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RHEUMATOLOGY PRODUCTS UPDATED PRIOR AUTHORIZATION CRITERIA

Dear Provider,

Effective June 1, 2021, the criteria for the rheumatology products listed in Table 1 will be updated to include quantity limits. These products are on the **non-Medicare** list of office-administered drugs requiring prior authorization. This letter is a notification of the upcoming change in prior authorization criteria required before administering this medication in a physician's office.

Table 1. List of Rheumatology Products that have Updated Prior Authorization Criteria

BRAND NAME	GENERIC NAME	HCPCS
Orencia	Abatacept	J0129
Simponi Aria	Golimumab Intravenous Injection	J1602
Rituxan	Rituximab	J9310 J9312
Truxima	Rituximab-abbs	Q5115
Actemra	Tocilizumab	J3262
Privigen **Bivigam** **Gammaplex** **Gamunex/Gamunex-C/Gammaked** **Other IVIG** **Octagam** **Gammagard liquid** **Flebogamma/Glebogamma Dif** **Other immune globulins IV** **Panzyga** **Asceniv**	Intravenous immunoglobulin (IVIG)	J1459 J1556 J1557 J1561 J1566 J1568 J1569 J1572 J1599

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (Kaiser Permanente) requires prior authorization for a select group of injectable drugs that may be administered under the medical benefit in a physician's office or by home infusion. These reviews are intended to ensure consistent benefit adjudication as well as appropriate utilization in accordance with the Kaiser Permanente Pharmacy & Therapeutics Committee's evidence-based criteria for coverage.

Prior Authorization Criteria for Rheumatology Products (changes are in bold):

DRUG NAME	COVERAGE CRITERIA
ABATACEPT	1) Patients with rheumatoid arthritis who clinically failed, been intolerant to or have contraindications to methotrexate 2) Patients ≥ 6 years old with juvenile idiopathic arthritis with failure, intolerance, or contraindications to methotrexate 3) Covered for patients with psoriatic arthritis with failure, intolerance, or contraindications to methotrexate **Quantity Limit:** • **1000 mg every 4 weeks** Note: Must be administered in a non-hospital setting. See site of care prior authorization criteria for coverage criteria in a hospital outpatient setting and exceptions for new starts. Site of care restriction does NOT apply to patients less than 13 years old.
GOLIMUMAB INTRAVENOUS INJECTION	For use in patients with rheumatoid arthritis who have failure, intolerance, or contraindication to methotrexate, two formulary-preferred TNF antagonists (e.g., etanercept, adalimumab, infliximab) • Limit dosing to 2 mg/kg at week 0 and week 4, then every 8 weeks Medical necessity review required for patients with psoriatic arthritis (PsA) or ankylosing spondylitis (AS). **Quantity Limit:** • **Induction: 200 mg at weeks 0 and 4** • **Maintenance: 200 mg every 8 weeks** Note: Must be administered in a non-hospital setting. See site of care prior authorization criteria for coverage criteria in a hospital outpatient setting and exceptions for new starts. Site of care restriction does NOT apply to patients less than 13 years old.

RITUXIMAB	Covered for new starts who have had an inadequate response or intolerance to a rituximab biosimilar declared equivalent by Kaiser Permanente Pharmacy & Therapeutics Committee* for the following diagnoses:
	• Any oncology diagnoses
	• Rheumatoid arthritis patients who have clinically failed, been intolerant to, or have contraindications to methotrexate
	• ITP patients who have clinically failed corticosteroid and IVIG
	• Granulomatosis polyangiitis (GPA or Wegener's) or microscopic polyangiitis (MPA) in patients who are antineutrophil cytoplasmic antibody (ANCA) positive
	• Multiple sclerosis (MS)
	• Myasthenia gravis
	• Covered for adult patients ≥ 18 years old with thyroid eye disease (TED) who meet the following criteria:
	  o Confirmed diagnosis of active TED by an oculoplastic surgeon
	  o Clinical Activity Score (CAS) ≥4 (on the 7-item scale)
	  o Moderate-to-severe active TED (not sight-threatening but has appreciable impact on daily life), associated with at least one of the following: lid retraction ≥2 mm, moderate or severe soft tissue involvement, exophthalmos ≥3 mm above normal for race and gender, or intermittent or constant diplopia
	  o Inadequate response, intolerance, or contraindication to IV steroid therapy with or without radiation therapy

DRUG NAME	COVERAGE CRITERIA
	• Patients ≥18 years old with neuromyelitis optica spectrum disorder (NMOSD) when prescribed by or in consultation with a Multiple sclerosis specialist or Neurologist AND AQP4 antibody seropositive • Established patients on Rituxan must have a documented inadequate response or intolerance to a rituximab biosimilar OR must provide evidence that switching to a rituximab biosimilar is clinically inappropriate (documentation required) *Kaiser Permanente equivalent rituximab products include rituximab-abbs (Truxima) Note: Must be administered in a non-hospital setting. See site of care prior authorization criteria for coverage criteria in a hospital outpatient setting and exceptions for new starts. Site of care restriction does NOT apply to patients less than 13 years old. Note: any oncology indication would not require patients to meet site of care criteria **Quantity Limits:** • **Rheumatoid arthritis** o **Induction: 1000 mg on day 1 and 15;** o **Maintenance: 1000 mg every 16 weeks** • **Granulomatosis polyangiitis** o **Induction: 1000 mg once weekly for 4 weeks;** o **Maintenance: 1000 mg every 16 weeks** • **Multiple Sclerosis** o **Induction: 1000 mg on day 1;** o **Maintenance 500 mg every 24 weeks** • **Note: Quantity limits do not apply to oncology diagnoses or other listed diagnoses**
RITUXIMAB-ABBS	• Criteria review not required for the following diagnoses: any oncology indication, multiple sclerosis (MS), myasthenia gravis • Rheumatoid arthritis patients who have clinically failed, been intolerant to, or have contraindications to methotrexate • ITP patients who have clinically failed corticosteroid and IVIG • Covered for treatment of granulomatosis polyangiitis (GPA or Wegener's) or microscopic polyangiitis (MPA) in patients who are antineutrophil cytoplasmic antibody (ANCA) positive • Covered for adult patients ≥ 18 years old with thyroid eye disease (TED) who meet the following criteria: o Confirmed diagnosis of active TED by an oculoplastic surgeon o Clinical Activity Score (CAS) ≥4 (on the 7-item scale) o Moderate-to-severe active TED (not sight-threatening but has appreciable impact on daily life), associated with at least one of the following: lid retraction ≥2 mm, moderate or severe soft tissue involvement, exophthalmos ≥3 mm above normal for race and gender, or intermittent or constant diplopia o Inadequate response, intolerance, or contraindication to IV steroid therapy with or without radiation therapy • Covered for patients ≥18 years old with neuromyelitis optica spectrum disorder (NMOSD) when prescribed by or in consultation with a Multiple sclerosis specialist or Neurologist AND AQP4 antibody seropositive

DRUG NAME	COVERAGE CRITERIA

	Note: Must be administered in a non-hospital setting. See site of care prior authorization criteria for coverage criteria in a hospital outpatient setting and exceptions for new starts. Site of care restriction does NOT apply to patients less than 13 years old.
	
	Any oncology indication would not require patients to meet site of care criteria.
	
	Quantity Limits:
	• **Rheumatoid arthritis**
	  ○ **Induction: 1000 mg on day 1 and 15;**
	  ○ **Maintenance: 1000 mg every 16 weeks**
	• **Granulomatosis polyangiitis**
	  ○ **Induction: 1000 mg once weekly for 4 weeks;**
	  ○ **Maintenance: 1000 mg every 16 weeks**
	• **Multiple Sclerosis**
	  ○ **Induction: 1000 mg on day 1;**
	  ○ **Maintenance 500 mg every 24 weeks**
	• **Note: Quantity limits do not apply to oncology diagnoses or other listed diagnoses**

TOCILIZUMAB	• Covered for adult patients ≥ 18 years old with thyroid eye disease (TED) who meet the following criteria:
	  ○ Confirmed diagnosis of active TED by an oculoplastic surgeon
	  ○ Clinical Activity Score (CAS) ≥4 (on the 7-item scale)
	  ○ Moderate-to-severe active TED (not sight-threatening but has appreciable impact on daily life), associated with at least one of the following:
	  ▪ Lid retraction ≥2 mm
	  ▪ Moderate or severe soft tissue involvement
	  ▪ Exophthalmos ≥3 mm above normal for race and gender
	  ▪ Intermittent or constant diplopia
	  ○ Inadequate response, intolerance, or contraindication to IV steroid therapy with or without radiation therapy
	• Covered for patients with neuromyelitis optica spectrum disorder (NMOSD) who meet the following criteria:
	  ○ Prescribed by or in consultation with a Multiple sclerosis specialist or Neurologist
	  ○ Age ≥18 years
	  ○ AQP4 antibody seropositive
	• Not covered under the medical benefit for other indications (hospital, clinic, or home infusion)
	  ○ Note: may be covered under the pharmacy benefit
	
	Quantity Limit:
	• **800 mg every 4 weeks**
	
	ICD-10 codes for diagnoses allowed under medical benefit (pending criteria review)
	1) E05.0, E05.1, E05.2, E05.3, E05.4, E05.8, E05.9 E07.0, E07.8, E07.9
	2) G36.0
	3) D89.831, D89.832, D89.833, D89.834, D89.835, D89.836, D89.837, D89.838, D89.839

DRUG NAME	COVERAGE CRITERIA
	Note: Must be administered in a non-hospital setting. See site of care prior authorization criteria for coverage criteria in a hospital outpatient setting and exceptions for new starts. Site of care restriction does NOT apply to patients less than 13 years old.
IVIG	1) Immune thrombocytopenic purpura 2) Primary humoral immunodeficiency 3) Kawasaki syndrome 4) Guillian-Barre syndrome (polyradiculoneuropathy) 5) Myasthenia gravis: approved for patients who are in myasthenic crisis and unresponsive to other immunosuppressive therapy (e.g., azathioprine, cyclosporine, methotrexate, mycophenolate mofetil, cyclophosphamide) and high dose steroids 6) Chronic inflammatory demyelinating polyneuropathy (CIDP) 7) Multifocal motor neuropathy (MMN) 8) B-cell chronic lymphocytic leukemia or multiple myeloma patients who have had 3 life-threatening infections within 1 year 9) In-network benefit available only for Kaiser Washington Home Infusion if administered in the home infusion setting. Please submit a referral to KP Specialty Home Infusion at 206-326-2139. **Quantity limit:** • **150,000 mg maximum daily dose** ICD-10 code needed to auto-auth with specific code 1) D69.3 2) D80.1, D80.2, D80.3, D80.4, D80.0, D80.5, D83.0, D83.2, D83.8, D83.9, D80.7 3) M30.3 4) G61.0 5) G70.00, G70.01 6) G61.81 7) C91.10, C91.90, C91.11, C91.Z2 8) C90.00, C90.01, C90.02 Note: Must be administered in a non-hospital setting. See site of care prior authorization criteria for coverage criteria in a hospital outpatient setting and exceptions for new starts. Site of care restriction does NOT apply to patients less than 13 years old.

Additional Information

A complete list of office-administered injectable drugs requiring prior authorization can be found on the Kaiser Permanente provider website at https://wa-provider.kaiserpermanente.org/ under the "Authorization & Clinical Review" section. Using the website search feature, search for the term "Non-Medicare Injectable Drugs Requiring Prior Authorization."

To request prior authorization review, please use the Referral Request online form located on the Kaiser Permanente provider website listed above. You can also fax your request to the Review Services department toll-free at 1-888-282-2685.

Thank you for the care you provide to our members, your patients. If you have any questions about this process, please call Review Services at 1-800-289-1363, Monday – Friday from 8 a.m. to 5 p.m. After business hours, please leave a voice message with your contact information. Messages received after normal business hours are returned on the next business day.

Sincerely,

Peter Barkett, MD, Chair
Pharmacy & Therapeutics Committee