Field Name	Field Description
Prior Authorization Group Description	**Specialty Biological Agents for Polyarticular Juvenile Idiopathic Arthritis**
Drugs	Actemra IV (tocilizumab) Simponi Aria (Golimumab) 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 rheumatologist
Coverage Duration	If all of the conditions are met, the request will be approved for 12 month duration.
Other Criteria	**Initial Authorization:** • Has a diagnosis of polyarticular juvenile idiopathic arthritis • The medication is being prescribed at an appropriate FDA approved dose (for age and weight) • The member has an adequate trial with one disease modifying anti-rheumatic drug (DMARD) (e.g. methotrexate) or leflunomide or sulfasalazine and is consistent with pharmacy claims/medical record data/chart notes/physician attestation, or one of the following is true: o Member has a documented medical reason (e.g. allergy, intolerance, contraindication) for not using conventional therapy to manage their condition. o Member has one or more of the following: Risk factors (positive rheumatoid factor, positive anti-cyclic citrullinated peptide antibodies, joint damage) and have involvement of high-risk joints, high disease activity, and those judged to be at high-risk of disabling joint damage **Reauthorization:** • The medication is being recommended or prescribed by a rheumatologist at an FDA-approved dosage. • 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).

Revision/Review Date 8/2023	**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 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.**