

**DIVISION OF HEALTH CARE FINANCING AND POLICY**  
**NEVADA MEDICAID**  
**DRUG USE REVIEW (DUR) BOARD**

**PROPOSED PRIOR AUTHORIZATION CRITERIA**

**Injectable Immunomodulator Drugs**

Actemra® (tocilizumab)  
Amevive® (alefacept)  
Cimzia® (certolizumab)  
Enbrel® (etanercept)  
Humira® (adalimumab)

Kineret® (anakinra)  
Orencia® (abatacept)  
Remicade® (infliximab)  
Simponi™ (golimumab)  
Stelara™ (ustekinumab)

Injectable immunomodulator drugs are a covered Nevada Medicaid benefit for recipients who meet the criteria for coverage:

1. Coverage and Limitations:

Approval will be given if the following criteria are met and documented:

A. Rheumatoid Arthritis (Orencia®, Humira®, Kineret®, Cimzia®, Enbrel®, Remicade®, Simponi®, Actemra®)

1. Diagnosis of moderately to severely active rheumatoid arthritis, AND
2. Rheumatology consult with date, AND
3. Inadequate response or adverse reaction of a disease modifying antirheumatic drug (DMARDs) (methotrexate, hydroxychloroquine, leflunomide, minocycline and sulfasalazine) AND
4. Negative tuberculin test (Orencia®, Humira®, Cimzia®, Enbrel®, Remicade®, Simponi®, Actemra®) AND
5. Patient does not have an active infection or a history of recurring infections

B. Psoriatic Arthritis (Enbrel®, Humira®, Remicade®, Simponi™):

1. Diagnosis of moderate or severe psoriatic arthritis, AND
2. Rheumatology consult with date OR Dermatology consult with date, AND
3. Inadequate response to any one non-steroidal antiinflammatory drug (NSAID) or contraindication to treatment with a NSAID OR to any one of the following disease modifying anti-rheumatic drugs (DMARDs) (methotrexate, leflunomide, cyclosporine or sulfasalazine)
4. Negative tuberculin test (Enbrel®, Humira®, Remicade®, Simponi™)
5. Patient does not have an active infection or a history of recurring infections.

- C. Ankylosing Spondylitis (Enbrel®, Humira®, Remicade®, Simponi™):
1. Diagnosis of ankylosing spondylitis, AND
  2. Inadequate response to Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) AND to any one of the Disease-Modifying Anti-Rheumatic Drugs (DMARDs) (sulfasalazine, methotrexate, hydroxychloroquine, leflunomide, minocycline) AND
  3. Negative tuberculin test (Enbrel®, Humira®, Remicade®, Simponi™) AND
  4. Patient does not have an active infection or a history of recurring infections.
- D. Juvenile Rheumatoid Arthritis/ Juvenile Idiopathic Arthritis (Enbrel®, Humira®, Oencia®):
1. Diagnosis of moderately or severely active juvenile rheumatoid arthritis AND,
  2. Patient is at least 2 years of age, AND
  2. At least five swollen joints, AND
  3. Three or more joints with limitation of motion and pain, tenderness, or both AND
  4. Inadequate response to one Disease-Modifying Anti-Rheumatic Drug (DMARD)
  5. Negative tuberculin test (Enbrel®, Humira®, Oencia®) AND
  6. Patient does not have an active infection or a history of recurring infections.
- E. Plaque Psoriasis (Amevive®, Enbrel®, Humira®, Remicade®, Stelara™)
1. Diagnosis of chronic, moderate to severe plaques psoriasis, and
  2. Prescribed by a dermatologist, and
  3. Failed to adequately respond to a topical agent, and
  4. Failed to adequately respond to at least one oral treatment.
  5. Negative tuberculin test (Amevive®, Enbrel®, Humira®, Remicade®, Stelara™)
  6. Patient does not have an active infection or a history of recurring infections.
- F. Crohn's Disease (Cimzia®, Humira®, Remicade®):
1. Diagnosis of Crohn's Disease, AND
  2. Failed to adequately respond to conventional therapy (e.g. sulfasalazine, leflunomide, azathioprine, mesalamine, antibiotics, corticosteroids, azathioprine, 6-mercaptopurine) OR patient has fistulizing Crohn's disease, AND
  3. Negative tuberculin test (Cimzia®, Humira®, Remicade®) AND
  4. Patient does not have an active infection or a history of recurring infections.
- G. Ulcerative Colitis (Remicade®):
1. Diagnosis of moderate to severe ulcerative colitis, and
  2. Failed to adequately respond to one or more of the following standard therapies:
    - a. Corticosteroids
    - b. 5-aminosalicylic acid agents
    - c. Immunosuppressants
  3. Negative tuberculin test AND
  4. Patient does not have an active infection or a history of recurring infections.
2. Coverage is not provided for use of more than one biologic at a time (combination therapy).
  3. Duration of Authorization: 1 year