iDrug and Biologic Coverage Policy

Effective Date 2/1/2024
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Coverage Policy Number IP0232

Abatacept Intravenous

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Related Coverage Resources

Abatacept Subcutaneous - (IP0231)

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. 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.

Overview

This policy supports medical necessity review for abatacept (**Orencia®**) intravenous

The coverage of abatacept (Orencia) subcutaneous is addressed in a separate coverage policy, refer to the related coverage policy resources section above (*Abatacept Subcutaneous - IP0231*).

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

Medical Necessity Criteria

Abatacept (Orencia) intravenous is considered medically necessary when ONE of the following is met:

1. **Graft-Versus-Host Disease – Prevention.** Individual meets **ALL** of the following:
   A. 2 years of age or older
   B. Orencia is being used for prevention of acute graft-versus-host disease
   C. Will also receive a calcineurin inhibitor (for example, cyclosporine and tacrolimus) for prevention of acute graft-versus-host disease
   D. Will also receive methotrexate for prevention of acute graft-versus-host disease
   E. Will undergo hematopoietic stem cell transplantation from **ONE** of the following donors:
      i. Matched unrelated donor
      ii. 1-allele-mismatched unrelated donor
   F. Medication is prescribed by, or in consultation with, an oncologist or hematologist

2. **Polyarticular Juvenile Idiopathic Arthritis (includes JIA or Juvenile Rheumatoid Arthritis).** Individual meets **BOTH** of the following criteria:
   A. Medication is being prescribed by, or in consultation with, a rheumatologist
   B. Non-Preferred Product Criteria is met, refer to the below table(s) [Employer Group Plans, Individual and Family Plan]

3. **Psoriatic Arthritis.** Individual meets **ALL** of the following criteria:
   A. 18 years of age 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. <u>For Axial disease</u>, failure to **ONE** disease-modifying anti-rheumatic drug (DMARD), <u>OR</u> a nonsteroidal anti-inflammatory drug (NSAID), unless contraindicated or intolerant
      iii. Already tried a biologic or targeted synthetic DMARD (tsDMARD) for Psoriatic Arthritis
   C. Medication is prescribed by, or in consultation with, a rheumatologist or dermatologist
   D. Non-Preferred Product Criteria is met, refer to the below table(s) [Employer Group Plans, Individual and Family Plan]

4. **Rheumatoid Arthritis.** Individual meets **ALL** of the following criteria:
   A. 18 years of age or older
   B. Documentation of **ONE** of the following:
      i. Failure to **ONE** disease-modifying anti-rheumatic drug (DMARD), unless contraindicated or intolerant
      ii. Already tried a biologic or targeted synthetic DMARD for Rheumatoid Arthritis
   C. Medication is prescribed by, or in consultation with, a rheumatologist
   D. Non-Preferred Product Criteria is met, refer to the below table(s) [Employer Group Plans, Individual and Family Plan]

Coverage varies across plans and may require the use of Preferred Products. Refer to the customer's benefit plan document for coverage details.

Employer Group Plans	
Condition	**Non-Preferred Product Criteria**
Polyarticular Juvenile Idiopathic Arthritis	**<u>Standard/Performance/Legacy Drug List Plans</u>** Documentation of failure, contraindication, or intolerance to **TWO** of the following: A. **Actemra SC** [requires prior authorization] B. **Adalimumab Product: Adalimumab-adaz/Hyrimoz** (by Sandoz/Novartis)**, Adalimumab – adbm/Cyltezo**, or **Humira** [requires prior authorization] C. **Enbrel** [requires prior authorization]

Employer Group Plans	
Condition	**Non-Preferred Product Criteria**
	D. **Xeljanz/Xeljanz Oral Solution** [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. **Actemra SC** [requires prior authorization] B. **Adalimumab Product: Adalimumab-adaz/Hyrimoz** (by Sandoz/Novartis)**, Adalimumab – adbm/Cyltezo**, **Hadlima**, or **Humira** [requires prior authorization] C. **Enbrel** [requires prior authorization] D. **Xeljanz/Xeljanz Oral Solution** [requires prior authorization]
Psoriatic Arthritis - Adult	**<u>Standard/Performance/Legacy Drug List Plans</u>** Documentation of failure, contraindication, or intolerance to **TWO** of the following: A. **Adalimumab Product: Adalimumab-adaz/Hyrimoz** (by Sandoz/Novartis)**, Adalimumab – adbm/Cyltezo**, or **Humira** [requires prior authorization] B. **Cimzia** [requires prior authorization] C. **Enbrel** [requires prior authorization] D. **Otezla** [requires prior authorization] E. **Rinvoq** [requires prior authorization] F. **Skyrizi SC** [requires prior authorization] G. **Stelara SC** [requires prior authorization] H. **Taltz** [requires prior authorization] I. **Tremfya** [requires prior authorization] J. **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** (by Sandoz/Novartis)**, Adalimumab – adbm/Cyltezo**, **Hadlima**, or **Humira** [requires prior authorization] B. **Cimzia** [requires prior authorization] C. **Enbrel** [requires prior authorization] D. **Otezla** [requires prior authorization] E. **Rinvoq** [requires prior authorization] F. **Skyrizi SC** [requires prior authorization] G. **Stelara SC** [requires prior authorization] H. **Taltz** [requires prior authorization] I. **Tremfya** [requires prior authorization] J. **Xeljanz/XR** [requires prior authorization]
Rheumatoid Arthritis	**<u>Standard/Performance/Legacy Drug List Plans</u>** Documentation of failure, contraindication, or intolerance to **TWO** of the following: A. **Actemra SC** [requires prior authorization] B. **Adalimumab Product: Adalimumab-adaz/Hyrimoz** (by Sandoz/Novartis)**, Adalimumab – adbm/Cyltezo**, or **Humira** [requires prior authorization] C. **Cimzia** [requires prior authorization] D. **Enbrel** [requires prior authorization] E. **Rinvoq** [requires prior authorization] F. **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:

Employer Group Plans	
Condition	**Non-Preferred Product Criteria**
	A. **Actemra SC** [requires prior authorization] B. **Adalimumab Product: Adalimumab-adaz/Hyrimoz** (by Sandoz/Novartis), **Adalimumab – adbm/Cyltezo**, **Hadlima**, or **Humira** [requires prior authorization] C. **Cimzia** [requires prior authorization] D. **Enbrel** [requires prior authorization] E. **Rinvoq** [requires prior authorization] F. **Xeljanz/XR** [requires prior authorization]

Individual and Family Plan	
Condition	**Non-Preferred Product Criteria**
Polyarticular Juvenile Idiopathic Arthritis	Documentation of failure, contraindication, or intolerance to **TWO** of the following: A. **Actemra SC** [requires prior authorization] B. **Adalimumab Product: Adalimumab-adaz/Hyrimoz** (by Sandoz/Novartis), **Adalimumab – adbm/Cyltezo**, **Hadlima**, or **Humira** [requires prior authorization] C. **Enbrel** [requires prior authorization] D. **Xeljanz/Xeljanz Oral Solution** [requires prior authorization]
Psoriatic Arthritis - Adult	Documentation of failure, contraindication, or intolerance to **TWO** of the following: A. **Adalimumab Product: Adalimumab-adaz/Hyrimoz** (by Sandoz/Novartis), **Adalimumab – adbm/Cyltezo**, **Hadlima**, or **Humira** [requires prior authorization] B. **Cimzia** [requires prior authorization] C. **Cosentyx** [requires prior authorization] D. **Enbrel** [requires prior authorization] E. **Otezla** [requires prior authorization] F. **Rinvoq** [requires prior authorization] G. **Skyrizi SC** [requires prior authorization] H. **Stelara SC** [requires prior authorization] I. **Tremfya** [requires prior authorization] J. **Xeljanz/XR** [requires prior authorization]
Rheumatoid Arthritis	Documentation of failure, contraindication, or intolerance to **TWO** of the following: A. **Actemra SC** [requires prior authorization] B. **Adalimumab Product: Adalimumab-adaz/Hyrimoz** (by Sandoz/Novartis), **Adalimumab – adbm/Cyltezo**, **Hadlima**, or **Humira** [requires prior authorization] C. **Cimzia** [requires prior authorization] D. **Enbrel** [requires prior authorization] E. **Rinvoq** [requires prior authorization] F. **Xeljanz/ XR** [requires prior authorization]

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.

Reauthorization Criteria

Continuation of abatacept (Orencia) intravenous is considered medically necessary for **Polyarticular Juvenile Idiopathic Arthritis**, **Psoriatic Arthritis-Adult** and **Rheumatoid Arthritis** when initial criteria are met AND beneficial response is demonstrated.

Graft-vs-Host Disease: Abatacept (Orencia) intravenous is not applicable for continuation beyond initial approval duration.

Authorization Duration

Initial approval duration:

- Graft-Versus-Host Disease: 4 doses
- Polyarticular Juvenile Arthritis, Psoriatic Arthritis, Rheumatoid Arthritis: Up to 12 months

Reauthorization approval duration:

- Graft-Versus-Host Disease: Not applicable for continuation beyond initial approval duration.
- Polyarticular Juvenile Arthritis, Psoriatic Arthritis, Rheumatoid Arthritis: 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. **Ankylosing Spondylitis.** In an open-label Phase II trial, Orencia was administered intravenously on Days 1, 15, 29, and every 28 days thereafter to patients with active ankylosing spondylitis.[5] Patients received a fixed dosage of Orencia of approximately 10 mg/kg based on body weight. The primary endpoint was a 40% improvement in disease activity at Week 24 in the Assessment of SpondyloArthritis international Society criteria (ASAS 40). At Week 24, the ASAS 40 was 13.3% (n = 2/15) in tumor necrosis factor inhibitor (TNFi)-naïve patients compared with no responses in patients who had previously failed TNFis (n = 15). ASAS 20 response was 26.7% (n = 4/15) in TNFi-naïve patients compared with 20% (n = 3/15) in those who had previously failed TNFis. A major response was not shown with treatment to Orencia.

2. **Concurrent Use with a Biologic or with a Targeted Synthetic DMARD.** Orencia intravenous should not be administered in combination with another biologic or with a targeted synthetic DMARD used for an inflammatory condition (see Appendix for examples).[1] Combination therapy is generally not recommended due to a higher rate of adverse events with combinations and lack of data supportive of additional efficacy.

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

3. **Inflammatory Bowel Disease (i.e., Crohn's Disease, Ulcerative Colitis).** In placebo-controlled trials evaluating the efficacy of Orencia intravenous for induction and maintenance in adults with active, moderate to severe Crohn's disease (n = 451) and ulcerative colitis (n = 490), Orencia was no more effective than placebo.[6] Patients were randomized to Orencia 30, 10, or 3 mg/kg (according to body weight) or placebo and dosed at Weeks 0, 2, 4, and 8. A total of 90 patients with Crohn's disease and 131 patients with ulcerative colitis who responded to induction were then randomized to Orencia 10 mg/kg or placebo every 4 weeks through Week 52. When used for induction of Crohn's disease, 17.2%, 10.2%, and 15.5% of patients receiving Orencia 30 mg, 10 mg, and 3 mg/kg achieved a clinical response at Weeks 8 and 12 compared with 14.4% of patients receiving placebo (P = not significant [NS] for all comparisons). In patients with Crohn's disease, response and remission at Week 52 was not significantly different between the Orencia intravenous and placebo treatment groups. When used as induction therapy in ulcerative colitis, 21.4%, 19.0%, and 20.3% of patients receiving Orencia 30 mg, 10 mg, and 3 mg/kg achieved a clinical response at Week 12 compared with 29.5% of patients receiving placebo (P = 0.043 for 10 mg/kg vs. placebo; other comparisons P = NS). At Week 52, 12.5% (n = 8/64) and 14.1% (n = 9/64) of patients with ulcerative colitis were in remission (P = NS) and 17.2% of patients in each treatment group (n = 11/64 for each group) had achieved a response.

4. **Psoriasis**. In the pivotal trial evaluating Orencia subcutaneous for psoriatic arthritis, there was not a significant difference at Week 24 in the proportion of patients with a 50% reduction in the Psoriasis Area and Severity Index (PASI 50) response vs. placebo ± conventional synthetic (cs)DMARD (27% vs. 20% with placebo ± csDMARD; P = NS).[8] In a multicenter, Phase I, 26-week, open-label dose-escalation study, 43 patients with stable plaque psoriasis (10% to 49% body surface area involvement) received four doses of Orencia given as a 1-hour intravenous infusion on Days 1, 3, 16 and 29.[7] The starting dose was 0.5 mg/kg. Four to six patients were accrued to each of eight dose levels: 0.5, 1, 2, 4, 8, 16, 25 and 50 mg/kg. A parallel control group was matched for age and overall disease severity. In all, 46% of patients on Orencia achieved a 50% or greater sustained improvement in clinical disease activity (Physician's Global Assessment of disease activity) compared with baseline psoriasis evaluation. Progressively greater effects were observed with the highest doses. Further studies are needed to establish safety and efficacy, as well as appropriate dosing, in plaque psoriasis.

Coding Information

1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

HCPCS Codes	Description
J0129	Injection, abatacept, 10 mg (code may be used for Medicare when drug administered under direct supervision of a physician, not for use when drug is self-administered)

Background

OVERVIEW

Orencia intravenous, a selective T-cell costimulation modulator, is indicated for the following uses:

- **Juvenile idiopathic arthritis**, in patients ≥ 2 years of age with moderately to severely active polyarticular disease.
- **Psoriatic arthritis**, in adults with active disease.
- **Rheumatoid arthritis**, in adults with moderately to severely active disease.
- **Graft-versus-host disease (GVHD)**, for prophylaxis of acute GVHD in combination with a calcineurin inhibitor and methotrexate, in patients ≥ 2 years of age undergoing hematopoietic stem cell transplantation from a matched or 1 allele-mismatched unrelated donor.

Orencia is not recommended for use concomitantly with other potent immunosuppressants such as biologics or Janus kinase inhibitors. Orencia is available as an intravenous infusion that is dosed on body weight. There is also a subcutaneous injection available in prefilled syringes. Some patients initiating therapy with Orencia subcutaneous will receive a single loading dose with Orencia intravenous.

Dosing and Availability

Graft-Versus-Host Disease

- Patient is ≥ 6 years of age: up to 10 mg/kg to a maximum of 1,000 mg per dose
- Patient is ≥ 2 and < 6 years of age: up to 15 mg/kg
- A dose is administered the day before transplantation, then on Days 5, 14, and 28 after transplantation

Polyarticular Juvenile Idiopathic Arthritis

- 10 mg/kg if the patient weighs < 75 kg
- 750 mg if the patient weighs 75 kg to 100 kg

- 1,000 mg if the patient weights > 100 kg
- The dose is administered at Weeks 0, 2, and 4, then every 4 weeks thereafter

Psoriatic Arthritis / Rheumatoid Arthritis
- 500 mg if the patients weighs < 60 kg
- 750 mg if the patient weighs 60 kg to 100 kg
- 1,000 mg if the patient weighs > 100 kg
- The dose is administered at Weeks 0, 2, and 4, then every 4 weeks thereafter

Intravenous Infusion
- For injection: 250 mg lyophilized powder in a single-dose vial

Subcutaneous Use
- Injection: 50 mg/0.4 mL, 87.5 mg/0.7 mL, 125 mg/mL solution in single-dose prefilled syringes
- Injection: 125 mg/mL solution in a single-dose prefilled ClickJect™ autoinjectors

Guidelines

Orencia is addressed in guidelines for treatment of various inflammatory conditions.

- **GVHD:** Guidelines for hematopoietic cell transplantation for pre-transplant recipient evaluation and management of GVHD are available from the National Comprehensive Cancer Network (NCCN) [version 5.2021 – September 30, 2021]. These guidelines were last updated prior to approval of Orencia for prevention of acute GVHD. Calcineurin inhibitors (e.g., tacrolimus, cyclosporine) are mentioned as immunosuppressants commonly used for the prevention and initial treatment of GVHD, often in combination with other agents. Additionally, Orencia is among the therapies listed for treatment of steroid-refractory chronic GVHD.
- **Juvenile Idiopathic Arthritis:** Guidelines from American College of Rheumatology (ACR) [2019] list biologics among the treatment options for subsequent therapy in patients with polyarthritis.[3] Initial therapy with a biologic may be considered for patients with risk factors and involvement of high-risk joints (e.g., cervical spine, wrist, or hip), high disease activity, and/or those judged to be at high risk of disabling joint damage. In patients with active sacroiliitis or enthesitis despite nonsteroidal anti-inflammatory drug use, a tumor necrosis factor inhibitor (TNFi) is recommended.
- **Psoriatic Arthritis** (PsA)**:** Guidelines from ACR (2018) recommend TNFis over other biologics for use in treatment-naïve patients with PsA and in those who were previously treated with an oral therapy.[4] However, Orencia may be considered over other biologics in patients with recurrent or serious infections.
- **Rheumatoid Arthritis:** Guidelines from the ACR (2021) recommend addition of a biologic or a targeted synthetic disease modifying anti-rheumatic drug (DMARD) for a patient taking the maximum tolerated dose of methotrexate who is not at target.[2]

References

1. Orencia® intravenous infusion [prescribing information]. Princeton, NJ: Bristol-Myers Squibb; December 2021.
2. Fraenkel L, Bathon JM, England BR, et al. 2021 American College of Rheumatology guideline for the treatment of rheumatoid arthritis. *Arthritis Rheumatol*. 2021;73(7):1108-1123.
3. 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):717-734.
4. Singh JA, Guyatt G, Ogdie A, et al. 2018 American College of Rheumatology/National Psoriasis Foundation Guideline for the treatment of psoriatic arthritis. *Arthritis Care Res (Hoboken)*. 2019;71(1):2-29.
5. Song IH, Heldmann F, Rudwaleit M, et al. Treatment of active ankylosing spondylitis with abatacept: an open-label, 24-week pilot study. *Ann Rheum Dis*. 2011;70(6):1108-1110.
6. Sandborn WJ, Colombel JF, Sands BE, et al. Abatacept for Crohn's disease and ulcerative colitis. *Gastroenterology*. 2012;143(1):62-69.e4.
7. Abrams JR, Lebwohl MG, Guzzo CA, et al. CTLA4Ig-mediated blockade of T-cell costimulation in patients with psoriasis vulgaris. *J Clin Invest.* 1999;103:1243-1252.

8. Mease PJ, Gottlieb AB, van der Heijde D, et al. Efficacy and safety of abatacept, a T-cell modulator, in a randomised, double-blind, placebo-controlled, phase III study in psoriatic arthritis. *Ann Rheum Dis*. 2017;76(9):1550-1558.
9. The NCCN Hematopoietic Cell Transplantation (HCT) Clinical Practice Guidelines in Oncology (version 5.2021 – September 30, 2021). © 2021 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on December 16, 2021.

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	--	--	--	--	--	--	√

	Rheumatology					Dermatology	Gastro-enterology
	Rheumatoid Arthritis	Juvenile Idiopathic Arthritis	Ankylosing Spondylitis	nr-axSpA	Psoriatic Arthritis	Plaque Psoriasis	Ulcerative Colitis
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.