IMPORTANT REMINDER: All providers must revalidate the Medical Assistance (MA) enrollment of each service location every 5 years. Providers should log into PROMISE to check the revalidation dates of each service location and submit revalidation applications at least 60 days prior to the revalidation dates. Enrollment (revalidation) applications may be found at: https://www.dhs.pa.gov/providers/Providers/Pages/PROMISEnorevalidation.aspx.

PURPOSE:

The purpose of this bulletin is to issue updated handbook pages that include the requirements for prior authorization and the type of information needed to evaluate the medical necessity of prescriptions for Cytokine and CAM Antagonists submitted for prior authorization.

SCOPE:

This bulletin applies to all licensed pharmacies and prescribers enrolled in the Medical Assistance (MA) Program. The guidelines to determine the medical necessity of Cytokine and CAM Antagonists will be utilized in the fee-for-service and managed care delivery systems. Providers rendering services to MA beneficiaries in the managed care delivery system should address any questions related to the prior authorization of Cytokine and CAM Antagonists to the appropriate managed care organization.

BACKGROUND:

The Department of Human Services’ (Department) Pharmacy and Therapeutics (P&T)

*01-23-37 09-23-36 27-23-27 33-23-34
02-23-25 11-23-25 30-23-28
03-23-23 14-23-24 31-23-38
08-23-40 24-23-33 32-23-23

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The appropriate toll-free number for your provider type.

Visit the Office of Medical Assistance Programs website at https://www.dhs.pa.gov/providers/Providers/Pages/Health%20Care%20for%20Providers/Contact-Information-for-Providers.aspx.
Committee reviews published peer-reviewed medical literature and recommends the following:

- Preferred or non-preferred status for new drugs and products in therapeutic classes already included on the Statewide Preferred Drug List (PDL).
- Changes to the statuses of drugs and products on the Statewide PDL from preferred to non-preferred and non-preferred to preferred.
- Therapeutic classes of drugs and products to be added to or deleted from the Statewide PDL.
- New quantity limits.
- New guidelines or revisions to existing guidelines to evaluate the medical necessity of prescriptions submitted for prior authorization.

**DISCUSSION:**

During the September 12, 2023, meeting, the P&T Committee recommended the following revisions to the guidelines to determine medical necessity of Cytokine and CAM Antagonists:

- Revisions to the guidelines for the treatment of chronic psoriasis.
- Addition of guidelines for the treatment of polymyalgia rheumatica.
- Clarification of the guidelines related to conventional non-biologic disease modifying anti-rheumatic drugs for the treatment of sarcoidosis.
- Addition of guidelines for the treatment of gout flares.

The revisions to the guidelines to determine medical necessity of prescriptions for Cytokine and CAM Antagonists submitted for prior authorization, as recommended by the P&T Committee, were subject to public review and comment and subsequently approved for implementation by the Department.

**PROCEDURE:**

The procedures for prescribers to request prior authorization of Cytokine and CAM Antagonists are located in SECTION I of the Prior Authorization of Pharmaceutical Services Handbook. The Department will take into account the elements specified in the clinical review guidelines (which are included in the provider handbook pages in the SECTION II chapter related to Cytokine and CAM Antagonists) when reviewing the prior authorization request to determine medical necessity.

As set forth in 55 Pa. Code § 1101.67(a), the procedures described in the handbook pages must be followed to ensure appropriate and timely processing of prior authorization requests for drugs and products that require prior authorization.

**ATTACHMENTS:**
RESOURCES:

Prior Authorization of Pharmaceutical Services Handbook – SECTION I
Pharmacy Prior Authorization General Requirements
https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Pharmacy-Prior-Authorization-General-Requirements.aspx

Prior Authorization of Pharmaceutical Services Handbook – SECTION II
Pharmacy Prior Authorization Guidelines
https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Clinical-Guidelines.aspx
I. Requirements for Prior Authorization of Cytokine and CAM Antagonists

A. Prescriptions That Require Prior Authorization

All prescriptions for Cytokine and CAM Antagonists must be prior authorized.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Cytokine and CAM Antagonist, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. Is prescribed the Cytokine and CAM Antagonist for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication; AND

2. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; AND

3. Is prescribed the Cytokine and CAM Antagonist by or in consultation with an appropriate specialist (e.g., gastroenterologist, dermatologist, rheumatologist, ophthalmologist, immunologist, genetic specialist, pulmonologist, oncologist, etc.); AND

4. If currently using a different Cytokine and CAM Antagonist, one of the following:
   a. Will discontinue use of that Cytokine and CAM Antagonist prior to starting the requested Cytokine and CAM Antagonist
   b. One of the following:
      i. Has a medical reason for concomitant use of both Cytokine and CAM Antagonists that is supported by peer-reviewed medical literature or national treatment guidelines,
      ii. Is dependent on glucocorticoids in addition to a Cytokine and CAM Antagonist to prevent life-threatening complications,
      iii. Has 2 or more autoimmune or autoinflammatory conditions for which a single Cytokine and CAM Antagonist is not sufficient;

   AND

5. Does not have a contraindication to the prescribed medication; AND

6. Is prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; AND

January 8, 2024
(Replacing January 9, 2023)
7. For a Cytokine and CAM Antagonist associated with an increased risk of infection according to the FDA-approved package labeling, was evaluated for both of the following:

a. Active or latent tuberculosis infection documented by results of a tuberculin skin test (purified protein derivative) or blood test (interferon-gamma release assay)
b. Hepatitis B virus infection documented by results of anti-HBs, HBsAg, and anti-HBc;

AND

8. For a Cytokine and CAM Antagonist associated with behavioral and/or mood changes as stated in the FDA-approved package labeling (e.g., Otezla, Siliq), was evaluated for a history of prior suicide attempt, bipolar disorder, or major depressive disorder; AND

9. For treatment of Crohn’s disease, one of the following:

a. Has a diagnosis of moderate to severe Crohn’s disease and one of the following:
   i. Failed to achieve remission with or has a contraindication or an intolerance to an induction course of corticosteroids
   ii. One of the following:
      a) Failed to maintain remission with a conventional immunomodulator in accordance with current consensus guidelines
      b) Has a contraindication or an intolerance to conventional immunomodulators in accordance with current consensus guidelines,

b. Has a diagnosis of Crohn’s disease that is associated with one or more high-risk or poor prognostic feature(s),

   c. Both of the following:
   i. Has achieved remission with the requested Cytokine and CAM Antagonist
   ii. Will be using the requested medication as maintenance therapy to maintain remission;

---

1 e.g., American College of Gastroenterology [ACG], American Gastroenterological Association [AGA], Canadian Association of Gastroenterology [CAG], European Crohn’s and Colitis Organization [ECCO]

2 Examples of high-risk or poor prognostic features in patients with Crohn’s disease include initial diagnosis or clinical evidence supports the onset of symptoms at <30 years of age, extensive anatomic involvement, presence of fistula, perianal and/or severe rectal disease, large or deep mucosal lesions on endoscopy or imaging, prior surgical resection, stricturing and/or penetrating behavior, need for steroid therapy at initial diagnosis, extra-intestinal manifestations, laboratory markers such as low hemoglobin, low albumin, high C-reactive protein, high fecal calprotectin levels, severe growth delay (AGA 2014; ECCO 2017; CAG 2019; ECCO-ESPGHAN 2021; AGA 2021).
10. For treatment of ulcerative colitis (UC), one of the following:
   a. Both of the following:
      i. Has one of the following diagnoses:
         a) Mild UC that is associated with multiple poor prognostic factors
         b) Moderate to severe UC
      ii. One of the following:
         a) Failed to achieve remission with or has a contraindication or an intolerance to an induction course of corticosteroids
         b) One of the following:
            (i) Failed to maintain remission with a conventional immunomodulator in accordance with current consensus guidelines
            (ii) Has a contraindication or an intolerance to conventional immunomodulators in accordance with current consensus guidelines
   b. Both of the following:
      i. Has achieved remission with the requested Cytokine and CAM Antagonist
      ii. Will be using the requested medication as maintenance therapy to maintain remission;

11. For treatment of moderately to severely active rheumatoid arthritis, has one of the following:
   a. A history of therapeutic failure of a 3-month trial of a conventional non-biologic disease-modifying antirheumatic drug (DMARD) in accordance with current consensus guidelines
   b. A contraindication or an intolerance to conventional non-biologic DMARDs;

---

3 Examples of poor prognostic factors in patients with ulcerative colitis include initial diagnosis or clinical evidence supports the onset of symptoms at <40 years of age, extensive colitis, severe endoscopic disease (presence of large and/or deep ulcers), hospitalization for colitis, elevated inflammatory markers, low serum albumin, extra-intestinal manifestations, early need for corticosteroids (ACG 2019; AGA 2019; AGA 2020).

4 e.g., American College of Gastroenterology [ACG], American Gastroenterological Association [AGA], Canadian Association of Gastroenterology [CAG], European Crohn’s and Collitis Organization [ECCO]

5 e.g., American College of Rheumatology [ACR], European League Against Rheumatism [EULAR]
MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

AND

12. For treatment of juvenile idiopathic arthritis (JIA), one of the following:

a. Has one of the following:
   i. A history of therapeutic failure of a 3-month trial of a conventional non-biologic DMARD
   ii. A contraindication or an intolerance to non-biologic DMARDs,

b. Has systemic JIA with active systemic features,\(^6\)

c. Has a diagnosis of JIA that is associated with both of the following:
   i. One or more risk factors\(^7\) for disease severity
   ii. At least one of the following:
      a) Involvement of high-risk joints (e.g., cervical spine, hip, wrist),
      b) High disease activity,
      c) High risk of disabling joint damage as judged by the prescriber,

d. Has active sacroiliitis and/or enthesitis and one of the following:
   i. A history of therapeutic failure of a 2-week trial of an oral non-steroidal anti-inflammatory drug (NSAID)
   ii. A contraindication or an intolerance to oral NSAIDs;

AND

13. For treatment of adult-onset Still’s disease, one of the following:

a. Has predominantly systemic disease and one of the following:
   i. Has a history of therapeutic failure of or a contraindication or an intolerance to systemic glucocorticoids
   ii. Both of the following:
      a) Has glucocorticoid-dependent Still’s disease
      b) Will be using the requested Cytokine and CAM Antagonist with the intent of discontinuing or decreasing the dose of the systemic glucocorticoid

\(^6\) Active systemic features in patients with JIA include the following: fever, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, and serositis (ACR 2013).

\(^7\) Risk factors for disease severity in patients with JIA include positive anti-cyclic citrullinated peptide antibodies, positive rheumatoid factor, presence of joint damage (ACR-AF 2019).
MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

b. Has predominantly joint disease and one of the following:
   i. A history of therapeutic failure of a conventional non-biologic DMARD
   ii. A contraindication or an intolerance to conventional non-biologic DMARDs;

AND

14. For treatment of ankylosing spondylitis or other axial spondyloarthritis, has one of the following:
   a. A history of therapeutic failure of a 2-week trial of continuous treatment with 2 different oral NSAIDs (i.e., an oral NSAID taken daily for 2 weeks and a different oral NSAID taken daily for 2 weeks)
   b. A contraindication or an intolerance to oral NSAIDs;

AND

15. For treatment of active\textsuperscript{8} psoriatic arthritis (PsA), one of the following:
   a. Has one of the following:
      i. A history of therapeutic failure of an 8-week trial of a conventional non-biologic DMARD
      ii. A contraindication or an intolerance to conventional non-biologic DMARDs,
   b. Has axial disease, dactylitis, and/or enthesitis,
   c. Has severe disease as determined by the prescriber,\textsuperscript{9}
   d. Has concomitant moderate to severe nail disease,
   e. Has concomitant active inflammatory bowel disease;

AND

16. For treatment of chronic psoriasis, both of the following:
   a. Has psoriasis associated with at least one of the following:

\textsuperscript{8} Active PsA is defined as disease causing symptoms at an unacceptable bothersome level as reported by the patient and judged by the examining clinician to be due to PsA based on 1 or more of the following: swollen joints, tender joints, dactylitis, enthesitis, axial disease, active skin and/or nail involvement, and extraarticular inflammatory manifestations such as uveitis or IBD (ACR-NPF 2018; EULAR 2015).

\textsuperscript{9} Examples of severe PsA include the presence of ≥1 of the following: a poor prognostic factor (erosive disease, dactylitis, elevated levels of inflammation markers such as C-reactive protein or erythrocyte sedimentation rate attributable to PsA), long-term damage that interferes with function (e.g., joint deformities, vision loss), highly active disease that causes major impairment in quality of life (i.e., active psoriatic inflammatory disease at many sites [including dactylitis, enthesitis] or function-limiting inflammatory disease at a few sites), and rapidly progressive disease (ACR-NPF 2018; EULAR 2015).
i. A body surface area (BSA) of 3% or more that is affected,
ii. A BSA of less than 3% that is affected with involvement of critical areas,\textsuperscript{10}
iii. Significant disability or impairment of physical, mental, or psychosocial functioning

b. Has one of the following:

i. Moderate to severe nail disease

ii. One of the following:

   a) A history of therapeutic failure of a 4-week trial of topical corticosteroids OR an 8-week trial of other topical pharmacologic therapy\textsuperscript{11}
   b) A contraindication or an intolerance to topical corticosteroids AND other topical pharmacologic therapy;

AND

17. For treatment of moderate to severe hidradenitis suppurativa (HS), one of the following:

a. For Hurley stage II disease, has a history of therapeutic failure of or a contraindication or an intolerance to both of the following:

   a) A 3-month trial of topical clindamycin
   b) An adequate trial of a systemic antibiotic\textsuperscript{12}

b. For Hurley stage III disease, one of the following:

   i. Has a history of therapeutic failure of or a contraindication or an intolerance to an adequate trial of a systemic antibiotic
   ii. Is a candidate for or has a history of surgical intervention for HS;

AND

18. For treatment of non-infectious uveitis, one of the following:

a. Has a diagnosis of uveitis associated with JIA or Behçet’s syndrome,

b. Has a history of therapeutic failure of or a contraindication or an intolerance to one of the following:

\textsuperscript{10} Critical areas in patients with psoriasis include, but are not restricted to, hands, feet, scalp, face, genitals, nails, and intertriginous areas (AAD-NPF 2018).
\textsuperscript{11} e.g., anthralin, calcineurin inhibitors, tar, tazarotene, vitamin D analogs
\textsuperscript{12} e.g., doxycycline, minocycline, or tetracycline; clindamycin; clindamycin + rifampin; rifampin + moxifloxacin + metronidazole; rifampin + levofloxacin + metronidazole; amoxicillin/clavulanate
MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

i. A systemic, topical, intraocular, or periocular corticosteroid
ii. A conventional systemic immunosuppressive,13

c. Both of the following:

   i. Has corticosteroid-dependent uveitis14
   ii. Will be using the requested Cytokine and CAM Antagonist with the intent of discontinuing or decreasing the dose of the systemic corticosteroid;

AND

19. For treatment of giant cell arteritis, one of the following:

   a. Has a history of therapeutic failure of or a contraindication or an intolerance to systemic glucocorticoids,
   b. Is at high-risk for glucocorticoid-related complications,
   c. Both of the following:

   i. Has glucocorticoid-dependent disease
   ii. Will be using the requested Cytokine and CAM Antagonist with the intent of discontinuing or decreasing the dose of the systemic glucocorticoid;

AND

20. For treatment of polymyalgia rheumatica, one of the following:

   a. Has a history of therapeutic failure of or a contraindication or an intolerance to systemic glucocorticoids
   b. Both of the following:

   i. Has glucocorticoid-dependent disease
   ii. Will be using the requested Cytokine and CAM Antagonist with the intent of discontinuing or decreasing the dose of the systemic glucocorticoid;

AND

21. For treatment of familial Mediterranean fever, has one of the following:

13 e.g., azathioprine, cyclophosphamide, cyclosporine, methotrexate, mycophenolate, tacrolimus
14 Corticosteroid-dependent uveitis is defined as requiring a daily systemic corticosteroid dose equivalent to 7.5 mg or greater of prednisone in adults for six weeks or longer.
MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

a. A history of therapeutic failure of at least a 3-month trial of colchicine at maximally
tolerated doses
b. A contraindication or an intolerance to colchicine;

AND

22. For treatment of Behçet’s syndrome, all of the following:

a. Has a diagnosis of Behçet’s syndrome according to current consensus guidelines,

b. Has recurrent oral ulcers associated with Behçet’s syndrome,

c. Has a history of therapeutic failure of or a contraindication or an intolerance to a
   topical corticosteroid (e.g., triamcinolone dental paste),

d. Has one of the following:
   i. A history of therapeutic failure of an adequate trial of colchicine at maximally
tolerated doses
   ii. A contraindication or an intolerance to colchicine;

AND

23. For treatment of sarcoidosis, both of the following:

a. One of the following:
   i. Has a history of therapeutic failure of or a contraindication or an intolerance to
      systemic glucocorticoids
   ii. Has glucocorticoid-dependent sarcoidosis

b. One of the following:
   i. Has a history of therapeutic failure of a conventional non-biologic DMARD
   ii. Has a contraindication or an intolerance to conventional non-biologic DMARDs;

AND

24. For treatment of alopecia areata, both of the following:

a. Has alopecia associated with at least one of the following:
   i. Alopecia universalis,
   ii. Alopecia totalis,

___________________________________________
15 e.g., EULAR, International Study Group for Behçet's Disease

January 8, 2024
(Replacing January 9, 2023)
iii. Greater than 50% scalp involvement,
iv. Significant disability or impairment of physical, mental, or psychosocial functioning

b. Has a current episode of alopecia areata of greater than 6 months’ duration;

AND

25. For Spevigo (spesolimab) for treatment of generalized pustular psoriasis (GPP) flares, one of the following:

a. For a beneficiary who has received a single dose of Spevigo (spesolimab) for the current GPP flare, continues to experience moderate to severe GPP flare symptoms since the previous dose of Spevigo (spesolimab)

b. For a beneficiary who has not received a dose of Spevigo (spesolimab) for the current GPP flare, is experiencing a moderate to severe GPP flare that warrants rapid stabilization or improvement in the opinion of the prescriber;

AND

26. For treatment of gout flares, all of the following:

a. Has a history of therapeutic failure of maximally tolerated doses of or a contraindication or an intolerance to NSAIDs,

b. Has a history of therapeutic failure of maximally tolerated doses of or a contraindication or an intolerance to colchicine,

c. One of the following:

   i. Has a history of therapeutic failure of maximally tolerated doses of or a contraindication or an intolerance to corticosteroids

   ii. Has a medical reason why repeated courses of corticosteroids are not appropriate;

AND

27. For all other diagnoses, has a history of therapeutic failure of or a contraindication or an intolerance to first line therapy(ies) if applicable according to consensus treatment guidelines; AND

28. For an oral Janus kinase (JAK) inhibitor, one of the following:

a. Has a history of therapeutic failure of at least one tumor necrosis factor (TNF) blocker or another biologic if recommended for the beneficiary’s diagnosis in the FDA-approved package labeling for the requested oral JAK inhibitor,
b. Has a contraindication or an intolerance to TNF blockers or other biologics if recommended for the beneficiary’s diagnosis in the FDA-approved package labeling for the requested oral JAK inhibitor,
c. Has a current history (within the past 90 days) of being prescribed an oral JAK inhibitor;

AND

29. For a non-preferred Cytokine and CAM Antagonist, one of the following:

a. Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Cytokine and CAM Antagonists approved or medically accepted for the beneficiary’s diagnosis
b. Has a current history (within the past 90 days) of being prescribed the same non-preferred Cytokine and CAM Antagonist (does not apply to non-preferred brands when the therapeutically equivalent generic, interchangeable biosimilar, or unbranded biologic is preferred or to non-preferred generics, interchangeable biosimilars, or unbranded biologics when the therapeutically equivalent brand, interchangeable brand, or brand biologic product is preferred)

See the Preferred Drug List (PDL) for the list of preferred Cytokine and CAM Antagonists at: https://papdl.com/preferred-drug-list;

AND

30. If a prescription for a Cytokine and CAM Antagonist is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter. The list of drugs that are subject to quantity limits, with accompanying quantity limits, is available at: https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx.

NOTE: If the beneficiary does not meet the clinical review guidelines above but, in the professional judgement of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR CYTOKINE AND CAM ANTAGONISTS: The determination of medical necessity of a request for renewal of a prior authorization for a Cytokine and CAM Antagonist that was previously approved will take into account whether the beneficiary:

1. One of the following:
   a. Experienced improvement in disease activity and/or level of functioning since

January 8, 2024
(Replacing January 9, 2023)
initiating therapy with the requested Cytokine and CAM Antagonist

b. Is prescribed an increased dose or more frequent administration of the requested Cytokine and CAM Antagonist that is supported by peer-reviewed medical literature or national treatment guidelines;

AND

2. Is prescribed the Cytokine and CAM Antagonist by or in consultation with an appropriate specialist (e.g., gastroenterologist, dermatologist, rheumatologist, ophthalmologist, immunologist, genetic specialist, pulmonologist, oncologist, etc.); AND

3. Is prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; AND

4. For a Cytokine and CAM Antagonist associated with behavioral and/or mood changes as stated in the FDA-approved package labeling, was recently reevaluated for behavioral and mood changes as recommended in the FDA-approved package labeling; AND

5. If a prescription for a Cytokine and CAM Antagonist is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter. The list of drugs that are subject to quantity limits, with accompanying quantity limits, is available at: https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx.

NOTE: If the beneficiary does not meet the clinical review guidelines above but, in the professional judgement of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for a Cytokine and CAM Antagonist. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

D. References


January 8, 2024
(Replacing January 9, 2023)
Psoriatic Arthritis


Polymyalgia Rheumatica

Autoinflammatory Syndromes

Behçet’s Syndrome

Cytokine Release Syndrome


January 8, 2024
(Replaces January 9, 2023)


