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DRUG POLICY

Cimzia (certolizumab pegol)

NOTICE

This policy contains information which is clinical in nature. The policy is not medical advice. The information in this policy is used by Wellmark to make determinations whether medical treatment is covered under the terms of a Wellmark member's health benefit plan. Physicians and other health care providers are responsible for medical advice and treatment. If you have specific health care needs, you should consult an appropriate health care professional. If you would like to request an accessible version of this document, please contact customer service at 800-524-9242.

BENEFIT APPLICATION

Benefit determinations are based on the applicable contract language in effect at the time the services were rendered. Exclusions, limitations or exceptions may apply. Benefits may vary based on contract, and individual member benefits must be verified. Wellmark determines medical necessity only if the benefit exists and no contract exclusions are applicable. This medical policy may not apply to FEP. Benefits are determined by the Federal Employee Program.

DESCRIPTION

The intent of the Cimzia drug policy is to ensure appropriate selection of patients for therapy based on product labeling, clinical guidelines and clinical studies while steering utilization to the most cost-effective medication within the therapeutic class. For this program, Humira, Enbrel, Cosentyx, Otezla, Rinvoq, Skyrizi, Stelara, Tremfya, and Xeljanz/Xeljanz XR are the preferred products and will apply to members requesting treatment with Cimzia prefilled syringes for an indication that is FDA-approved for the preferred product. The criteria will require the use of two of the health plan's preferred products before the use of non-preferred products unless there are clinical circumstances that exclude the use of all the preferred products, the patient is currently receiving treatment with the non-preferred drug and experience a positive therapeutic outcome, or there is only one preferred product for an indication. Additionally for this program, infliximab biosimilars (Avsola, Inflectra, Renflexis), Entyvio, Ilumya, Stelara IV, and Simponi Aria are the preferred products and will apply to members requesting treatment with Cimzia Lyophilized Powder for reconstitution and administration by a healthcare professional for an indication that is FDA-approved for the preferred product. Coverage for targeted products is provided based on clinical circumstances that would exclude the use of the preferred product and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made.

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

1. 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.
2. Treatment of adults with moderately to severely active rheumatoid arthritis.

3. Treatment of adult patients with active psoriatic arthritis.
4. Treatment of adults with active ankylosing spondylitis.
5. Treatment of adults with active non-radiographic axial spondyloarthritis with objective signs of inflammation.
6. Treatment of adults with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy.

POLICY

Required Documentation

Submission of the following information is necessary to initiate the prior authorization review:

A) Rheumatoid arthritis (RA)

1. For initial requests:
 - a) Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.
 - b) Laboratory results, chart notes, or medical record documentation of biomarker testing (i.e., rheumatoid factor [RF], anti-cyclic citrullinated peptide [anti-CCP], and C-reactive protein [CRP] and/or erythrocyte sedimentation rate [ESR]) (if applicable).
2. For continuation requests: Chart notes or medical record documentation supporting positive clinical response.

B) Psoriatic arthritis (PsA): For continuation requests: Chart notes or medical record documentation supporting positive clinical response.

C) Ankylosing spondylitis (AS) and active axial spondyloarthritis:

1. Initial requests: Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.
2. Continuation requests: Chart notes or medical record documentation supporting positive clinical response.

D) Crohn's disease

1. Initial requests
 - a) Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.
 - b)
2. Continuation requests: Chart notes or medical record documentation supporting positive clinical response to therapy or remission.

E) Plaque psoriasis

1. Initial requests:
 - a) Chart notes or medical record documentation of affected area(s) and body surface area (BSA) affected (if applicable).
 - b) Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.
2. Continuation requests: Chart notes or medical record documentation of decreased body surface area (BSA) affected and/or improvement in signs and symptoms.

Must meet BOTH the Preferred Drug Plan Design and Criteria for Initial Approval/Continuation of Therapy when both are applicable.

Preferred Drug Plan Design for Cimzia prefilled syringes

A) Ankylosing Spondylitis

1. Criteria for initial approval for ankylosing spondylitis will only apply when at least ONE of the following criteria are met:
 - a) Member has had an inadequate response to treatment or intolerable adverse event with at least TWO of the preferred products (Cosentyx, Enbrel, Humira, Rinvoq, and Xeljanz/Xeljanz XR)
 - b) Member is currently receiving treatment with the requested product through insurance (excludes obtainment as samples or via manufacturer's patient assistance programs) and experiencing a positive therapeutic outcome
 - c) The member is currently pregnant or breastfeeding

B) Axial Spondyloarthritis

1. Criteria for initial approval for ankylosing spondylitis will only apply when at least ONE of the following criteria are met:
 - a) Member has had an inadequate response to treatment or intolerable adverse event with the preferred product, Cosentyx
 - b) Member is currently receiving treatment with the requested product through insurance (excludes obtainment as samples or via manufacturer's patient assistance programs) and experiencing a positive therapeutic outcome
 - c) The member is currently pregnant or breastfeeding

C) Psoriatic arthritis

1. Criteria for initial approval for psoriatic arthritis will only apply when at least ONE of the following criteria are met:
 - a) Member has had an inadequate response to treatment or intolerable adverse event with at least TWO of the preferred products (Cosentyx, Enbrel, Humira, Otezla, Rinvoq, Stelara, Tremfya, and Xeljanz/Xeljanz XR)
 - b) Member is currently receiving treatment with the requested product through insurance (excludes obtainment as samples or via manufacturer's patient assistance programs) and experiencing a positive therapeutic outcome
 - c) The member is currently pregnant or breastfeeding

D) Rheumatoid Arthritis

1. Criteria for initial approval for rheumatoid arthritis will only apply when at least ONE of the following criteria are met:
 - a) Member has had an inadequate response to treatment or intolerable adverse event with at least TWO of the preferred products (Humira, Enbrel, Rinvoq, and Xeljanz/Xeljanz XR)
 - b) Member is currently receiving treatment with the requested product through insurance (excludes obtainment as samples or via manufacturer's patient assistance programs) and experiencing a positive therapeutic outcome
 - c) The member is currently pregnant or breastfeeding

E) Crohn's Disease

1. Criteria for initial approval for Crohn's disease will only apply when at least ONE of the following criteria are met:
 - a) Member has had an inadequate response to treatment or intolerable adverse event with at least two of the preferred products (Humira, Skyrizi, and Stelara)

- b) Member is currently receiving treatment with the requested product through insurance (excludes obtainment as samples or via manufacturer's patient assistance programs) and experiencing a positive therapeutic outcome
- c) The member is currently pregnant or breastfeeding

F) Plaque Psoriasis

1. Criteria for initial approval on moderate to severe plaque psoriasis will only apply when at least ONE of the following criteria are met:
 - a) Member has had an inadequate response to treatment or intolerable adverse event with at least TWO of the preferred products (Humira, Enbrel, Cosentyx, Otezla, Skyrizi, Stelara, and Tremfya)
 - b) Member is currently receiving treatment with requested product through insurance (excludes obtainment as samples or via manufacturer's patient assistance programs) and experiencing a positive therapeutic outcome
 - c) The member is currently pregnant or breastfeeding

Preferred Drug Plan Design for Cimzia Lyophilized Powder for reconstitution and administration by a healthcare professional

A) Ankylosing Spondylitis

1. Criteria for initial approval for ankylosing spondylitis will only apply when at least ONE of the following criteria are met:
 - a) Member has had an inadequate response to treatment or intolerable adverse event with each of the following:
 - a. Infliximab biosimilar (Avsola, Inflectra, Renflexis)
 - b. Simponi Aria
 - b) Member is currently receiving treatment with the requested product through insurance (excludes obtainment as samples or via manufacturer's patient assistance programs) and experiencing a positive therapeutic outcome
 - c) The member is currently pregnant or breastfeeding

B) Psoriatic arthritis

1. Criteria for initial approval for psoriatic arthritis will only apply when at least ONE of the following criteria are met:
 - a) Member has had an inadequate response to treatment or intolerable adverse event with each of the following:
 - a. Infliximab biosimilar (Avsola, Inflectra, Renflexis)
 - b. Simponi Aria
 - b) Member is currently receiving treatment with the requested product through insurance (excludes obtainment as samples or via manufacturer's patient assistance programs) and experiencing a positive therapeutic outcome
 - c) The member is currently pregnant or breastfeeding

C) Rheumatoid Arthritis

1. Criteria for initial approval for rheumatoid arthritis will only apply when at least ONE of the following criteria are met:
 - a) Member has had an inadequate response to treatment or intolerable adverse event with each of the following:
 - a. Infliximab biosimilar (Avsola, Inflectra, Renflexis)
 - b. Simponi Aria
 - b) Member is currently receiving treatment with the requested product through insurance (excludes obtainment as samples or via manufacturer's patient assistance programs) and experiencing a positive therapeutic outcome
 - c) The member is currently pregnant or breastfeeding

D) Crohn's Disease

1. Criteria for initial approval for Crohn's disease will only apply when at least ONE of the following criteria are met:
 - a) Member has had an inadequate response to treatment or intolerable adverse event to each of the following:
 - a. Infliximab biosimilar (Avsola, Inflectra, Renflexis)
 - b. Entyvio
 - b) Member is currently receiving treatment with the requested product through insurance (excludes obtainment as samples or via manufacturer's patient assistance programs) and experiencing a positive therapeutic outcome
 - c) The member is currently pregnant or breastfeeding

E) Plaque Psoriasis

1. Criteria for initial approval on moderate to severe plaque psoriasis will only apply when at least ONE of the following criteria are met:
 - a) Member has had an inadequate response to treatment or intolerable adverse event with each of the following:
 - a. Infliximab biosimilar (Avsola, Inflectra, Renflexis)
 - b. Ilumya
 - b) Member is currently receiving treatment with requested product through insurance (excludes obtainment as samples or via manufacturer's patient assistance programs) and experiencing a positive therapeutic outcome
 - c) The member is currently pregnant or breastfeeding

Note: Submission of chart notes detailing the outcomes of treatment, intolerable adverse event(s) experienced, contraindication(s), or exclusion(s) to treatment with preferred product(s) is required (where applicable).

Criteria for Initial Approval

A) Moderately to severely active rheumatoid arthritis (RA)

1. Authorization of 12 months may be granted for members who have previously received a biologic or targeted synthetic DMARD (e.g., Rinvoq, Xeljanz) indicated for moderately to severely active rheumatoid arthritis.
2. Authorization of 12 months may be granted for treatment of moderately to severely active RA when all of the following criteria are met:
 - a. Member meets either of the following criteria:
 - i. Member has been tested for either of the following biomarkers and the test was positive:
 - Rheumatoid Factor (RF)
 - Anti-cyclic citrullinated peptide (anti-CCP)
 - ii. Member has been tested for ALL of the following biomarkers:
 - RF
 - Anti-CCP
 - C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR)
 - b. Member meets either of the following criteria:
 - i. Member has experienced an inadequate response to at least a 3-month trial of methotrexate despite adequate dosing (i.e., titrated to at least 15 mg/week).
 - ii. Member has an intolerance or contraindication to methotrexate (see Appendix A).

B) Active psoriatic arthritis (PsA)

1. Authorization of 12 months may be granted for treatment of active psoriatic arthritis (PsA).

C) Active ankylosing spondylitis (AS) and active axial spondyloarthritis

1. Authorization of 12 months may be granted for members who have previously received a biologic indicated for active ankylosing spondylitis or active axial spondyloarthritis.
2. Authorization of 12 months may be granted for treatment of active ankylosing spondylitis or active axial spondyloarthritis when any of the following criteria is met:
 - a. Member has experienced an inadequate response to at least two non-steroidal anti-inflammatory drugs (NSAIDs).
 - b. Member has an intolerance or contraindication to two or more NSAIDs.

D) Moderately to severely active Crohn's disease (CD)

1. Authorization of 12 months may be granted for members who have previously received a biologic indicated for the treatment of Crohn's disease.
2. Authorization of 12 months may be granted for the treatment of moderately to severely active CD when the member has had an inadequate response, intolerance or contraindication to at least one conventional therapy option (see Appendix B).

E) Moderate to severe plaque psoriasis (PsO)

1. Authorization of 12 months may be granted for members who have previously received Otezla or a biologic indicated for the treatment of moderate to severe plaque psoriasis.
2. Authorization of 12 months may be granted for treatment of moderate to severe plaque psoriasis in members when any of the following criteria is met:
 - a. Crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected.
 - b. At least 10% of the body surface area (BSA) is affected.
 - c. At least 3% of body surface area (BSA) is affected and the member meets any of the following criteria:
 - i. Member has had an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin.
 - ii. Member has a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine and acitretin (See Appendix C).

Continuation of Therapy

A) Moderately to severely active rheumatoid arthritis (RA)

Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for moderately to severely active rheumatoid arthritis and who achieve or maintain a positive clinical response as evidenced by disease activity improvement of at least 20% from baseline in tender joint count, swollen joint count, pain, or disability.

B) Active psoriatic arthritis (PsA)

Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for active psoriatic arthritis and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:

1. Number of swollen joints
2. Number of tender joints
3. Dactylitis
4. Enthesitis
5. Skin and/or nail involvement

C) Ankylosing spondylitis (AS) and active axial spondyloarthritis

Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for active ankylosing spondylitis or active axial spondyloarthritis and who achieve or maintain a positive clinical response with the requested medication as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:

1. Functional status
2. Total spinal pain
3. Inflammation (e.g. morning stiffness)

D) Moderately to severely active Crohn's disease

1. Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for moderately to severely active Crohn's disease and who achieve or maintain remission.
2. Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for moderately to severely active Crohn's disease and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:
 - i. Abdominal pain or tenderness
 - ii. Diarrhea
 - iii. Body weight
 - iv. Abdominal mass
 - v. Hematocrit
 - vi. Endoscopic appearance of the mucosa
 - vii. Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index [CDAI] score)

E) Moderate to severe plaque psoriasis (PsO)

Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for moderate to severe plaque psoriasis and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when any of the following is met:

1. Reduction in body surface area (BSA) affected from baseline
2. Improvement in signs and symptoms from baseline (e.g., itching, redness, flaking, scaling, burning, cracking, pain)

Other

For all indications: Member has had a documented negative TB test (which can include a tuberculosis skin test [PPD], an interferon-release assay [IGRA], or a chest x-ray)* within 6 months of initiating therapy for persons who are naïve to biologic DMARDs or targeted synthetic DMARDs associated with an increased risk of TB.

* If the screening testing for TB is positive, there must be further testing to confirm there is no active disease. Do not administer the requested medication to members with active TB infection. If there is latent disease, TB treatment must be started before initiation of the requested medication.

For all indications: Member cannot use the requested medication concomitantly with any other biologic DMARD or targeted synthetic DMARD.

Cimzia is considered **not medically necessary** for members who do not meet the criteria set forth above.

Dosage and Administration

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Quantity Limits Apply

| Trade Name | Generic Name | Quantity Limit |
|------------|--------------------|---|
| Cimzia® | Certolizumab pegol | <p>Initiation of therapy: 3 maintenance kits (6 syringes/vials) (or 1 starter kit) per first 28days</p> <p>Maintenance for Plaque Psoriasis: 2 kits (4 x 200mg vials/syringes) per 28 days</p> <p>Maintenance for all other indications: 1 kit (2 x 200mg vials/syringes) per 28 days</p> |

APPENDIX

Appendix A: Examples of Contraindications to Methotrexate

1. Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease
2. Breastfeeding
3. Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
4. Elevated liver transaminases
5. History of intolerance or adverse event
6. Hypersensitivity
7. Interstitial pneumonitis or clinically significant pulmonary fibrosis
8. Myelodysplasia
9. Pregnancy or currently planning pregnancy
10. Renal impairment
11. Significant drug interaction

Appendix B: Examples of Conventional Therapy Options for CD

1. Mild to moderate disease – induction of remission:
 - a). Oral budesonide
 - b). Alternatives: metronidazole, ciprofloxacin, rifaximin
2. Mild to moderate disease – maintenance of remission:
 - a). Azathioprine, mercaptopurine
 - b). Alternatives: oral budesonide, methotrexate intramuscularly (IM) or subcutaneously (SC), sulfasalazine
3. Moderate to severe disease – induction of remission:
 - a). Prednisone, methylprednisolone intravenously (IV)
 - b). Alternatives: methotrexate IM or SC
4. Moderate to severe disease – maintenance of remission:
 - a). Azathioprine, mercaptopurine
 - b). Alternative: methotrexate IM or SC
5. Perianal and fistulizing disease – induction of remission:
 - a). Metronidazole ± ciprofloxacin, tacrolimus
6. Perianal and fistulizing disease – maintenance of remission:
 - a). Azathioprine, mercaptopurine
 - b). Alternative: methotrexate IM or SC

Appendix C: Examples of Clinical Reasons to Avoid Pharmacologic Treatment with Methotrexate, Cyclosporine or Acitretin.

1. Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease
2. Breastfeeding
3. Drug interaction
4. Cannot be used due to risk of treatment-related toxicity
5. Pregnancy or currently planning pregnancy
6. Significant comorbidity prohibits use of systemic agents (examples include liver or kidney disease, blood dyscrasias, uncontrolled hypertension)

PROCEDURES AND BILLING CODES

To report provider services, use appropriate CPT* codes, Alpha Numeric (HCPCS level 2) codes, Revenue codes, and/or ICD diagnostic codes.

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

REFERENCES

- Cimzia [package insert]. Smyrna, GA: UCB, Inc.; September 2019.
- van der Heijde D, Ramiro S, Landewe R, et al. 2016 Update of the international ASAS-EULAR management recommendations for axial spondyloarthritis. *Ann Rheum Dis.* 2017;0:1-14.
- Smolen JS, Landewé RBM, Bijlsma JWJ, Billsma J, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2019 update. *Ann Rheum Dis.* 2020;79(6):685-699. doi:10.1136/annrheumdis-2019-216655.
- Singh JA, Saag KG, Bridges SL Jr, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Rheumatol.* 2016;68(1):1-26.
- Saag KG, Teng GG, Patkar NM, et al. American College of Rheumatology 2008 recommendations for the use of nonbiologic and biologic disease-modifying antirheumatic drugs in rheumatoid arthritis. *Arthritis Rheum.* 2008;59(6):762-784.
- Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Section 6: Guidelines of care for the treatment of psoriasis and psoriatic arthritis: case-based presentations and evidence-based conclusions. *J Am Acad Dermatol.* 2011;65(1):137-174.
- Gossec L, Smolen JS, Ramiro S, et al. European League Against Rheumatism (EULAR) recommendations for the management of psoriatic arthritis with pharmacological therapies; 2015 update. *Ann Rheum Dis.* 2016;75(3):499-510.
- Gladman DD, Antoni C, P Mease, et al. Psoriatic arthritis: epidemiology, clinical features, course, and outcome. *Ann Rheum Dis.* 2005;64(Suppl II):ii14–ii17.
- Peluso R, Lervolino S, Vitiello M, et al. Extra-articular manifestations in psoriatic arthritis patients. [Published online ahead of print May 8, 2014]. *Clin Rheumatol.* 2014.
- Braun J, van den Berg R, Baraliakos X, et al. 2010 update of the ASAS/EULAR recommendations for the management of ankylosing spondylitis. *Ann Rheum Dis.* 2011;70:896–904.
- Landewe R, Braun J, Deodhar A, et al. Efficacy of certolizumab pegol on signs and symptoms of axial spondyloarthritis including ankylosing spondylitis: 24-week results of a double-blind randomised placebo-controlled Phase 3 study. *Ann Rheum Dis.* 2014;73(1):39-47.
- Ward MM, Deodhar A, Gensler LS, et al. 2019 Update of the American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network Recommendations for the treatment of Ankylosing Spondylitis and Nonradiographic Axial Spondyloarthritis. *Arthritis Rheumatol.* 2019;71(10):1599-1613. doi: 10.1002/art.41042.
- Talley NJ, Abreu MT, Achkar J, et al. An evidence-based systematic review on medical therapies for inflammatory bowel disease. *Am J Gastroenterol.* 2011;106(Suppl 1):S2-S25.
- Lichtenstein GR, Loftus Jr EV, Isaacs KI, et al. ACG Clinical Guideline: Management of Crohn's Disease in Adults. *Am J Gastroenterol.* 2018;113:481-517.
- Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. *J Am Acad Dermatol.* 2019;80(4):1029-1072.

- Utilization Management (UM) Criteria Review CVS Caremark P&T Subgroup. Gastroenterology – IBD Agents – UM Criteria. December 2018. Tuberculosis (TB). TB risk factors. Centers for Disease Control and Prevention. Retrieved on 05 August 2020 from: <https://www.cdc.gov/tb/topic/basics/risk.htm>.
- Singh JA, Guyatt G, Ogdie A, et al. 2018 American College of Rheumatology/National Psoriasis Foundation Guideline for the Treatment of Psoriatic Arthritis. *Arthritis Rheumatol*. 2019;71(1):5-32. doi:10.1002/art.40726.
- Menter, A, Cordero, KM, Davis, DM, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis in pediatric patients. *J Am Acad Dermatol*. 2020;82(1):161-201.
- Menter, A, Gelfand, JM, Connor, C, et al. Joint AAD-NPF guidelines of care for the management of psoriasis with systemic nonbiologic therapies. *J Am Acad Dermatol*. 2020;82(6): 1445-86.
- Aletaha D, Neogi T, Silman, et al. 2010 Rheumatoid arthritis classification criteria: an American College of Rheumatology/European League Against Rheumatism collaborative initiative. *Arthritis Rheum*. 2010;62(9):2569-81.
- Clinical Consult: CVS Caremark Clinical Programs Review. Focus on Rheumatology Clinical Programs. March 2021.
Smolen JS, Aletaha D. Assessment of rheumatoid arthritis activity in clinical trials and clinical practice. In: UpToDate, Post TW (Ed), UpToDate, Waltham, MA. Available with subscription. URL: www.uptodate.com. Accessed March 19, 2021.
- Feuerstein J, Ho E, Shmidt E, et al. AGA Clinical Practice Guidelines on the Medical Management of Moderate to Severe Luminal and Perianal Fistulizing Crohn’s Disease. *Gastroenterology*. 2021; 160:2496-2508.
- Elmets C, Korman N, et al. Guidelines of Care for the Management and Treatment of Psoriasis with Topical Therapy and Alternative Medicine Modalities for Psoriasis Severity Measures. *J Am Acad Dermatol*. 2021; 84:432-470.
- Fraenkel L, Bathon JM, England BR, et al. 2021 American College of Rheumatology guideline for the treatment of rheumatoid arthritis. *Arthrit Care Res*. 2021;0:1-16.

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POLICY HISTORY

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