Field Name	Field Description
Prior Authorization Group Description	**Specialty Biological Agents for Crohn's Disease**
Drugs	**<u>Preferred Biological Agent(s)</u>:** Infliximab Skyrizi (risankizumab) **<u>Non-Preferred Biological Agents</u>:** Avsola (infliximab-axxq) Remicade (infliximab) Renflexis (infliximab-abda)Inflectra (infliximab-dyyb) Entyvio (vedolizumab) Stelara IV (ustekinumab) Tysabri (natalizumab)Or any newly marketed agent
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist
Coverage Duration	If all of the conditions are met, the request will be approved for 12 month duration.
Other Criteria	**Initial Authorization:** 1. One of the following: a. The member has a diagnosis of severe/fulminant or perianal/fistulizing Crohn's disease b. The member has moderate-to-severe/moderate-to-high risk Crohn's disease AND has had an adequate trial of, or a documented medical reason (e.g. allergy, intolerance, contraindication) for not using at least one of the following:, azathioprine, 6-mercaptupurine, methotrexate, or corticosteroids 2. If the request is for a non-preferred agent, documented adequate trial of a preferred biological agent **Reauthorization:** 1. The medication is being recommended and prescribed by a gastroenterologist at an FDA-approved dosage. 2. The member has been receiving the medication and documentation was provided that the prescriber has evaluated the member and recommends continuation of therapy (clinical benefit). **Continuation of Therapy** • Members with history (within the past 90 days) of a non- preferred biological agent are not required to try a preferred biological agent or

Revision/Review Date 8/2023	the above mentioned conventional therapies prior to receiving the non- preferred agent. • Members with history (within the past 90 days) of a preferred biological agent are not required to try the above mentioned conventional therapies prior to receiving the preferred biological agent. **Medical Director/Clinical reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.**