Effective Date **6/1/2024**
Coverage Policy Number **IP0244**

Certolizumab

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Related Coverage Resources

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 certolizumab (**Cimzia®**).

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

Medical Necessity Criteria

Certolizumab (Cimzia) is considered medically necessary when ONE of the following is met:

1. **Ankylosing Spondylitis.** Individual meets **BOTH** of the following criteria:
   A. 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)
   B. Medication is prescribed by, or in consultation with, a rheumatologist
   C. Preferred Product Step Therapy criteria is met, refer to the tables below [Employer Group, Individual and Family Plan]

2. **Crohn's Disease.** Individual meets **ALL** of the following criteria:
   A. 6 years of age or older
   B. Documentation of **ONE** of the following:
      i. Failure, contraindication or intolerance to **ONE** corticosteroid, OR a corticosteroid will be taken concurrently with certolizumab
      ii. Failure to **ONE** other conventional systemic therapy, unless contraindicated or intolerant, OR conventional systemic therapy will be taken concurrently with certolizumab
      iii. Already tried a biologic for Crohn's Disease
      iv. Meets **ONE** of the following:
         a. Severe disease needing hospitalization
         b. Involvement of the upper GI tract
         c. Smoker
         d. Less than 40 years of age
         e. Stricturing disease
         f. Perianal disease
         g. Other enterocutaneous fistula
         h. Extraintestinal manifestations (ankylosing spondylitis, pyoderma gangrenosum, erythema nodosum)
         i. Previous Crohn's disease-related surgery (for example, ileocolonic resection (to reduce the chance of Crohn's disease recurrence)
         j. Bowel obstruction
         k. History of abscess or perforation (after healing)
   C. Medication is prescribed by, or in consultation with, a gastroenterologist
   D. Preferred Product Step Therapy criteria is met, refer to the below table(s) [Employer Group, Individual and Family Plan]

3. **Non-Radiographic Axial Spondyloarthritis.** Individual meets **ALL** of the following criteria:
   A. 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)
   B. **ONE** of the following:
      i. Documented failure, contraindication or intolerance to **ONE** non-steroidal anti-inflammatory drug (NSAID)
      ii. Already tried a biologic or targeted synthetic DMARD (tsDMARD) for Non-radiographic Axial Spondyloarthritis
   C. Medication is prescribed by, or in consultation with, a rheumatologist

4. **Plaque Psoriasis.** Individual meets **ALL** of the following criteria:
   A. 18 years of age or older
   B. Body Surface Area (BSA) of greater than 5%, OR BSA less than 5% and there is and there is involvement of the scalp, face, the palms and soles, or genitals
   C. Documentation of **ONE** of the following (i or ii):
      i. Failure to **ONE** of the following, unless contraindicated or intolerant to **ALL** of the following:
         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 Step Therapy criteria is met, refer to the below table(s) [Employer Group, Individual and Family Plan]

5. **Psoriatic Arthritis.** Individual meets **BOTH** of the following criteria:
   A. Medication is prescribed by, or in consultation with, a rheumatologist or dermatologist

B. Preferred Product Step Therapy criteria is met, refer to the below table(s) [Employer Group, Individual and Family Plan]

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

7. **Spondyloarthritis (non-axial disease): Reactive Arthritis (Reiter's disease) and Undifferentiated Arthritis.** Individual meets **ALL** of the following criteria:
   A. Has arthritis primarily in the knees, ankles, elbows, wrists, hands, and/or feet
   B. Documentation of **ONE** of the following:
      i. Failure to **ONE** conventional synthetic disease-modifying anti-rheumatic drug (csDMARD), unless contraindicated or intolerant
      ii. Already tried a biologic for non-axial spondyloarthritis
   C. Medication is prescribed by, or in consultation with, a rheumatologist

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	**Preferred Product Step Therapy Criteria**
Ankylosing Spondylitis	Documentation of failure, contraindication or intolerance to **TWO** of the following: A. **Adalimumab Product: Adalimumab-adaz/Hyrimoz** (by Sandoz/Novartis)**, Adalimumab – adbm/Cyltezo**, **Adalimumab-ryvk/Simlandi**, or **Humira** (by AbbVie) [requires prior authorization] B. **Enbrel** [requires prior authorization] C. **Rinvoq** [requires prior authorization] D. **Taltz** [requires prior authorization] E. **Xeljanz/XR** [requires prior authorization]
Crohn's Disease - Adult	Documentation of failure, contraindication or intolerance to **ONE** of the following **adalimumab products:** A. **Adalimumab-adaz or Hyrimoz** (by Sandoz/Novartis) [requires prior authorization] B. **Adalimumab–adbm or Cyltezo** [requires prior authorization] C. **Adalimumab-ryvk or Simlandi** [requires prior authorization] D. **Humira** (by AbbVie) [requires prior authorization]
Non-Radiographic Axial Spondyloarthritis	**Preferred** [requires prior authorization]
Plaque Psoriasis - Adult	Documentation of failure, contraindication or intolerance to **TWO** of the following: A. **Adalimumab Product: Adalimumab-adaz/Hyrimoz** (by Sandoz/Novartis)**, Adalimumab – adbm/Cyltezo**, **Adalimumab-ryvk/Simlandi**, or **Humira** (by AbbVie) [requires prior authorization] B. **Enbrel** [requires prior authorization] C. **Otezla** [requires prior authorization] D. **Skyrizi SC** [requires prior authorization] E. **Sotyktu** [requires prior authorization]

Employer Group Plans	
Condition	**Preferred Product Step Therapy Criteria**
	F. **Stelara SC** [requires prior authorization] G. **Taltz** [requires prior authorization] H. **Tremfya** [requires prior authorization]
Psoriatic Arthritis	Documentation of failure, contraindication or intolerance to **TWO** of the following: A. **Adalimumab Product: Adalimumab-adaz/Hyrimoz** (by Sandoz/Novartis)**, Adalimumab – adbm/Cyltezo**, **Adalimumab-ryvk/Simlandi**, or **Humira** (by AbbVie) [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]
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**, **Adalimumab-ryvk/Simlandi**, or **Humira** (by AbbVie), [requires prior authorization] C. **Enbrel** [requires prior authorization] D. **Rinvoq** [requires prior authorization] E. **Xeljanz/XR** [requires prior authorization]

Individual and Family Plan	
Condition	**Preferred Product Step Therapy Criteria**
Ankylosing Spondylitis	Documentation of failure, contraindication or intolerance to **TWO** of the following: A. **Adalimumab Product: Adalimumab-adaz/Hyrimoz** (by Sandoz/Novartis)**, Adalimumab – adbm/Cyltezo**, **Adalimumab-ryvk/Simlandi,** or **Humira** (by AbbVie) B. **Cosentyx** [requires prior authorization] C. **Enbrel** [requires prior authorization] D. **Rinvoq** [requires prior authorization] E. **Xeljanz/XR** [requires prior authorization]
Crohn's Disease - Adult	Documentation of failure, contraindication or intolerance to **ONE** of the following **adalimumab products:** A. **Adalimumab-adaz or Hyrimoz** (by Sandoz/Novartis) [requires prior authorization] B. **Adalimumab–adbm or Cyltezo** [requires prior authorization] C. **Adalimumab-ryvk or Simlandi** [requires prior authorization] D. **Humira** (by AbbVie) [requires prior authorization]
Non-Radiographic Axial Spondyloarthritis	**Preferred** [requires prior authorization]
Plaque Psoriasis - Adult	Documentation of failure, contraindication or intolerance to **TWO** of the following: A. **Adalimumab Product: Adalimumab-adaz/Hyrimoz** (by Sandoz/Novartis)**, Adalimumab – adbm/Cyltezo**, **Adalimumab-ryvk/Simlandi,** or **Humira** (by AbbVie) [requires prior authorization]

Individual and Family Plan	
Condition	**Preferred Product Step Therapy Criteria**
	B. **Cosentyx** [requires prior authorization] C. **Enbrel** [requires prior authorization] D. **Otezla** [requires prior authorization] E. **Skyrizi SC** [requires prior authorization] F. **Stelara SC** [requires prior authorization] G. **Tremfya** [requires prior authorization]
Psoriatic Arthritis	Documentation of failure, contraindication or intolerance to **TWO** of the following: A. **Adalimumab Product: Adalimumab-adaz/Hyrimoz** (by Sandoz/Novartis)**, Adalimumab – adbm/Cyltezo**, **Adalimumab-ryvk/Simlandi,** or **Humira** (by AbbVie) [requires prior authorization] B. **Cosentyx** [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. **Tremfya** [requires prior authorization] I. **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**, **Adalimumab-ryvk/Simlandi,** or **Humira** (by AbbVie) [requires prior authorization] C. **Enbrel** [requires prior authorization] D. **Rinvoq** [requires prior authorization] E. **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 certolizumab (Cimzia) is considered medically necessary for ALL covered diagnoses when initial criteria are met AND beneficial response is demonstrated.

Authorization Duration

Initial approval duration is up to 12 months.
Reauthorization approval duration is 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):

Concurrent Use with a Biologic or with a Targeted Synthetic Disease-Modifying Antirheumatic Drug (tsDMARD). Cimzia should not be administered in combination with another biologic or targeted synthetic

DMARD used for an inflammatory condition. Combination therapy is generally not recommended due to potentially higher rates of adverse events with combinations and lack of data supportive of additional efficacy.[7,8]

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

Background

OVERVIEW
Cimzia, a tumor necrosis factor inhibitor (TNFi), is indicated for the following uses:[1]

- **Ankylosing spondylitis**, for the treatment of adults with active disease.
- **Crohn's disease**, for reducing signs and symptoms and maintaining clinical responses in adults with moderate to severe active disease who have had an inadequate response to conventional therapy.
- **Non-radiographic axial spondyloarthritis**, in patients with objective signs of inflammation.
- **Plaque psoriasis**, for the treatment of adults with moderately to severely active disease who are candidates for systemic therapy or phototherapy.
- **Psoriatic arthritis**, for the treatment of adult patients with active disease.
- **Rheumatoid arthritis**, for the treatment of adults with moderately to severely active disease.

Cimzia may be used as monotherapy or in combination with conventional synthetic disease-modifying antirheumatic drugs (csDMARDs).

Dosing Information
Approved induction dosing is 400 mg given subcutaneously at Weeks 0, 2, and 4. For psoriasis, maintenance dosing is 400 mg given every 2 weeks. For other indications, maintenance dosing is generally given as 400 mg subcutaneously per 28-day period. This dose may be administered as a single 200 mg injection given once every 2 weeks or as two 200 mg doses (400 mg dose) given once every 4 weeks.

Guidelines
TNFis feature prominently in guidelines for treatment of inflammatory conditions:

- **Crohn's Disease:** The American College of Gastroenterology has guidelines for Crohn's disease (2018).[3] TNFis are listed as an option for disease that is resistant to corticosteroids, severely active disease, perianal fistulizing disease, and maintenance of remission. In post-operative Crohn's disease, a TNFi should be started within 4 weeks of surgery to prevent recurrence.

- **Plaque Psoriasis:** Guidelines from the American Academy of Dermatologists and National Psoriasis Foundation (2019) recommend TNFis as a monotherapy treatment option for adults with moderate to severe disease.[4] Based on extrapolation of data, Cimzia is likely to have class characteristics similar to the other TNFis.

- **Psoriatic Arthritis:** Guidelines from ACR (2019) recommend TNFis over other biologics for use in treatment-naïve patients and in those who were previously treated with an oral therapy.[5]

- **Rheumatoid Arthritis:** Guidelines from the American College of Rheumatology (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.[6]

- **Spondyloarthritis:** Guidelines for ankylosing spondylitis and nonradiographic axial spondyloarthritis are published by the ACR/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network (2019).[2] TNFis are recommended for the initial biologic. In those who are secondary nonresponders to a TNFi, a second TNFi is recommended over switching out of the class.

References

1. Cimzia® subcutaneous injection [prescribing information]. Smyrna, GA: UCB; September 2019.
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;71(10):1599-1613.
3. Lichtenstein GR, Loftus EV, Isaacs KL, et al. ACG Clinical Guideline: management of Crohn's Disease in adults. Am J Gastroenterol. 2018:113(4):481-517.
4. 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.
5. 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.
6. 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.
7. Feuerstein JD, Ho EY, Shmidt E, et al. AGA clinical practice guidelines on the medical management of moderate to severe luminal and perianal fistulizing Crohn's disease. Gastroenterology. 2021;160(7):2496-2508.

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.