Drug Coverage Policy

Effective Date.....02/02/2024
Coverage Policy Number.....IP0223

Inflammatory Conditions – Cosentyx Subcutaneous

- Cosentyx® (secukinumab subcutaneous injection – Novartis)

INSTRUCTIONS FOR USE
The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment and have discretion in making individual coverage determinations. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Medical Necessity Criteria

Cosentyx subcutaneous is considered medically necessary when ONE of the following criteria is met:

1. **Ankylosing Spondylitis (AS).** Individual meets **ALL** of the following criteria:
    A. Age 18 years or older
    B. Documentation of **ONE** of the following:
        i. Failure, contraindication or intolerance to **ONE** non-steroidal anti-inflammatory drug (NSAID)

ii. Already tried a biologic or targeted synthetic DMARD (tsDMARD)
C. Medication is prescribed by, or in consultation with, a rheumatologist
D. Preferred product criteria is met for the products listed in the below table(s) [Employer Group Plans]

2. **Enthesitis-Related Arthritis.** Individual meets **ALL** of the following criteria:
   A. Age 4 years or older
   B. Medication is prescribed by, or in consultation with, a rheumatologist
   C. Preferred product criteria is met for the products listed in the below table(s) [Employer Group Plans]

3. **Hidradenitis Suppurativa.** Individual meets **ALL** of the following criteria:
   A. Age 18 years or older
   B. Documentation of failure, contraindication, or intolerance to **ONE** of the following:
      i. intralesional or oral corticosteroids (for example, triamcinolone, prednisone)
      ii. systemic antibiotics (for example, clindamycin, dicloxacillin, erythromycin)
      iii. isotretinoin
   C. Medication is prescribed by, or in consultation with, a dermatologist

4. **Non-Radiographic Axial Spondyloarthritis (nr-axSpA).** Individual meets **ALL** of the following criteria:
   A. Age 18 years or older
   B. Has objective signs of inflammation, defined as **ONE** of the following:
      i. C-reactive protein (CRP) elevated beyond the upper limit of normal for the reporting laboratory
      ii. Sacroiliitis reported on magnetic resonance imaging (MRI)
   C. Medication is prescribed by, or in consultation with, a rheumatologist
   D. Preferred product criteria is met for the products listed in the below table(s) [Employer Group Plans]

5. **Plaque Psoriasis.** Individual meets **ALL** of the following criteria:
   A. Age 6 years or older
   B. Body Surface Area (BSA) of greater than 5% OR BSA less than 5% and there is involvement of the scalp, face, the palms and soles (i.e., palmoplantar disease), or genitals
   C. Documentation of **ONE** of the following:
      i. Failure to **ONE** of the following, unless contraindicated or intolerant:
         a. Topical therapy (for example, topical corticosteroids, topical vitamin D analogs, Tazorac)
         b. Systemic therapy (for example, methotrexate, cyclosporine, Soriatane)
         c. Phototherapy
      ii. Already tried a biologic or targeted synthetic DMARD (tsDMARD) for Plaque Psoriasis
   D. Medication is prescribed by, or in consultation with, a dermatologist
   E. Preferred product criteria is met for the products listed in the below table(s) [Employer Group Plans]

6. **Psoriatic Arthritis.** Individual meets **ALL** of the following criteria:
   A. Age 2 years or older
   B. Documentation of **ONE** of the following:
      i. <u>For Non-axial disease</u>, failure to **ONE** disease-modifying anti-rheumatic drug (DMARD), unless contraindicated or intolerant

ii. For Axial disease, failure to **ONE** disease-modifying anti-rheumatic drug (DMARD), OR a nonsteroidal anti-inflammatory drug (NSAID), unless contraindicated or intolerant
iii. Already tried a biologic or targeted synthetic DMARD (tsDMARD

C. Medication is prescribed by, or in consultation with, a rheumatologist or dermatologist
D. Preferred product criteria is met for the products listed in the below table(s) [Employer Group Plans]

Employer Group Plans	
Condition	**Non-Preferred Product Criteria**
Ankylosing Spondylitis	**Standard/Performance/Legacy Drug List Plans** Documentation of failure, contraindication, or intolerance to **TWO** of the following: A. **Adalimumab Product** (**adalimumab-adaz/Hyrimoz** [manufactured by Sandoz/Novartis], **adalimumab – adbm/Cyltezo**, or **Humira**) [requires prior authorization] B. **Enbrel** [requires prior authorization] C. **Rinvoq** [requires prior authorization] D. **Taltz** [requires prior authorization] E. **Xeljanz/XR** [requires prior authorization] **Value/Advantage/Cigna Total Savings Drug List Plans** Documentation of failure, contraindication, or intolerance to **TWO** of the following: A. **Adalimumab Product** (**adalimumab-adaz/Hyrimoz** [manufactured by Sandoz/Novartis], **adalimumab – adbm/Cyltezo**, **Hadlima,** or **Humira**) [requires prior authorization] B. **Enbrel** [requires prior authorization] C. **Rinvoq** [requires prior authorization] D. **Taltz** [requires prior authorization] E. **Xeljanz/XR** [requires prior authorization]
Enthesitis-Related Arthritis	**Standard/Performance/Legacy Drug List Plans** Documentation of failure, contraindication, or intolerance to **ONE** of the following: A. **Adalimumab Product** (**adalimumab-adaz/Hyrimoz** [manufactured by Sandoz/Novartis], **adalimumab – adbm/Cyltezo**, or **Humira**) [requires prior authorization] B. **Enbrel** [requires prior authorization] **Value/Advantage/Cigna Total Savings Drug List Plans** Documentation of failure, contraindication, or intolerance to **ONE** of the following: A. **Adalimumab Product** (**adalimumab-adaz/Hyrimoz** [manufactured by Sandoz/Novartis], **adalimumab – adbm/ Cyltezo**, **Hadlima,** or **Humira**) [requires prior authorization] B. **Enbrel** [requires prior authorization]

Employer Group Plans	
Condition	**Non-Preferred Product Criteria**
Non-Radiographic Axial Spondyloarthritis	Documentation of failure, contraindication, or intolerance to **TWO** of the following: A. **Cimzia** [requires prior authorization] B. **Rinvoq** [requires prior authorization] C. **Taltz** [requires prior authorization]
Plaque Psoriasis - Adult	**Standard/Performance/Legacy Drug List Plans** Documentation of failure, contraindication, or intolerance to **TWO** of the following: A. **Adalimumab Product** (**adalimumab-adaz/Hyrimoz** [manufactured by Sandoz/Novartis], **adalimumab – adbm/Cyltezo**, or **Humira**) [requires prior authorization] B. **Enbrel** [requires prior authorization] C. **Otezla** [requires prior authorization] D. **Skyrizi SC** [requires prior authorization] E. **Stelara SC** [requires prior authorization] F. **Taltz** [requires prior authorization] G. **Tremfya** [requires prior authorization] **Value/Advantage/Cigna Total Savings Drug List Plans** Documentation of failure, contraindication, or intolerance to **TWO** of the following: A. **Adalimumab Product** (**adalimumab-adaz/Hyrimoz** [manufactured by Sandoz/Novartis], **adalimumab – adbm/ Cyltezo**, **Hadlima,** or **Humira**) [requires prior authorization] B. **Enbrel** [requires prior authorization] C. **Otezla** [requires prior authorization] D. **Skyrizi SC** [requires prior authorization] E. **Stelara SC** [requires prior authorization] F. **Taltz** [requires prior authorization] G. **Tremfya** [requires prior authorization]
Plaque Psoriasis - Pediatric and Adolescent	Documentation of failure, contraindication, or intolerance to **TWO** of the following: A. **Enbrel** [requires prior authorization] B. **Stelara SC** [requires prior authorization] C. **Taltz** [requires prior authorization]
Psoriatic Arthritis - Adult	**Standard/Performance/Legacy Drug List Plans** Documentation of failure, contraindication, or intolerance to **TWO** of the following: A. **Adalimumab Product** (**adalimumab-adaz/Hyrimoz** [manufactured by Sandoz/Novartis], **adalimumab – adbm/Cyltezo**, or **Humira**) [requires prior authorization] B. **Enbrel** [requires prior authorization] C. **Otezla** [requires prior authorization] D. **Rinvoq** [requires prior authorization] E. **Skyrizi SC** [requires prior authorization] F. **Stelara SC** [requires prior authorization] G. **Taltz** [requires prior authorization]

Employer Group Plans	
Condition	**Non-Preferred Product Criteria**
	H. **Tremfya** [requires prior authorization] I. **Xeljanz/XR** [requires prior authorization] **<u>Value/Advantage/Cigna Total Savings Drug List Plans</u>** Documentation of failure, contraindication, or intolerance to **TWO** of the following: A. **Adalimumab Product** (**adalimumab-adaz/Hyrimoz** [manufactured by Sandoz/Novartis], **adalimumab – adbm/ Cyltezo**, **Hadlima,** or **Humira**) [requires prior authorization] B. **Enbrel** [requires prior authorization] C. **Otezla** [requires prior authorization] D. **Rinvoq** [requires prior authorization] E. **Skyrizi SC** [requires prior authorization] F. **Stelara SC** [requires prior authorization] G. **Taltz** [requires prior authorization] H. **Tremfya** [requires prior authorization] I. **Xeljanz/XR** [requires prior authorization]
Psoriatic Arthritis - Pediatric and Adolescent	**<u>Standard/Performance/Legacy Drug List Plans</u>** Documentation of failure, contraindication, or intolerance to **BOTH** of the following: A. **Adalimumab Product** (**adalimumab-adaz/Hyrimoz** [manufactured by Sandoz/Novartis], **adalimumab – adbm/Cyltezo**, or **Humira**) <u>OR</u> **Enbrel** [requires prior authorization] B. **Stelara SC** [requires prior authorization] **<u>Value/Advantage/Cigna Total Savings Drug List Plans</u>** Documentation of failure, contraindication, or intolerance to **BOTH** of the following: A. **Adalimumab Product** (**adalimumab-adaz/Hyrimoz** [manufactured by Sandoz/Novartis], **adalimumab – adbm/Cyltezo**, **Hadlima**, or **Humira**) <u>OR</u> **Enbrel** [requires prior authorization] B. **Stelara SC** [requires prior authorization]

Individual and Family Plan	
Condition	
Ankylosing Spondylitis	**Preferred** [requires prior authorization]
Enthesitis-Related Arthritis	
Hidradenitis Suppurativa	
Non-Radiographic Axial Spondyloarthritis	

Individual and Family Plan	
Condition	
Plaque Psoriasis - Adult	
Plaque Psoriasis - Pediatric and Adolescent	
Psoriatic Arthritis - Adult	
Psoriatic Arthritis - Pediatric and Adolescent	

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Receipt of sample product does not satisfy any criteria requirements for coverage.

Reauthorization Criteria

Continuation of s secukinumab subcutaneous injection (Cosentyx) is considered medically necessary for **ALL** covered diagnoses when the above medical necessity criteria are met AND there is documentation of beneficial response.

Authorization Duration

Initial approval duration: up to 12 months
Reauthorization approval duration: up to 12 months

Conditions Not Covered

Any other use is considered experimental, investigational or unproven, including the following (this list may not be all inclusive):

1. **Concurrent Use with other Biologics or Targeted Synthetic Disease-Modifying Antirheumatic Drugs (tsDMARDs).** Cosentyx should not be administered in combination with another biologic or targeted synthetic DMARD used for an inflammatory condition (See Appendix for examples). Combination therapy is generally not recommended due to a potential for a higher rate of adverse effects with combinations and lack of evidence for additive efficacy.

   This does NOT exclude the use of conventional synthetic DMARDs (e.g., methotrexate, leflunomide, hydroxychloroquine, and sulfasalazine) in combination with Cosentyx.

2. **Crohn's Disease.** Exacerbations of Crohn's disease, in some cases serious, occurred in clinical trials with Cosentyx-treated patients.[1] In a Phase II published study in patients with Crohn's disease (n = 59), an intravenous formulation of Cosentyx did not reduce the

Crohn's disease activity index by ≥ 50 points compared with placebo and the study was terminated prematurely.[6]

3. **Rheumatoid Arthritis.** In a published, double-dummy Phase III study, Cosentyx was less effective that current treatments in patients with rheumatoid arthritis who were previously treated with a TNFi.[7] Patients were randomized to one of four treatment groups: 1) induction with an intravenous formulation of Cosentyx (10 mg/kg) followed by Cosentyx 150 mg subcutaneously given once every 4 weeks Q4W) [n = 137]; 2) secukinumab intravenous induction (10 mg/kg) followed by Cosentyx 75 mg subcutaneously Q4W (n = 138). At Week 24, ACR 20 response was significantly better with Cosentyx 150 mg subcutaneously (31%) and Orencia intravenous (43%) vs. placebo (18%). ACR 20 response with Cosentyx 75 mg was 28%, which was not significantly better than the placebo group. ACR 50/70 responses were 17%/10% with Cosentyx 150 mg and 12%/5% with Cosentyx 75 mg which was not significantly different than placebo (9%/5%). The group treated with Orencia intravenous had significantly improved ACR 50/70 responses at Week 24 (28%/12%). Using as observed data, ACR 20/50/70 responses at Week 52 were 63%/46%/19% with Cosentyx 150 mg, 57%/26%/7% with Cosentyx 75 mg, and 75%/52%/23% with Orencia intravenous. There is a published Phase II dose-ranging study (n = 237) evaluating Cosentyx in rheumatoid arthritis.[8-10] The ACR 20 response at Week 16 (using last observation carried forward analysis) was 34%, 46.9%, 46.5%, 53.7% for the 25, 75, 150, and 300 mg doses vs. 36% for placebo; however, this did not achieve statistical significance. After Week 16, patients who responded to Cosentyx sustained their response through Week 52 with patients on the 150 mg dose having the greatest improvement over time (55% and 40% of patients with ACR 50 and ACR 70 responses, respectively, at Week 52). In another Phase II study, Cosentyx did not achieve higher ACR 20 response rates at Week 12 vs. placebo.[11] There was an open-label treatment period where ACR responses were generally maintained through Week 52. Some patients were treated with an intravenous formulation of secukinumab and generally responded similarly to those treated with Cosentyx. In another Phase II study, an intravenous formulation of secukinumab demonstrated limited efficacy in biologic-naïve patients with rheumatoid arthritis associated with the HLA-DRB1 allele.[12]

4. **Uveitis.** Efficacy is not established for this condition. There was not a statistically significant difference between Cosentyx SC and placebo in three Phase III studies that included patients with Behcet's uveitis (n = 118); active, noninfectious, non-Behcet's uveitis (n = 31); and quiescent, noninfectious, non-Behcet's uveitis (n = 125) [SHEILD, INSURE, and ENDURE studies, respectively].[13]

Background

OVERVIEW

Cosentyx subcutaneous, an interleukin (IL)-17A antagonist, is indicated in the following conditions:[1]

- **Enthesitis-related arthritis**, in patients ≥ 4 years of age with active disease.
- **Hidradenitis suppurativa**, in adults with moderate to severe disease.
- **Plaque psoriasis**, in patients ≥ 6 years of age with moderate to severe disease who are candidates for systemic therapy or phototherapy.
- **Psoriatic arthritis**, in patients ≥ 2 years of age with active disease.
- **Ankylosing spondylitis**, in adults with active disease.
- **Non-radiographic axial spondyloarthritis**, in adults with active disease and objective signs of inflammation.

In the pivotal trial for non-radiographic axial spondyloarthritis, patients were required to have objective signs of inflammation, indicated by elevated C-reactive protein and/or sacroiliitis on magnetic resonance imaging.

Guidelines
Il-17 blockers are mentioned in multiple guidelines for treatment of inflammatory conditions.

- **Enthesitis-Related Arthritis:** Guidelines for juvenile idiopathic arthritis from the American College of Rheumatology (ACR) [2018] address treatment of enthesitis-related arthritis.[14] These recommendations were developed prior to approval of Cosentyx. A tumor necrosis factor inhibitor (TNFi) is recommended over use of methotrexate or sulfasalazine in those who have tried a nonsteroidal anti-inflammatory drug (NSAID).
- **Plaque Psoriasis:** Joint guidelines of care for the management and treatment of psoriasis with biologics were published by the American Academy of Dermatology (AAD) and the National Psoriasis Foundation (2019).[3] All of the biologics are generally recommended for treatment of moderate to severe disease. The AAD also recommends methotrexate (unless contraindicated) and other systemic therapies for treatment of moderate to severe psoriasis.[4] Traditional systemic agents can benefit widespread psoriasis. Studies have assessed response to methotrexate following 6 weeks to 4 months of treatment.
- **Psoriatic Arthritis:** Guidelines from ACR/National Psoriasis Foundation (2018) generally recommend TNFis as the first-line treatment strategy over other biologics (e.g., IL-17 blockers) with differing mechanisms of action.[5]
- **Ankylosing Spondylitis and Non-Radiographic Axial Apondyloarthritis:** Guidelines for ankylosing spondylitis and non-radiographic axial spondyloarthritis are published by the ACR/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network (2019).[2] Following primary nonresponse to a TNFi, either Cosentyx or Taltz® (ixekizumab injection) is recommended; however, if the patient is a secondary nonresponder, a second TNFi is recommended over switching out of the class. In patients with a contraindication to a TNFi, use of an IL-17 blocker is recommended over traditional oral agents such as methotrexate or sulfasalazine.

References

1. Cosentyx® [prescribing information]. East Hanover, NJ: Novartis; October 2023.
2. 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;(10):1599-1613.
3. 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.
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7. Blanco FJ, Möricke R, Dokoupilova E, et al. Secukinumab in active rheumatoid arthritis: a Phase III randomized, double-blind, active comparator- and placebo-controlled study. *Arthritis Rheumatol*. 2017;69(6):1144-1153.

8. Genovese MC, Durez P, Richards HB, et al. One-year efficacy and safety results of secukinumab in patients with rheumatoid arthritis: phase II, dose-finding, double-blind, randomized, placebo-controlled study. *J Rheumatol*. 2014;41(3):414-421.
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10. Strand V, Kosinski M, Gnanasakthy A, et al. Secukinumab treatment in rheumatoid arthritis is associated with incremental benefit in the clinical outcomes and HRQoL improvements that exceed minimally important thresholds. *Health Qual Life Outcomes*. 2014;12:31.
11. Tlustochowicz W, Rahman P, Seriolo B, et al. Efficacy and safety of subcutaneous and intravenous loading dose regimens of secukinumab in patients with active rheumatoid arthritis: results from a randomized Phase II study. *J Rheumatol.* 2016;43(3):495-503.
12. Burmester GR, Durez P, Shestakova G, et al. Association of HLA-DRB1 alleles with clinical responses to the anti-interleukin-17A monoclonal antibody secukinumab in active rheumatoid arthritis. *Rheumatology (Oxford).* 2016;55(1):49-55.
13. Dick AD, Tugal-Tutkun I, Foster S, et al. Secukinumab in the treatment of noninfectious uveitis: results of three randomized, controlled clinical trials. *Ophthalmology*. 2013;120(4):777-787.
14. Ringold S, Angeles-Han ST, Beukelman T, et al. 2019 American College of Rheumatology/Arthritis Foundation Guideline for the treatment of juvenile idiopathic arthritis: therapeutic approaches for non-systemic polyarthritis, sacroiliitis, and enthesitis. *Arthritis Rheumatol.* 2019;71(6):846-863.

APPENDIX

Table 1. Approved TNFis for Targeted Indications.

	Rheumatology					Dermatology	Gastroenterology	
	RA	**JIA**	**AS**	**nr-axSpA**	**PsA**	**PsO**	**CD**	**UC**
Tumor Necrosis Factor Inhibitors								
Cimzia	√	--	√	√	√	√	√	--
Enbrel	√	√	√	--	√	√	--	--
Adalimumab products (Humira, biosimilars)	√	√	√	--	√	√	√	√
Infliximab Products	√	--	√	--	√	√	√	√
Simponi Subcutaneous	√	--	√	--	√	--	--	√
Simponi Aria	√	√	√	--	√	--	--	--

TNFis – Tumor necrosis factor inhibitors; RA – Rheumatoid arthritis; JIA – Juvenile idiopathic arthritis; AS – Ankylosing spondylitis; nr-axSpA – Non-radiographic spondyloarthritis; PsA – Psoriatic arthritis; PsO – Plaque psoriasis; CD – Crohn's disease; UC – Ulcerative colitis.

Table 2. Approved IL-17, IL-23, and IL-12/23 Blockers for Targeted Indications.

	Rheumatology			Dermatology	Gastroenterology	
	Ankylosing Spondylitis	**nr-axSpA**	**Psoriatic Arthritis**	**Plaque Psoriasis**	**Crohn's Disease**	**Ulcerative Colitis**
Interleukin-17 Blockers						
Cosentyx	√	√	√	√	--	--
Siliq	--	--	--	√	--	--
Taltz	√	√	√	√	--	--
Interleukin-23 Blockers						
Ilumya	--	--	--	√	√	--

Skyrizi Intravenous	--	--	--	--	√#	--
Skyrizi Subcutaneous	--	--	√	√	√^	--
Tremfya	--	--	√	√	--	--
Interleukin-12/23 Blockers						
Stelara Subcutaneous	--	--	√	√	√^	√^
Stelara Intravenous	--	--	--	--	√#	√#

IL – Interleukin; nr-axSpA – Non-radiographic spondyloarthritis; ^ Maintenance dosing only; # Induction dosing only

Table 3. Approved Oral tsDMARDs for Targeted Indications.

	Rheumatology					Dermatology	Gastro-enterology
	Rheumatoid Arthritis	**Juvenile Idiopathic Arthritis**	**Ankylosing Spondylitis**	**nr-axSpA**	**Psoriatic Arthritis**	**Plaque Psoriasis**	**Ulcerative Colitis**
Janus Kinases Inhibitors							
Olumiant	√	--	--	--	--	--	--
Rinvoq	√	--	√	√	√	--	√
Xeljanz tablets	√	√#	√	--	√	--	√
Xeljanz oral solution	--	√#	--	--	--	--	--
Xeljanz XR	√	--	√	--	√	--	√
Phosphodiesterase Type 4 Inhibitor							
Otezla	--	--	--	--	√	√	--
Sphingosine 1-Phosphate Receptor Modulator							
Zeposia	--	--	--	--	--	--	√
Tyrosine Kinase 2 Inhibitor							
Sotyktu	--	--	--	--	--	√	--

tsDMARDs – Targeted synthetic disease-modifying antirheumatic drugs; # Indicated in polyarticular JIA.

Table 4. Other Approved Biologics for Targeted Indications.

	Rheumatology		
	Rheumatoid Arthritis	**Juvenile Idiopathic Arthritis**	**Psoriatic Arthritis**
Interleukin-6 Blockers			
Actemra Intravenous	√	√^	--
Actemra Subcutaneous	√	√^	--
Kevzara	√	--	--
Interleukin-1 Blocker			
Kineret	√	--	--
T-Cell Costimulation Modulator			
Orencia Intravenous	√	√#	√
Orencia Subcutaneous	√	√#	√
CD20-Directed Cytolytic Antibody			
Rituximab Intravenous Products	√	--	--

^ Indicated in polyarticular and systemic JIA; # Indicated in polyarticular JIA.

Revision Details

Type of Revision	Summary of Changes	Date
Selected Revision	Preferred product requirements updated	2/1/2024
Selected Revision	Removed Hidradenitis suppurativa product requirements	2/2/2024