Field Name	Field Description
Prior Authorization Group Description	**Specialty Biological Agents for Rheumatoid Arthritis**
Drugs	**PREFERRED BIOLOGICAL AGENTS:** Infliximab **NON-PREFERRED BIOLOGICAL AGENTS:** Avsola (infliximab-axxq) Remicade (infliximab) Simponi Aria (golimumab) Remicade (infliximab) Renflexis (infliximab-abda) Inflectra (infliximab-dyyb) 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:** 1. The member has a diagnosis of rheumatoid arthritis 2. The medication is being prescribed at an appropriate FDA approved dose (for age and weight) 3. The member has an adequate trial with at least one non-biologic disease modifying anti-rheumatic drug (DMARD) (e.g. methotrexate, leflunomide, sulfasalazine or hydroxychloroquine) and is consistent with pharmacy claims/medical record data/chart notes/physician attestation OR Member has a documented medical reason (e.g. allergy, intolerance, contraindication) for not using a non-biologic disease modifying anti-rheumatic drug (DMARD) (e.g., methotrexate leflunomide, sulfasalazine or hydroxychloroquine) to manage their condition. 4. If the request is for a non-preferred biological agent, documented (consistent with pharmacy claims/medical record data), adequate trial of a preferred product or medical reason as to why patient is unable to utilize the preferred product.

Revision/Review Date 8/2023	**Reauthorization:** 1. The medication is prescribed 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 product are not required to try two preferred biological agents or methotrexate used in combination with another DMARD prior to receiving the non-preferred agent. • Members with history (within the past 90 days) of two preferred biological agents are not required to try methotrexate used in combination with another DMARD 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.**