and are considered safe, effective, and generally well tolerated. Other topical therapies that may be used for the treatment of pediatric psoriasis include tazarotene, anthralin, and coal tar. Phototherapy may be efficacious and well tolerated for pediatric patients with generalized psoriasis or localized psoriasis refractory to topical agents. Systemic non-biologic therapies, such as methotrexate, cyclosporine, and acitretin, are options for moderate to severe psoriasis. Biologic therapies (e.g., adalimumab, etanercept, infliximab, ustekinumab) have also shown efficacy in moderate to severe plaque psoriasis in this patient population.

INFLAMMATORY BOWEL DISEASE

Crohn's Disease (CD)

Crohn's disease (CD) is a chronic inflammatory bowel disease with genetic, immunologic, and environmental influences. It can affect any portion of the gastrointestinal tract but involves the small intestine and proximal colon most often. The most common symptom is diarrhea, but abdominal pain, fatigue, fever, weight loss, and vomiting are also prevalent. Symptoms typically occur as a chronic, intermittent course, with only a minority of patients having continuously active symptomatic disease or a prolonged remission. In most cases, CD is a chronic, progressive, destructive disease. Early diagnosis and management of CD can lead to better outcomes and less negative impact on quality of life.

Patients are considered to have moderate to severe disease if they have failed to respond to treatment for mild to moderate disease, or if they present with more prominent symptoms of CD. Inflammation-related biomarkers are more likely to be abnormal, and greater endoscopic disease burden is typical. This includes larger or deeper ulcers, strictures, or extensive areas of disease and/or evidence of stricturing, penetrating, or perianal disease. The International Organization for the Study of Inflammatory Bowel Diseases characterizes patients with severe disease as having at least 10 loose stools per day, daily abdominal pain, presence of anorectal symptoms, systemic corticosteroid use within the prior year, lack of symptomatic improvement despite prior exposure to biologics and/or immunosuppressive agents, or significant impact of the disease on activities of daily living. They are also at a high risk for adverse disease-related complications, including surgery, hospitalization, and disability, based on a combination of structural damage, inflammatory burden, and impact of quality of life. Patients with severe disease may have large or deep mucosal lesions on endoscopy or imaging, presence of fistula and/or perianal abscess, presence of strictures, prior intestinal resections, presence of a stoma, and/or extensive disease (e.g., involvement of long bowel segments, pancolitis).

The choice of therapy in CD is dependent on the anatomic location of the disease, the severity of disease, and whether the treatment is needed to induce remission or maintain remission. The goal of treatment for induction of remission is to achieve clinical response and control of inflammation within 3 months of treatment initiation. After inducing clinical remission, patients should be transitioned to steroid-sparing maintenance therapy. In the absence of immunomodulator or biologic treatment, corticosteroid dependency and/or resistance occurs in up to half of patients. In general, the drug(s) used for induction of remission should be continued as maintenance therapy, with the exception of corticosteroids.

The American Gastroenterological Association (AGA) 2021 guideline provides the following recommendations and guidance:

- Biologic therapy:
    - The AGA suggest early introduction with a biologic, with or without an immunomodulator, rather than delaying their use until after failure of 5-aminosalicylates and/or corticosteroids (Conditional recommendation, low certainty of evidence)
        - Earlier therapy with a biologic may result in overtreating some patients and potentially exposing them to treatment-related risks and costs with limited benefit. However, step-up therapy comes with a potential risk of harm from disease progression related to inadequate disease therapy.
    - Anti-tumor necrosis factor (TNF) (i.e., infliximab or adalimumab) and ustekinumab are recommended over no treatment for the induction and maintenance of remission
    - Vedolizumab is suggested over no treatment for the induction and maintenance of remission
    - AGA suggests against the use of natalizumab over no treatment for the induction and maintenance of remission
    - Patients naïve to biologic therapy, the AGA recommends infliximab, adalimumab, or ustekinumab over certolizumab pegol and suggests the use of vedolizumab over certolizumab pegol for the induction of remission
    - Patients with primary non-response to anti-TNF, the AGA recommends ustekinumab and suggests vedolizumab for induction of remission
    - Patients with secondary non-response to infliximab, the AGA recommends use of adalimumab or ustekinumab and suggests the use of vedolizumab for the induction of remission (if adalimumab was the first line drug, there is indirect evidence to suggest using infliximab as a second-line agent)
- Corticosteroid therapy:
    - Corticosteroids are suggested over no treatment for the induction of remission, and are recommended against for maintenance of remission
        - In patients with CD involving the distal ileum and/or ascending colon who are more concerned about systemic corticosteroids and less concerned about the lower efficacy, they may reasonably choose budesonide over systematic corticosteroids for inducing remission
- Disease modifying antirheumatic drug (DMARD) therapy:

- Patients in corticosteroid induced remission or with quiescent moderate to severe CD, the AGA suggests thiopurines for maintenance of remission
- Subcutaneous or intramuscular methotrexate are suggested over no treatment for the induction and maintenance of remission
- The AGA recommends against the use of 5-aminosalicylates or sulfasalazine over no treatment for the induction or maintenance of remission
- The AGA suggests against the use of thiopurines over no treatment for achieving remission and recommends biologic drug monotherapy over thiopurine monotherapy for induction of remission
- The AGA suggests against the use of oral methotrexate monotherapy over no treatment for the induction and maintenance of remission

- Combination therapy:
  - Patients that are naïve to biologics and immunomodulators, the AGA suggest use of infliximab in combination with thiopurines over infliximab monotherapy for the induction and maintenance of remission (combination infliximab with methotrexate may be more effective over infliximab monotherapy)
  - Patients that are naïve to biologics and immunomodulators, the AGA suggest use of adalimumab in combination with thiopurines over adalimumab monotherapy for the induction and maintenance of remission (combination adalimumab with methotrexate may be more effective over adalimumab monotherapy)
  - No recommendations are being made regarding the use of ustekinumab or vedolizumab in combination with thiopurines or methotrexate over biologic monotherapy for induction or maintenance or remission

The American College of Gastroenterology (ACG) 2025 guideline provides the following recommendations and guidance:

- Biologic therapy:
  - Biologic agents are effective for treating patients with active CD and previous inadequate response to corticosteroids, thiopurines, and/or methotrexate
  - Suggest against requiring failure of conventional therapy before initiation of advanced therapy for the management of CD (conditional recommendation, low level of evidence)
    - The risk of adverse effects and high cost of biologic agents may not be justifiable in a lower risk population
  - Recommend the following drugs for induction and maintenance of remission for moderately to severely active CD:
    - Anti-TNF agents (i.e., infliximab, adalimumab, certolizumab), vedolizumab, ustekinumab, risankizumab, mirikizumab, guselkumab
  - Recommend combination therapy of intravenous infliximab with immunomodulators (thiopurines) as compared with treatment with either immunomodulators alone or intravenous infliximab alone in patients with CD who are naïve to those agents

- Recommend the use of risankizumab as compared with ustekinumab in patients with moderate to severe CD and prior exposure to anti-TNF therapy
- Biosimilar infliximab, adalimumab, and ustekinumab are effective treatments for patients with moderate-to-severe CD and can be used for de novo induction and maintenance therapy
- There are data to support the safety and efficacy of transitioning or switching to biosimilar infliximab or adalimumab for patients with CD in stable disease maintenance

- Janus kinase (JAK) inhibitor therapy:
  - Recommend upadacitinib use for induction and maintenance of remission for patients with moderate-to-severe CD who have previously been exposed to anti-TNF agents
- Corticosteroid therapy:
  - Recommend oral corticosteroids for short-term induction of remission in patients with moderately to severely active CD
    - Recommend controlled ileal release budesonide at a dose of 9 mg daily for induction of symptomatic remission in patients with mildly to moderately active ileocecal CD
  - Corticosteroids should not be used for maintaining remission, and their use should not exceed 3 continuous months without attempting to introduce a steroid-sparing agent (such as an immunomodulator)
- DMARD therapy:
  - Recommend against azathioprine or 6-mercaptopurine for induction of remission in moderately to severely active CD
    - Due to their slow onset of action of 8 to 12 weeks, thiopurines are not effective agents for induction of remission
  - Suggest azathioprine or 6-mercaptopurine for maintenance of remission in patients with moderately to severely active CD who had induction of remission with corticosteroids
  - Suggest methotrexate (up to 25 mg once weekly intramuscular or subcutaneous) for maintenance of remission in patients with moderately to severely active CD who had induction of remission with corticosteroids
  - Azathioprine, 6-mercaptopurine, or methotrexate may be used in the treatment of active CD and as adjunctive therapy for reducing immunogenicity associated with anti-TNF therapy

POSITION STATEMENT:

Site of Care: If certolizumab pegol (Cimzia) is administered in a hospital-affiliated outpatient setting, additional requirements may apply depending on the member's benefit. Refer to 09-J3000-46: Site of Care Policy for Select Specialty Medications.

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 list of self-administered products with prerequisites for certain indications can be found at Preferred Agents and Drug List.

Initiation of certolizumab pegol (Cimzia) meets the definition of medical necessity when **ALL** of the following are met ("1" to "5"):

1. **ONE** of the following ("a", "b", or "c"):
    a. The member has been treated with certolizumab pegol (starting on samples is not approvable) within the past 90 days
    b. The prescriber states the member has been treated with certolizumab pegol (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. Certolizumab pegol will be used for the treatment of an indication listed in Table 1, and **ALL** of the indication-specific criteria are met
        ii. **EITHER** of the following if the member has an FDA-approved indication ("I" or "II")
            I. The member's age is within FDA labeling for the requested indication for certolizumab pegol
            II. The prescriber has provided information in support of using certolizumab pegol for the member's age for the requested indication
2. The prescriber is a specialist in the area of the member's diagnosis (e.g., rheumatologist for PsA, PJIA, RA; gastroenterologist for CD; dermatologist for PS) 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 certolizumab pegol
4. Member will **NOT** be using certolizumab pegol in combination with another biologic immunomodulator agent (full list in "Other" section); Janus kinase (JAK) inhibitor [Cibinqo (abrocitinib), Leqselvi (deuruxolitinib), Litfulo (ritlecitinib), Olumiant (baricitinib), Opzelura (ruxolitinib), Rinvoq/Rinvoq LQ (upadacitinib), and Xeljanz/Xeljanz XR (tofacitinib)]; Otezla/Otezla XR (apremilast); Sotyktu (deucravacitinib); or sphingosine-1-phosphate (S1P) modulator [Velsipity (etrasimod) and Zeposia (ozanimod)]
5. **ANY** of the following ("a", "b", "c", or "d"):
    a. The dosage does not exceed:
        - Loading dose:
            - AS, nr-axSpA: Initial dose of 400 mg on day 1 and at week 2 and week 4, followed by maintenance doses starting 2 or 4 weeks later
                - QL: 6 X 200 mg/mL syringe, starter kit - 1 starter kit (3 doses)/180 days
            - CD: Initial dosing of 400 mg on day 1 and at week 2 and week 4, followed by maintenance doses starting 4 weeks later
                - QL: 6 X 200 mg/mL syringe, starter kit - 1 starter kit (3 doses)/180 days

- PJIA:
    - 10 kg (22 lbs) to less than 20 kg (44 lbs): Initial dose of 100 mg on day 1 and at week 2 and week 4, followed by maintenance doses starting 2 weeks later
        - QL: 400 mg vial kit (two 200 mg vials) – 1 kit/28 days
    - 20 kg (44 lbs) to less than 40 kg (88 lbs): Initial dose of 200 mg on day 1 and at week 2 and week 4, followed by maintenance doses starting 2 weeks later
        - QL: 400 mg vial kit (two 200 mg vials) – 1 kit/28 days
    - Greater than or equal to 40 kg (88 lbs): Initial dose of 400 mg on day 1 and at week 2 and week 4, followed by maintenance doses starting 2 weeks later
        - QL: 6 X 200 mg/mL syringe, starter kit – 1 starter kit (3 doses)/180 days
- PsA and RA: Initial dosing of 400 mg on day 1 and at week 2 and week 4, followed by maintenance doses starting 2 or 4 weeks later
    - QL: 6 X 200 mg/mL syringe, starter kit – 1 starter kit (3 doses)/180 days
- PS: member's body weight ≤90 kg – initial dose of 400 mg on day 1 and at week 2 and week 4, followed by maintenance doses starting 2 weeks later
    - QL: 6 X 200 mg/mL syringe, starter kit – 1 starter kit (3 doses)/180 days

- Maintenance dose:
    - AS, CD, nr-axSpA, PsA and RA: 200 mg every 2 weeks (14 days) or 400 mg every 4 weeks (28 days)
        - QL: 2 x 200 mg/mL syringe, kit - 1 kit/28 days
        - QL: 400 mg vial kit (two 200 mg vials) – 1 kit/28 days
    - PJIA:
        - 10 kg (22 lbs) to less than 20 kg (44 lbs): 50 mg every 2 weeks
            - QL: 400 mg vial kit (two 200 mg vials) – 1 kit/28 days
        - 20 kg (44 lbs) to less than 40 kg (88 lbs): 100 mg every 2 weeks
            - QL: 400 mg vial kit (two 200 mg vials) – 1 kit/28 days
        - Greater than or equal to 40 kg (88 lbs): 200 mg every 2 weeks
            - QL: 400 mg vial kit (two 200 mg vials) – 1 kit/28 days
            - QL: 2 x 200 mg/mL syringe, kit - 1 kit/28 days
    - PS and other indications: 400 mg every 2 weeks (14 days)
        - QL: 2 x 200 mg/mL syringe, kit - 2 kits/28 days
        - QL: 400 mg vial kit (two 200 mg vials) – 2 kits/28 days

b. The member has an FDA labeled indication for the requested agent, **AND EITHER** of the following ("i" or "ii"):

i. The requested quantity (dose) does **NOT** exceed the maximum FDA labeled dose 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

ii. **ALL** of the following ("1", "2", and "3"):

1. The requested quantity (dose) exceeds the FDA maximum labeled dose for the requested indication

2. The member has tried and had an inadequate response to at least a 3-month trial of the maximum FDA labeled dose for the requested indication (medical records required)

3. **EITHER** of the following ("a" or "b"):

a. The requested quantity (dose) does **NOT** exceed the maximum compendia supported dose 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

b. The requested quantity (dose) exceeds the maximum FDA labeled dose **AND** the maximum compendia supported dose for the requested indication, **AND** there is support for therapy with a higher dose or shortened dosing interval for the requested indication (submitted copy of clinical trials, phase III studies, guidelines required)

c. The member has a compendia supported indication for the requested agent, **AND EITHER** of the following ("i" or "ii"):

i. The requested quantity (dose) does **NOT** exceed the maximum compendia supported dose 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

ii. The requested quantity (dose) exceeds the maximum compendia supported dose for the requested indication, **AND** there is support for therapy with a higher dose or shortened dosing interval for the requested indication (submitted copy of clinical trials, phase III studies, guidelines required)

d. The member does **NOT** have an FDA labeled indication **NOR** a compendia supported indication for the requested agent, **AND BOTH** of the following ("i" and "ii"):

i. 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

ii. There is support for therapy with a higher dose or shortened dosing interval for the requested indication (submitted copy of clinical trials, phase III studies, guidelines required)

Compendia Allowed: AHFS, DrugDex 1 or 2a level of evidence, or NCCN 1 or 2a recommended use

Approval duration: Loading dose (doses on day 1, 15, and 29) for 1 month, then maintenance dose for 11 additional months [12 months for total duration of approval]

Table 1

Diagnosis	Criteria
Moderately to severely active rheumatoid arthritis (RA)	**BOTH** of the following: 1. **ONE** of the following: a. The member has tried and had an inadequate response to maximally tolerated methotrexate (e.g., titrated to 25 mg weekly) after at least a 3-month duration of therapy **OR** b. The member has tried and had an inadequate response **ONE** conventional agent (i.e., hydroxychloroquine, leflunomide, sulfasalazine) used in the treatment of RA after at least a 3-month duration of therapy **OR** c. The member has an intolerance or hypersensitivity to **ONE** conventional agent (i.e., methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) used in the treatment of RA **OR** d. The member has an FDA labeled contraindication to **ALL** conventional agents (i.e., methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) used in the treatment of RA **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 or AHFS for the treatment of RA **AND** 2. **ANY** of the following* (submitted medical records/chart notes are required for confirmation): a. The member has tried and had an inadequate response to at least **TWO** preferred products after at least a 3-month trial per product **OR** b. The member has tried and had an inadequate response to **ONE** preferred product after at least a 3-month duration of therapy, **AND** an intolerance (defined as an intolerance to the drug or its excipients, not to the route of administration) or hypersensitivity to **ONE** preferred product **OR**

	c. The member has an intolerance (defined as an intolerance to the drug or its excipients, not to the route of administration) or hypersensitivity to at least **TWO** preferrer products **OR** d. The member has an FDA labeled contraindication to **ALL** preferred products **OR** e. **ALL** preferred prodcuts not clinically appropriate for the member, **AND** the prescriber has provided a complete list of previously tried products for the requested indication **The preferred RA products are:** • Adalimumab-aaty • Adalimumab-adaz • Enbrel (etanercept) • Hadlima (adalimumab-bwwd) • Humira (adalimumab) • Rinvoq (upadacitinib) • Simlandi (adalimumab-ryvk) • Xeljanz/Xeljanz XR (tofacitinib)
Moderately to severely active polyarticular juvenile idiopathic arthritis (PJIA)	**ALL** of the following: 1. **ONE** of the following: a. The member has tried and had an inadequate response to **ONE** conventional agent (i.e., methotrexate, leflunomide) used in the treatment of PJIA after at least a 3-month duration of therapy **OR** b. The member has an intolerance or hypersensitivity to **ONE** conventional agent used in the treatment of PJIA **OR** c. The member has a labeled contraindication to **ALL** conventional agents used in the treatment of PJIA **OR** d. 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 or AHFS for the treatment of PJIA

	AND 2. **ANY** of the following* (submitted medical records/chart notes are required for confirmation): a. The member has tried and had an inadequate response to at least **TWO** preferred products after at least a 3-month trial per product **OR** b. The member has tried and had an inadequate response to **ONE** preferred product after at least a 3-month duration of therapy, **AND** an intolerance (defined as an intolerance to the drug or its excipients, not to the route of administration) or hypersensitivity to **ONE** preferred product **OR** c. The member has an intolerance (defined as an intolerance to the drug or its excipients, not to the route of administration) or hypersensitivity to at least **TWO** preferred products **OR** d. The member has an FDA labeled contraindication to **ALL** preferred products **OR** e. **ALL** preferred products are not clinically appropriate for the member, **AND** the prescriber has provided a complete list of previously tried products for the requested indication **The preferred PJIA products are:** • Adalimumab-aaty • Adalimumab-adaz • Enbrel (etanercept) • Hadlima (adalimumab-bwwd) • Humira (adalimumab) • Rinvoq/Rinvoq LQ (upadacitinib) • Simlandi (adalimumab-ryvk) • Xeljanz (tofacitinib) **AND** 3. If the product is being self-administered, the member weighs at least 40 kg (88 lbs)

Active psoriatic arthritis (PsA)	**BOTH** of the following: 1. **ONE** of the following: a. The member has tried and had an inadequate response to **ONE** conventional agent (i.e., cyclosporine, leflunomide, methotrexate, sulfasalazine) used in the treatment of PsA after at least a 3-month duration of therapy **OR** b. The member has an intolerance or hypersensitivity to **ONE** conventional agent used in the treatment of PsA **OR** c. The member has an FDA labeled contraindication to **ALL** conventional agents used in the treatment of PsA **OR** d. The member has severe active PsA (e.g., erosive disease, elevated markers of inflammation [e.g., ESR, CRP] attributable to PsA, long-term damage that interferes with function [i.e., joint deformities, vision loss], rapidly progressive) **OR** e. The member has concomitant severe psoriasis (PS) (e.g., greater than 10% body surface area involvement, occurring on select locations [i.e., hands, feet, scalp, face, or genitals], intractable pruritus, serious emotional consequences) **OR** f. The member's medication history indicates use of another biologic immunomodulator agent **OR** Otezla/Otezla XR that is FDA labeled or supported in DrugDex with 1 or 2a level of evidence or AHFS for the treatment of PsA **AND** 2. **ANY** of the following* (submitted medical records/chart notes are required for confirmation): a. The member has tried and had an inadequate response to at least **TWO** preferred products after at least a 3-month trial per product **OR** b. The member has tried and had an inadequate response to **ONE** preferred product after at least a 3-month duration of therapy, **AND** an intolerance (defined as an intolerance to the drug or its excipients, not to the route of administration) or hypersensitivity to **ONE** preferred product

	OR c. The member has an intolerance (defined as an intolerance to the drug or its excipients, not to the route of administration) or hypersensitivity to at least **TWO** preferred products **OR** d. The member has an FDA labeled contraindication to **ALL** preferred products **OR** e. **ALL** preferred products are not clinically appropriate for the member, **AND** the prescriber has provided a complete list of previously tried products for the requested indication **The preferred PsA products are:** • Adalimumab-aaty • Adalimumab-adaz • Cosentyx (secukinumab) • Enbrel (etanercept) • Hadlima (adalimumab-bwwd) • Humira (adalimumab) • Otezla/Otezla XR (apremilast) • Rinvoq/Rinvoq LQ (upadacitinib) • Selarsdi (ustekinumab-aekn) • Simlandi (adalimumab-ryvk) • Skyrizi (risankizumab-rzaa) • Stelara (ustekinumab) • Steqeyma (ustekinumab-stba) • Tremfya (guselkumab) • Xeljanz/Xeljanz XR (tofacitinib) • Yesintek (ustekinumab-kfce)
Moderate to severe plaque psoriasis (PS)	**BOTH** of the following: 1. **ONE** of the following: a. The member has tried and had an inadequate response to **ONE** conventional agent (i.e., acitretin, calcipotriene, calcitriol, coal tar, cyclosporine, methotrexate, pimecrolimus, PUVA [phototherapy],

	tacrolimus, tazarotene, topical corticosteroids) used in the treatment of PS after at least a 3-month duration of therapy **OR** b. The member has an intolerance or hypersensitivity to **ONE** conventional agent used in the treatment of PS **OR** c. The member has an FDA labeled contraindication to **ALL** conventional agents used in the treatment of PS **OR** d. The member has severe active PS (e.g., greater than 10% body surface area involvement, occurring on select locations [i.e., hands, feet, scalp, face, or genitals], intractable pruritus, serious emotional consequences) **OR** e. The member has concomitant severe psoriatic arthritis (PsA) (e.g., erosive disease, elevated markers of inflammation [e.g., ESR, CRP] attributable to PsA, long-term damage that interferes with function [i.e., joint deformities, vision loss], rapidly progressive) **OR** f. The member's medication history indicates use of another biologic immunomodulator agent **OR** Otezla/Otezla XR that is FDA labeled or supported in DrugDex with 1 or 2a level of evidence or AHFS for the treatment of PS **AND** 2. **ANY** of the following* (submitted medical records/chart notes are required for confirmation): a. The member has tried and had an inadequate response to at least **TWO** preferred products after at least a 3-month trial per product **OR** b. The member has tried and had an inadequate response to **ONE** preferred product after at least a 3-month duration of therapy, **AND** an intolerance (defined as an intolerance to the drug or its excipients, not to the route of administration) or hypersensitivity to **ONE** preferred product **OR** c. The member has an intolerance (defined as an intolerance to the drug or its excipients, not to the route of administration) or hypersensitivity to at least **TWO** preferred products

	OR d. The member has an FDA labeled contraindication to **ALL** preferred products **OR** e. **ALL** preferred products are not clinically appropriate for the member, **AND** the prescriber has provided a complete list of previously tried products for the requested indication **The preferred PS products are:** • Adalimumab-aaty • Adalimumab-adaz • Cosentyx (secukinumab) • Enbrel (etanercept) • Hadlima (adalimumab-bwwd) • Humira (adalimumab) • Otezla/Otezla XR (apremilast) • Selarsdi (ustekinumab-aekn) • Simlandi (adalimumab-ryvk) • Skyrizi (risankizumab) • Sotyktu (deucravacitinib) • Stelara (ustekinumab) • Steqeyma (ustekinumab-stba) • Tremfya (guselkumab) • Yesintek (ustekinumab-kfce)
Moderately to severely active Crohn's disease (CD)	**BOTH** of the following: 1. **ONE** of the following: a. The member has tried and had an inadequate response to **ONE** conventional agent (i.e., 6-mercaptopurine, azathioprine, corticosteroids [e.g., prednisone, budesonide EC capsule], methotrexate) used in the treatment of CD after at least a 3-month duration of therapy **OR** b. The member has an intolerance or hypersensitivity to **ONE** conventional agent used in the treatment of CD

	OR c. The member has an FDA labeled contraindication **ALL** conventional agents used in the treatment of CD **OR** d. 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 or AHFS for the treatment of CD **AND** 2. **ANY** of the following* (submitted medical records/chart notes are required for confirmation): a. The member has tried and had an inadequate response to at least **TWO** preferred products after at least a 3-month trial per product **OR** b. The member has tried and had an inadequate response to **ONE** preferred product after at least a 3-month duration of therapy, **AND** an intolerance (defined as an intolerance to the drug or its excipients, not to the route of administration) or hypersensitivity to **ONE** preferred product **OR** c. The member has an intolerance (defined as an intolerance to the drug or its excipients, not to the route of administration) or hypersensitivity to at least **TWO** preferred products **OR** d. The member has an FDA labeled contraindication to **ALL** preferred products **OR** e. **ALL** preferred products are not clinically appropriate for the member, **AND** the prescriber has provided a complete list of previously tried products for the requested indication **The preferred CD products are:** • Adalimumab-aaty • Adalimumab-adaz • Entyvio (vedolizumab) subcutaneous injection • Hadlima (adalimumab-bwwd) • Humira (adalimumab) • Selarsdi (ustekinumab-aekn)

	• Simlandi (adalimumab-ryvk) • Skyrizi (risankizumab) • Stelara (ustekinumab) • Steqeyma (ustekinumab-stba) • Tremfya (guselkumab) • Yesintek (ustekinumab-kfce)
Active ankylosing spondylitis (AS)	**BOTH** of the following: 1. **ONE** of the following: a. The member has tried and had an inadequate response to **TWO** different NSAIDs used in the treatment of AS after at least a 4-week TOTAL duration of therapy **OR** b. The member has tried and had an inadequate response to **ONE** NSAID used in the treatment of AS after at least a 4-week duration of therapy **AND** an intolerance or hypersensitivity to **ONE** additional NSAID used in the treatment of AS **OR** c. The member has an intolerance or hypersensitivity to **TWO** different NSAIDs used in the treatment of AS **OR** d. The member has an FDA labeled contraindication to **ALL** NSAIDs used in the treatment of AS **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 or AHFS for the treatment of AS **AND** 2. **ANY** of the following* (submitted medical records/chart notes are required for confirmation): a. The member has tried and had an inadequate response to at least **TWO** preferred products after at least a 3-month trial per product **OR** b. The member has tried and had an inadequate response to **ONE** preferred product after at least a 3-month duration of therapy, **AND** an intolerance (defined as an intolerance to the drug or its

	excipients, not to the route of administration) or hypersensitivity to **ONE** preferred product **OR** c. The member has an intolerance (defined as an intolerance to the drug or its excipients, not to the route of administration) or hypersensitivity to at least **TWO** preferred products **OR** d. The member has an FDA labeled contraindication to **ALL** preferred products **OR** e. **ALL** preferred products are not clinically appropriate for the member, **AND** the prescriber has provided a complete list of previously tried products for the requested indication: **The preferred AS products are:** • Adalimumab-aaty • Adalimumab-adaz • Cosentyx (secukinumab) • Enbrel (etanercept) • Hadlima (adalimumab-bwwd • Humira (adalimumab) • Rinvoq (upadacitinib) • Simlandi (adalimumab-ryvk) • Xeljanz/Xeljanz XR (tofacitinib)
Active non-radiographic axial spondyloarthritis (nr-axSpA)	**ONE** of the following: 1. The member has tried and had an inadequate response to **TWO** different NSAIDs used in the treatment of nr-axSpA after at least a 4-week TOTAL duration of therapy **OR** 3. The member has tried and had an inadequate response to **ONE** NSAID used in the treatment of nr-axSpA after at least a 4-week duration of therapy **AND** an intolerance or hypersensitivity to **ONE** additional NSAID used in the treatment of nr-axSpA **OR** 3. The member has an intolerance or hypersensitivity to **TWO** different NSAIDs used in the treatment of nr-axSpA

	OR 4. The member has an FDA labeled contraindication to **ALL** NSAIDs used in the treatment of nr-axSpA **OR** 5. 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 or AHFS for the treatment of nr-axSpA
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
*Members initiating provider-administered (i.e., submitted as a medical claim with J0717) certolizumab therapy are **NOT** required to have had an inadequate response to the preferred self-administered (i.e., subcutaneous) products. However, members transitioning to self-administered treatment after a single provider-administered first dose must still meet the preferred self-administered biologic product requirement.	

Continuation of certolizumab pegol (Cimzia) **meets the definition of medical necessity** when **ALL** of the following are met ("1" to "6"):

1. An authorization or reauthorization for certolizumab pegol has been previously approved by Florida Blue [Note: members not previously approved for the requested agent will require initial evaluation review]
2. Member has had clinical benefit with certolizumab pegol therapy
3. The prescriber is a specialist in the area of the member's diagnosis (e.g., rheumatologist for PJIA, PsA, RA; gastroenterologist for CD; dermatologist for PS) 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 certolizumab pegol
5. Member will **NOT** be using certolizumab pegol in combination with another biologic immunomodulator agent (full list in "Other" section); Janus kinase (JAK) inhibitor [Cibinqo (abrocitinib), Leqselvi (deuruxolitinib), Litfulo (ritlecitinib), Olumiant (baricitinib), Opzelura (ruxolitinib), Rinvoq/Rinvoq LQ (upadacitinib), and Xeljanz/Xeljanz XR (tofacitinib)]; Otezla/Otezla XR (apremilast); Sotyktu (deucravacitinib); or sphingosine-1-phosphate (S1P) modulator [Velsipity (etrasimod) and Zeposia (ozanimod)]
6. **ANY** of the following ("a", "b", "c", or "d"):
    a. The dosage does not exceed the following:
        - AS, CD, nr-axSpA, PsA and RA: 200 mg every 2 weeks (14 days) or 400 mg every 4 weeks (28 days)
            - QL: 2 x 200 mg/mL syringe, kit - 1 kit/28 days
            - QL: 400 mg vial kit (two 200 mg vials) – 1 kit/28 days

- PJIA:
  - 10 kg (22 lbs) to less than 20 kg (44 lbs): 50 mg every 2 weeks
    - QL: 400 mg vial kit (two 200 mg vials) – 1 kit/28 days
  - 20 kg (44 lbs) to less than 40 kg (88 lbs): 100 mg every 2 weeks
    - QL: 400 mg vial kit (two 200 mg vials) – 1 kit/28 days
  - Greater than or equal to 40 kg (88 lbs): 200 mg every 2 weeks
    - QL: 400 mg vial kit (two 200 mg vials) – 1 kit/28 days
    - QL: 2 x 200 mg/mL syringe, kit - 1 kit/28 days
- PS and other indications: 400 mg every 2 weeks (14 days)
  - QL: 2 x 200 mg/mL syringe, kit - 2 kits/28 days
  - QL: 400 mg vial kit (two 200 mg vials) – 2 kits/28 days

b. The member has an FDA labeled indication for the requested agent, **AND EITHER** of the following ("i" or "ii"):

   i. The requested quantity (dose) does **NOT** exceed the maximum FDA labeled dose 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

   ii. **ALL** of the following ("1", "2", and "3"):

      1. The requested quantity (dose) exceeds the FDA maximum labeled dose for the requested indication
      2. The member has tried and had an inadequate response to at least a 3-month trial of the maximum FDA labeled dose for the requested indication (medical records required)
      3. **EITHER** of the following ("a" or "b"):
         a. The requested quantity (dose) does **NOT** exceed the maximum compendia supported dose 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
         b. The requested quantity (dose) exceeds the maximum FDA labeled dose **AND** the maximum compendia supported dose for the requested indication, **AND** there is support for therapy with a higher dose or shortened dosing interval for the requested indication (submitted copy of clinical trials, phase III studies, guidelines required)

c. The member has a compendia supported indication for the requested agent, **AND EITHER** of the following ("i" or "ii"):

   i. The requested quantity (dose) does **NOT** exceed the maximum compendia supported dose 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

ii. The requested quantity (dose) exceeds the maximum compendia supported dose for the requested indication, **AND** there is support for therapy with a higher dose or shortened dosing interval for the requested indication (submitted copy of clinical trials, phase III studies, guidelines required)

d. The member does **NOT** have an FDA labeled indication NOR a compendia supported indication for the requested agent, **AND BOTH** of the following ("i" and "ii"):

i. 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

ii. There is support for therapy with a higher dose or shortened dosing interval for the requested indication (submitted copy of clinical trials, phase III studies, guidelines required)

Compendia Allowed: AHFS, DrugDex 1 or 2a level of evidence, or NCCN 1 or 2a recommended use

Approval duration: 12 months

DOSAGE/ADMINISTRATION:

THIS INFORMATION IS PROVIDED FOR INFORMATIONAL PURPOSES ONLY AND SHOULD NOT BE USED AS A SOURCE FOR MAKING PRESCRIBING OR OTHER MEDICAL DETERMINATIONS. PROVIDERS SHOULD REFER TO THE MANUFACTURER'S FULL PRESCRIBING INFORMATION FOR DOSAGE GUIDELINES AND OTHER INFORMATION RELATED TO THIS MEDICATION BEFORE MAKING ANY CLINICAL DECISIONS REGARDING ITS USAGE.

FDA-approved indications:

Certolizumab pegol is indication for:

- Reducing signs and symptoms of Crohn's disease and maintaining clinical response in adult patients with moderately to severely active disease who have had an inadequate response to conventional therapy
- Treatment of adults with moderately to severely active rheumatoid arthritis
- Treatment of active polyarticular juvenile idiopathic arthritis in patients 2 years of age and older
- Treatment of adult patients with active psoriatic arthritis
- Treatment of adults with active ankylosing spondylitis
- Treatment of adults with active non-radiographic axial spondyloarthritis with objective signs of inflammation
- Treatment of adults with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy

Crohn's Disease:

- Initial Dose: 400 mg (given as 2 subcutaneous injections of 200 mg) initially, and at weeks 2 and 4.
- Maintenance Dose: In members who obtain a clinical response, the recommended maintenance regimen is 400 mg every 4 weeks (starting at week 8).

Plaque Psoriasis:

- 400 mg (given as 2 subcutaneous injections of 200 mg) every other week
- For some patients (with body weight ≤90 kg), 400 mg (given as 2 subcutaneous injections of 200 mg each) initially and at Weeks 2 and 4, followed by 200 mg every other week can be considered.

Polyarticular Juvenile Idiopathic Arthritis:

- 10 kg (22 lbs) to less than 20 kg (44 lbs)
  - Initial Dose: 100 mg at Week 0, 2 and 4
  - Maintenance Dose: 50 mg every 2 weeks
- 20 kg (44 lbs) to less than 40 kg (88 lbs)
  - Initial Dose: 200 mg at Week 0, 2 and 4
  - Maintenance Dose: 100 mg every 2 weeks
- Greater than or equal to 40 kg (88 lbs)
  - Initial Dose: 400 mg at Week 0, 2 and 4
  - Maintenance Dose: 200 mg every 2 weeks
- There is no dosage form for Cimzia that allows for patient self-administration for doses below 200 mg. Doses less than 200 mg require administration by a health care professional using the vial kit.

Rheumatoid Arthritis, Active Psoriatic Arthritis, Ankylosing Spondylitis, and Non-radiographic Axial Spondyloarthritis:

- Initial Dose: 400 mg (given as 2 subcutaneous injections of 200 mg) initially, and at weeks 2 and 4.
- Maintenance Dose: 200 mg every other week (starting at week 6). 400 mg every 4 weeks can be considered (starting at week 8).

Administration: Certolizumab is administered by subcutaneous injection. Rotate injection sites and do not give injections into areas where the skin is tender, bruised, red, or hard. When a 400 mg dose is needed (given as 2 subcutaneous injections of 200 mg), injections should occur at separate sites in the thigh or abdomen

Powder for solution: Prepare the lyophilized powder and administer by a health care provider.

Prefilled syringe: A member may self-inject certolizumab if a health care provider determines that it is appropriate, with medical follow-up, as necessary, after proper training in subcutaneous injection technique. Instruct members using certolizumab to inject the full amount in the syringe (1 mL).

Drug Availability: certolizumab is available as:

- Lyophilized powder for reconstitution – contains two 200 mg vials of lyophilized powder for reconstitution and supplies needed for reconstitution

- Prefilled syringe for injection – contains two 200 mg/mL syringes
- Starter kit – contains six 200 mg/mL prefilled syringes to provide for the three 400 mg inial induction doses on week 0, 2, and 4

Refrigerate intact carton between 2 to 8 °C (36 to 46 °F). Do not freeze. Do not separate contents of carton prior to use. Protect solution from light.

PRECAUTIONS:

Boxed Warning

- **Infections:** Increased risk of serious infections leading to hospitalization or death including tuberculosis (TB), invasive fungal, and other opportunistic infections, some fatal, have occurred. Perform test for latent TB; if positive, start treatment for TB prior to starting therapy. Monitor all patients for active TB, even if initial tuberculin skin test is negative. Discontinue treatment if a patient develops a serious infection or sepsis.
- **Malignancy**: lymphoma and other malignancies, some fatal have been reported in children and adolescent individuals treated with TNF blockers including certolizumab. Post-marketing cases of hepatosplenic T-cell lymphoma (HSTCL), a rare type of T-cell lymphoma, have occurred in adolescents and young adults with inflammatory bowel disease. Certolizumab pegol is not indicated for use in pediatric patients.

Contraindications

- Serious hypersensitivity reaction to certolizumab pegol or to any of the excipients

Precautions/Warnings

- **Serious Infections:** certolizumab should not be initiated in members during an active infection. If an infection develops, monitor carefully, and discontinue certolizumab if infection becomes serious.
- **Invasive fungal infections:** If a member develops a systemic infection while on certolizumab therapy, consider empiric antifungal therapy for those who reside or travel to regions where mycoses are endemic
- **Anaphylaxis:** anaphylaxis or serious allergic reactions may occur.
- **Hepatitis B virus reactivation:** members who are HBV caries should be monitored during and several months after therapy. If reactivation occurs during therapy, discontinue certolizumab and initiate anti-viral therapy.
- **Demyelinating disease:** exacerbation of new onset may occur
- **Cytopenia, pancytopenia:** advise members to seek immediate medical attention if symptoms develop and consider discontinuing certolizumab.
- **Heart failure:** worsening or new onset heart failure may occur.
- **Lupus-like syndrome:** discontinue certolizumab if syndrome develops.
- **Drug Interactions:** avoid concomitant use with abatacept (Orencia®) and anakinra (Kineret®), due to increased risk of serious infection.
- **Laboratory tests:** may interfere with certain aPTT tests

- **Immunizations:** Avoid administration of live vaccines during or immediately prior to initiation of therapy with certolizumab. Update immunizations in agreement with current immunization guidelines prior to initiating certolizumab therapy.
- **Pregnancy and Lactation**
    - Certolizumab is classified as pregnancy category B. Developmental toxicity studies performed in animals have revealed no evidence of harm to the fetus.
    - Because many immunoglobulins are secreted in milk and the potential for serious adverse reactions exists, a decision should be made whether to discontinue nursing or discontinue the drug, taking into account the importance of the drug to the mother.

BILLING/CODING INFORMATION:

The following codes may be used to describe:

HCPCS Coding:

J0717	Injection, certolizumab pegol, 1 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when self-administered)

ICD-10 Diagnosis Codes That Support Medical Necessity:

K50.00 – K50.919	Crohn's disease [regional enteritis]
L40.0	Psoriasis vulgaris
L40.50 – L40.59	Arthropathic psoriasis
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 – M05.7A	Rheumatoid arthritis with rheumatoid factor without organ or systems involvement
M05.80 – M05.8A	Other rheumatoid arthritis with rheumatoid factor
M05.9	Rheumatoid arthritis with rheumatoid factor, unspecified
M05.A	Abnormal rheumatoid factor and anti-citrullinated protein antibody with rheumatoid arthritis
M06.00 – M06.0A	Rheumatoid arthritis without rheumatoid factor
M06.20 – M06.29	Rheumatoid bursitis
M06.30 – M06.39	Rheumatoid nodule
M06.80 – M06.8A	Other specified rheumatoid arthritis
M06.9	Rheumatoid arthritis, unspecified
M08.09	Unspecified juvenile rheumatoid arthritis, multiple sites
M08.3	Juvenile rheumatoid polyarthritis (seronegative)

M08.89	Other juvenile arthritis, multiple sites
M45.0 – M45.9	Ankylosing spondylitis
M45.A0 – M45.AB	Non-radiographic axial spondyloarthritis
M46.81 – M46.89	Other specified inflammatory spondylopathies
T45.AX5A	Adverse effect of immune checkpoint inhibitors and immunostimulant drugs, initial encounter
T45.AX5D	Adverse effect of immune checkpoint inhibitors and immunostimulant drugs, subsequent encounter
T45.AX5S	Adverse effect of immune checkpoint inhibitors and immunostimulant drugs, sequela

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. The Site of Care Policy for Select Specialty Medications does not apply to Medicare Advantage members.

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.

If this Medical Coverage Guideline contains a step therapy requirement, in compliance with Florida law 627.42393, members or providers may request a step therapy protocol exemption to this requirement if based on medical necessity. The process for requesting a protocol exemption can be found at Coverage Protocol Exemption Request.

DEFINITIONS:

Crohn's disease: a chronic granulomatous inflammatory disease of unknown etiology, involving any part of the gastrointestinal tract from mouth to anus, but commonly involving the terminal ileum with scarring and thickening of the bowel wall. It frequently leads to intestinal obstruction and fistula and abscess formation and has a high rate of recurrence after treatment.

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., baricitinib, tofacitinib, apremilast), and (3) biological DMARDs (bDMARD), which can be either a biosimilar DMARD (bsDMARD) or biological originator DMARD (boDMARD).

Mild-Moderate Crohn's Disease: Mild-moderate Crohn's disease applies to ambulatory members able to tolerate oral alimentation without manifestations of dehydration, toxicity (high fevers, rigors, prostration), abdominal tenderness, painful mass, obstruction, or >10% weight loss**.**

Moderate to Severe Crohn's Disease: Moderate to severe disease applies to patients who have failed to respond to treatment for mild to moderate disease or those with more prominent symptoms of fevers, significant weight loss, abdominal pain or tenderness, intermittent nausea or vomiting (without obstructive findings), or significant anemia.

Monoclonal antibody: derived from a single cell; pertaining to a single clone. Widely used to measure proteins and drugs in the serum, type tissue and blood, identify infectious agents, identify classification and follow-up therapy of leukemias and lymphomas, and identify tumor antibodies.

Plaque psoriasis: It is the most common form of psoriasis. It affects 80 to 90% of people with psoriasis. Plaque psoriasis typically appears as raised areas of inflamed skin covered with silvery white scaly skin. These areas are called plaques.

Psoriatic arthritis (PsA): joint inflammation that occurs in about 5% to 10% of people with psoriasis (a common skin disorder). It is a severe form of arthritis accompanied by inflammation, psoriasis of the skin or nails, and a negative test for rheumatoid factor. Enthesitis refers to inflammation of entheses, the site where ligaments or tendons insert into the bones. It is a distinctive feature of PsA and does not occur with other forms of arthritis. Common locations for enthesitis include the bottoms of the feet, the Achilles' tendons, and the places where ligaments attach to the ribs, spine, and pelvis.

Rheumatoid arthritis: An inflammatory disease of the synovium or lining of the joint that 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 Products, 09-J0000-46
Anakinra (Kineret), 09-J0000-45
Apremilast (Otezla) Tablet, 09-J2000-19
Baricitinib (Olumiant), 09-J3000-10
Bimekizumab (Bimzelx), 09-J4000-70
Brodalumab (Siliq) Injection, 09-J2000-74
Deucravacitinib (Sotyktu), 09-J4000-37
Etanercept (Enbrel), 09-J0000-38
Golimumab (Simponi, Simponi Aria), 09-J1000-11
Guselkumab (Tremfya), 09-J2000-87
Infliximab Products, 09-J0000-39
Ixekizumab (Taltz), 09-J2000-62

Natalizumab (Tysabri) IV, 09-J0000-73
Psoralens with Ultraviolet A (PUVA), 02-10000-16
Risankizumab (Skyrizi), 09-J3000-45
Rituximab Products, 09-J0000-59
Sarilumab (Kevzara), 09-J2000-87
Secukinumab (Cosentyx), 09-J2000-30
Tildrakizumab-asmn (Ilumya), 09-J3000-04
Tocilizumab Products (Actemra, Tofidence, Tyenne), 09-J1000-21
Tofacitinib (Xeljanz, Xeljanz XR) Oral Solution, Tablet and Extended-Release Tablet, 09-J1000-86
Upadacitinib (Rinvoq), 09-J3000-51
Ustekinumab (Stelara), 09-J1000-16
Vedolizumab (Entyvio), 09-J2000-18

OTHER:

NOTE: The list of biologic immunomodulator agents not permitted as concomitant therapy can be found at Biologic Immunomodulator Agents Not Permitted as Concomitant Therapy.

Table 2: Xolair (omalizumab) - Conventional Synthetic DMARDs

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

Table 3: 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 Committee on 11/11/25.

GUIDELINE UPDATE INFORMATION:

09/15/08	New Medical Coverage Guideline.
01/01/09	Annual HCPCS coding update: deleted code 90772; added codes 96372.
04/01/09	Annual HCPCS coding update: added HCPCS code C9249 & deleted J3490.
04/15/09	Revision; consisting of adding ICD-9 codes.
06/15/09	Revision; consisting of adding rheumatoid arthritis indication and updating boxed warning.
10/15/09	Review and revision; consisting of updating administration and dosage section and references.

01/01/10	Annual HCPCS coding update: added HCPCS code J0718 and deleted code C9249.
04/15/10	Revision; consisting of adding specific continuation criteria.
08/15/10	Review and revision; consisting of updating precautions and references.
01/15/11	Revision; consisting of adding ICD-10 codes.
08/15/11	Review and revision to guideline; consisting of updating precautions, coding and references.
08/15/12	Review and revision to guideline; consisting of reformatting position statement, updating precautions and references.
10/15/12	Revision to guideline; consisting of modifying continuation criteria.
01/15/13	Revision to guideline; consisting of reformatting position statement; revising and reformatting description, dosage/administration, and precautions sections.
03/07/13	Revision to guideline; additions to position statement.
04/15/13	Revision to guideline; consisting of revising position statement to include duration of approval.
09/15/13	Review and revision to guideline; consisting of reformatting position statement; updating related guidelines, references, program exceptions, and coding.
01/01/14	Revision to guideline; consisting of updating position statement, coding, and references.
04/15/14	Revision to guideline; consisting of updating position statement.
09/15/14	Review and revision to guideline; consisting of updating position statement, references, and coding.
09/15/15	Review and revision to guideline; consisting of updating description section, position statement, dosage/administration, warnings/precautions, billing/coding, related guidelines, and references.
12/15/15	Revision to guideline consisting of updating the position statement.
09/15/16	Review and revision to guideline consisting of updating description section, position statement, billing/coding, and references.
11/15/16	Revision to guideline consisting of updating position statement with ustekinumab prerequisite therapy requirement for Crohn's disease indication.
10/15/17	Review and revision to guideline consisting of updating description, position statement, 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. Secukinumab is now a preferred product for psoriatic arthritis and axial spondyloarthritis and use of three preferred products is required. Tofacitinib (Xeljanz, Xeljanz XR) added as prerequisite therapy for rheumatoid arthritis when certolizumab pegol is used as self-administered therapy.
07/01/18	Revision to guideline consisting of updating the position statement.
07/15/18	Revision to guideline consisting of updating the description section, position statement, dosage/administration, warnings/precautions, billing/coding, related guidelines, definitions, and references based on a new FDA-approved indication of plaque psoriasis.
10/15/18	Review and revision to guideline consisting of updating the position statement, related guidelines, and references.

05/15/18	Revision to guideline consisting of updating the description section and dosage/administration section based on the new FDA-approved indication of non-radiographic axial spondyloarthritis.
07/15/19	Revision to guideline consisting of updating the position statement.
09/01/19	Revision to guideline consisting of updating the position statement.
10/15/19	Review and revision to guideline consisting of updating the statement and references.
11/11/19	Revision to guideline consisting of adding a reference to the Site of Care Policy for Select Specialty Medications and updating the Program Exceptions.
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 definitions.
01/01/21	Review and revision to guideline consisting of updating the position statement and references.
03/15/21	Revision to guideline consisting of updating Table 1 in the position statement.
10/01/21	Revision: Addition of new ICD-10 code range M45.A0 – M45.AB.
11/15/21	Revision to guideline consisting of updating the position statement.
01/01/22	Review and revision to guideline consisting of updating the description, position statement, related guidelines, other section, and references.
2/15/22	Update to Table 1 in Position Statement.
03/15/22	Revision to guideline consisting of updating the position statement and other section.
05/15/22	Update to Table 1 in Position Statement.
07/15/22	Revision to guideline consisting of updating the position statement.
09/15/22	Update to Table 1 in Position Statement.
10/15/22	Revision to guideline consisting of updating the position statement to include either Skyrizi or Stelara as a second preferred agent (in addition to Humira) prior to the use of self-administered Cimzia for the treatment of Crohn's disease.
01/01/23	Review and revision to guideline consisting of updating the position statement, other section, and references. New drugs were added to the list of drugs that are not permitted for use in combination.
04/15/23	Revision to guideline consisting of updating the position statement and other section.
07/01/23	Revision to guideline consisting of updating the position statement and other section. Amjevita and Hadlima added as Step 1a agents. Rinvoq added as a Step 1b agent for CD. Humira biosimilar products added to list of Biologic Immunomodulator Agents Not Permitted as Concomitant Therapy.
01/01/24	Review and revision to guideline consisting of updating the description (NCCN info), position statement, other section, billing/coding, and references. Amjevita low-concentration [10 mg/0.2 mL, 20 mg/0.4 mL, and 40 mg/0.8 mL concentrations only] clarified as the preferred prerequisite product. Update to Table 1 in Position Statement. New drugs were added to the list of drugs that are not permitted for use in combination.
07/01/24	Revision to guideline consisting of updating the description, position statement, related guidelines, and other section. Amjevita low-concentration removed as a required prerequisite agent. Updates to the positioning of agents in Table 1. Removal of latent TB

	testing requirement. New drugs added to the list of Biologic Immunomodulator Agents Not Permitted as Concomitant Therapy.
10/01/24	Revision to guideline consisting of updating the position statement and billing/coding. Updates to Table 1. Simlandi added among the required prerequisite agents for self-administered Cimzia for AS, RA, CD, PS, and PsA. Rinvoq LQ added among the required prerequisite agents for self-administered Cimzia for PsA. New ICD-10 codes.
11/15/24	Revision to guidelines consisting of updates to the description, position statement, dosage/administration, billing/coding, and references based on the new FDA-approved indication for the treatment of active PJIA in patients 2 years of age and older.
01/01/25	Review and revision to guideline consisting of updating the position statement, other section, and references. Adalimumab-aaty and Adalimumab-adaz added among the prerequisite therapies for AS, CD, PJIA, PsA, PS, and RA. Entyvio (vedolizumab) subcutaneous injection (now a step 1a agent) added among the prerequisite therapies for CD. Sotyktu (deucravacitinib) (now a step 1a agent) added among the prerequisite therapies for PS. Update to original Table 1 which is now a link out from the Position Statement. Table titles updated. Revised wording regarding maximum dosage exceptions. New drugs were added to the list of drugs that are not permitted for use in combination.
04/01/25	Revision to guidelines consisting of updates to the position statement. Self-administered Cimzia moved from a step 3c (triple step) to step 3a (double step) agent for PJIA. For the Crohn's disease indication, self-administered Cimzia is a 3a agent (double step), but the step no longer always requires an adalimumab product.
05/15/25	Revision. Tremfya added among the preferred agents for CD for self-administered Cimzia.
07/01/25	Revision: Added Selarsdi, Steqeyma and Yesintek among the preferred agents for CD, PS, and PsA for for self-administered Cimzia.
10/01/25	Revision: Added ICD-10 code M05.A. Updated ICD-10 code ranges for RA.
01/01/26	Review and revision to guideline consisting of updating the description, position statement and references.