## Clinical Policy: Certolizumab (Cimzia)

Reference Number: PA.CHIP.PHAR.247
Effective Date: 01/2026
Last Review Date: 10/2025

**Description**
Certolizumab (Cimzia®) is a tumor necrosis factor (TNF) blocker.

**FDA Approved Indication(s)**
Cimzia is indicated for:

- Reducing signs and symptoms of Crohn's disease (CD) and maintaining clinical response in adult patients with moderately to severely active disease who have had an inadequate response to conventional therapy
- Treatment of adults with moderately to severely active rheumatoid arthritis (RA)
- Treatment of adult patients with active psoriatic arthritis (PsA)
- Treatment of adults with active ankylosing spondylitis (AS)
- Treatment of adults with active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation
- Treatment of adults with moderate-to-severe plaque psoriasis (PsO) who are candidates for systemic therapy or phototherapy
- Treatment of active polyarticular juvenile idiopathic arthritis (pJIA) in patients 2 years of age and older

**Policy/Criteria**
*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that the member has met all approval criteria.*

It is the policy of PA Health & Wellness® that Certolizumab (Cimzia) is **medically necessary** when the following criteria are met:

**I. Initial Approval Criteria**

**A. Axial Spondylitis** (must meet all)**:**

1. Diagnosis of AS or nr-axSpA;
2. Prescribed by or in consultation with a rheumatologist;
3. Age ≥ 18 years;
4. Failure of at least TWO non-steroidal anti-inflammatory drugs (NSAIDs) at up to maximally indicated doses, each used for ≥ 4 weeks unless clinically significant adverse effects are experienced or all are contraindicated;
5. For AS, member meets ALL* of the following, each used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated (a and b, *see Appendix D*):
   a. Failure of one adalimumab product (e.g., *Hadlima™, Simlandi®, Yusimry™, adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, and adalimumab-fkjp are preferred*), unless the member has had a history of failure of two TNF blockers;
   b. If member has not responded or is intolerant to one or more TNF blockers, Xeljanz®/Xeljanz XR®, unless member has cardiovascular risk and benefits do not outweigh the risk of treatment;

   **Prior authorization may be required for adalimumab products and Xeljanz/Xeljanz XR*

6. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
7. Dose does not exceed 400 mg at weeks 0, 2, and 4, followed by maintenance dose of 400 mg every 4 weeks.

**Approval duration: 6 months**

**B. Crohn's Disease** (must meet all)**:**

1. Diagnosis of CD;
2. Prescribed by or in consultation with a gastroenterologist;
3. Age ≥ 18 years;
4. Member meets one of the following (a or b):
   a. Failure of a ≥ 3 consecutive month trial of at least ONE immunomodulator (e.g., azathioprine, 6-mercaptopurine [6-MP], methotrexate [MTX]) at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated;
   b. Medical justification supports inability to use immunomodulators (*see Appendix D*);
5. Member meets ONE of the following, unless contraindicated or clinically significant adverse effects are experienced (a or b, *see Appendix D*):
   a. Failure of a ≥ 3 consecutive month trial of one adalimumab* product (e.g., *Hadlima, Simlandi, Yusimry, adalimumab-aaty, adalimumab-adaz, adalimumab- adbm, and adalimumab-fkjp are preferred*);
   b. History of failure of two TNF blockers;
   **Prior authorization may be required for adalimumab products*
6. Failure of a ≥ 3 consecutive month trial of one ustekinumab product (e.g. *Otulfi®, Pyzchiva® (branded), Steqeyma®, Yesintek™ are preferred*), unless clinically significant adverse effects are experienced or all are contraindicated;
   **Prior authorization may be required for ustekinumab products*
7. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
8. Dose does not exceed 400 mg at weeks 0, 2, and 4, followed by maintenance dose of 400 mg every 4 weeks.

**Approval duration: 6 months**

**C. Plaque Psoriasis** (must meet all)**:**

1. Diagnosis of moderate-to-severe PsO as evidenced by involvement of one of the following (a or b):
   a. ≥ 3% of total body surface area;
   b. Hands, feet, scalp, face, or genital area;
2. Prescribed by or in consultation with a dermatologist or rheumatologist;
3. Age ≥ 18 years;
4. Member meets one of the following (a, b or c):
   a. Failure of a ≥ 3 consecutive month trial of MTX at up to maximally indicated doses;
   b. Member has intolerance or contraindication to MTX (*see Appendix D*), and failure of a ≥ 3 consecutive month trial of cyclosporine or acitretin at up to maximally indicated doses, unless clinically significant adverse effects are experienced or both are contraindicated;

c. Member has intolerance or contraindication to MTX, cyclosporine, and acitretin, and failure of phototherapy, unless contraindicated or clinically significant adverse effects are experienced;

5. Member meets ONE of the following, unless contraindicated or clinically significant adverse effects are experienced (a or b, *see Appendix D*):
   a. Failure of a ≥ 3 consecutive month trial of one adalimumab* product (e.g., *Hadlima, Simlandi, Yusimry, adalimumab-aaty, adalimumab-adaz, adalimumab- adbm, and adalimumab-fkjp are preferred*);
   b. History of failure of two TNF blockers;

   **Prior authorization may be required for adalimumab products*
6. Failure of a ≥ 3 consecutive month trial of one ustekinumab product (e.g. *Otulfi®, Pyzchiva® (branded), Steqeyma®, Yesintek™ are preferred*), unless clinically significant adverse effects are experienced or all are contraindicated;
   **Prior authorization may be required for ustekinumab products*
7. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
8. Dose does not exceed 400 mg every 2 weeks.

**Approval duration: 6 months**

**D. Psoriatic Arthritis** (must meet all)**:**
1. Diagnosis of PsA;
2. Prescribed by or in consultation with a dermatologist or rheumatologist;
3. Age ≥ 18 years;
4. Failure of ALL* of the following, each used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated (a, b, c, and d, *see Appendix D*):
   a. One adalimumab product (e.g., *Hadlima, Simlandi, Yusimry, adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, and adalimumab-fkjp are preferred*), unless the member has had a history of failure of two TNF blockers;
   b. Otezla®;
   c. One ustekinumab product (e.g. *Otulfi®, Pyzchiva® (branded), Steqeyma®, Yesintek™ are preferred*);
   d. If member has not responded or is intolerant to one or more TNF blockers, Xeljanz®/Xeljanz XR®, unless member has cardiovascular risk and benefits do not outweigh the risk of treatment;

   **Prior authorization may be required for adalimumab products, Otezla, ustekinumab products, and Xeljanz/Xeljanz XR*
5. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
6. Dose does not exceed 400 mg at weeks 0, 2, and 4, followed by maintenance dose of 400 mg every 4 weeks.

**Approval duration: 6 months**

**E. Rheumatoid Arthritis** (must meet all)**:**
1. Diagnosis of RA per American College of Rheumatology (ACR) criteria (*see Appendix E*);
2. Prescribed by or in consultation with a rheumatologist;
3. Age ≥ 18 years;

4. Member meets one of the following (a or b):
   a. Failure of a ≥ 3 consecutive month trial of MTX at up to maximally indicated doses;
   b. Member has intolerance or contraindication to MTX (*see Appendix D*), and failure of a ≥ 3 consecutive month trial of at least ONE conventional disease-modifying anti-rheumatic drug [DMARD] (e.g., sulfasalazine, leflunomide, hydroxychloroquine) at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated;
5. Failure of ALL* of the following, each used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated (a, b, and c, *see Appendix D*):
   a. One adalimumab product (e.g. *Hadlima, Simlandi, Yusimry, adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, and adalimumab-fkjp are preferred*), unless the member has had a history of failure of two TNF blockers;
   b. Actemra®;
   c. If member has not responded or is intolerant to one or more TNF blockers, Xeljanz/Xeljanz XR, unless member has cardiovascular risk and benefits do not outweigh the risk of treatment;

   **Prior authorization may be required for adalimumab products, Actemra, and Xeljanz/Xeljanz XR*
6. Documentation of one of the following baseline assessment scores (a or b):
   a. Clinical disease activity index (CDAI) score (*see Appendix F*);
   b. Routine assessment of patient index data 3 (RAPID3) score (*see Appendix G)*;
7. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
8. Dose does not exceed 400 mg at weeks 0, 2, and 4, followed by maintenance dose of 400 mg every 4 weeks.

**Approval duration: 6 months**

**F. Polyarticular Juvenile Idiopathic Arthritis**(must meet all)**:**
1. Diagnosis of PJIA* as evidenced by ≥ 5 joints with active arthritis;
   **Overlap of diagnosis exists in children with JIA and non-systemic polyarthritis, which may include children from ILAR JIA categories of enthesitis-related arthritis*
2. Prescribed by or in consultation with a rheumatologist;
3. Age ≥ 2 years;
4. Member meets one of the following (a, b, c, or d):
   a. Failure of a ≥ 3 consecutive month trial of MTX at up to maximally indicated doses;
   b. Member has intolerance or contraindication to MTX (*see Appendix D*), and failure of a ≥ 3 consecutive month trial of leflunomide or sulfasalazine at up to maximally indicated doses, unless clinically significant adverse effects are experienced or both are contraindicated;
   c. For sacroiliitis/axial spine involvement (i.e., spine, hip), failure of a ≥ 4 week trial of an NSAID at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
   d. Documentation of high disease activity;
5. Failure of ALL* of the following, each used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated (a, b, and

c, *see Appendix D*):
   a. ONE adalimumab product (e.g. *Hadlima, Simlandi, Yusimry, adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, and adalimumab-fkjp are preferred*), unless the member has had a history of failure of two TNF blockers;
   b. Actemra;
   c. If member has not responded or is intolerant to one or more TNF blockers, Xeljanz, unless member has cardiovascular risk and benefits do not outweigh the risk of treatment;

**Prior authorization may be required for adalimumab products, Actemra,, and Xeljanz*

6. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
7. Dose does not exceed one of the following (a, b, or c):
   a. Weight 10 kg (22 lbs) to < 20 kg (44 lbs) (both i and ii):
      i. Loading dose: 100 mg at week 0, 2, and 4;
      ii. Maintenance dose: 50 mg at week 6 and every 2 weeks thereafter;
   b. Weight 20 kg (44 lbs) to < 40 kg (88 lbs) (both i and ii):
      i. Loading dose: 200 mg at week 0, 2, and 4;
      ii. Maintenance dose: 100 mg at week 6 and every 2 weeks thereafter;
   c. Weight ≥ 40 kg (88 lbs) (both i and ii):
      i. Loading dose: 400 mg at week 0, 2, and 4;
      ii. Maintenance dose: 200 mg at week 6 and every 2 weeks thereafter.

**Approval duration: 6 months**

**G. Other diagnoses/indications** (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

**II.Continued Therapy**

**A. All Indications in Section I** (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Fidelis benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member meets one of the following (a or b):
   a. For RA: Member is responding positively to therapy as evidenced by one of the following (i or ii):
      i. A decrease in CDAI (*see Appendix F*) or RAPID3 (*see Appendix G*) score

from baseline;
ii. Medical justification stating inability to conduct CDAI re-assessment, and submission of RAPID3 score associated with disease severity that is similar to initial CDAI assessment or improved;

b. For all other indications: Member is responding positively to therapy;

3. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
4. If request is for a dose increase, new dose does not exceed one of the following (a, b, or c):
   a. For CD, RA, PsA, AS, nr-axSpA: 400 mg every 4 weeks;
   b. For pJIA: 200 mg every 2 weeks;
   c. For PsO: 400 mg every 2 weeks.

**Approval duration: 12 months**

**B. Other diagnoses/indications** (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

## III.Diagnoses/Indications for which coverage is NOT authorized:

**A.** Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.PMN.53 for Medicaid or evidence of coverage documents;

**B.** Combination use with biological disease-modifying antirheumatic drugs (bDMARDs) or potent immunosuppressants, including but not limited to any tumor necrosis factor (TNF) antagonists [e.g., Cimzia®, Enbrel®, Humira® and its biosimilars, Remicade® and its biosimilars, Simponi®], interleukin agents [e.g., Actemra® (IL-6RA) and its biosimilars, Arcalyst® (IL-1 blocker), Bimzelx® (IL-17A and F antagonist), Cosentyx® (IL-17A inhibitor), Ilaris® (IL-1 blocker), Ilumya™ (IL-23 inhibitor), Kevzara® (IL-6RA), Kineret® (IL-1RA), Omvoh™ (IL-23 antagonist), Siliq™ (IL-17RA), Skyrizi™ (IL-23 inhibitor), Spevigo® (IL-36 antagonist), Stelara® (IL-12/23 inhibitor) and its biosimilars, Taltz® (IL-17A inhibitor), Tremfya® (IL-23 inhibitor)], Janus kinase inhibitors (JAKi) [e.g., Cibinqo™, Olumiant™, Rinvoq™, Xeljanz®/Xeljanz® XR,], anti-CD20 monoclonal antibodies [Rituxan® and its biosimilars], selective co-stimulation modulators [Orencia®], integrin receptor antagonists [Entyvio®], tyrosine kinase 2 inhibitors [Sotyktu™], and sphingosine 1-phosphate receptor modulator [Velsipity™] because of the additive immunosuppression, increased risk of neutropenia, as well as increased risk of serious infections.

## IV.Appendices/General Information

*Appendix A: Abbreviation/Acronym Key*

6-MP: 6-mercaptopurine

AS: ankylosing spondylitis
CD: Crohn's disease
CDAI: clinical disease activity index
cJADAS-10: 10-joint clinical juvenile arthritis disease activity score
DMARD: disease-modifying antirheumatic drug
FDA: Food and Drug Administration
JAKi: Janus kinase inhibitors
MTX: methotrexate
nr-axSpA: non-radiographic axial spondyloarthritis
NSAID: non-steroidal anti-inflammatory drug
pJIA: polyarticular juvenile idiopathic arthritis
PsA: psoriatic arthritis
PsO: plaque psoriasis
RA: rheumatoid arthritis
RAPID3: routine assessment of patient index 3
TNF: tumor necrosis factor

*Appendix B: Therapeutic Alternatives*
*This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.*

| Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose |
|---|---|---|
| acitretin (Soriatane®) | **PsO**<br>25 or 50 mg PO QD | 50 mg/day |
| azathioprine (Azasan®, Imuran®) | **RA**<br>1 mg/kg/day PO QD or divided BID<br><br>**CD*** | 2.5 mg/kg/day |

| Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose |
|---|---|---|
| | 1.5 – 2.5 mg/kg/day PO | |
| corticosteroids | **CD*** <br>prednisone 40 mg – 60 mg PO QD for 1 to 2 weeks, then taper daily dose by 5 mg weekly until 20 mg PO QD, and then continue with 2.5 – 5 mg decrements weekly or IV 50 – 100 mg Q6H for 1 week <br><br>budesonide (Entocort EC®) 6 – 9 mg PO QD | Various |
| Cuprimine® (d-penicillamine) | **RA*** <br>Initial dose: <br>125 or 250 mg PO QD <br>Maintenance dose: <br>500 – 750 mg/day PO QD | 1,500 mg/day |
| cyclosporine (Sandimmune®, Neoral®) | **RA, PsO** <br>2.5 – 4 mg/kg/day PO divided BID | 4 mg/kg/day |
| hydroxychloroquine (Plaquenil®) | **RA*** <br>Initial dose: <br>400 – 600 mg/day PO QD <br>Maintenance dose: <br>200 – 400 mg/day PO QD | 600 mg/day |
| leflunomide (Arava®) | **PJIA*** <br>Weight < 20 kg: 10 mg every other day <br>Weight 20 - 40 kg: 10 mg/day <br>Weight > 40 kg: 20 mg/day <br><br>**RA** <br>100 mg PO QD for 3 days, then 20 mg PO QD | 20 mg/day |
| 6-mercaptopurine (Purixan®) | **CD*** <br>50 mg PO QD or 0.75 – 1.5 mg/kg/day PO | 1.5 mg/kg/day |
| methotrexate (Trexall®, Otrexup™, Rasuvo®, RediTrex®, Rheumatrex®, Jylamvo®) | **CD*** <br>15 – 25 mg/week IM or SC <br><br>**PJIA*** <br>10 – 20 mg/m$^2$/week PO, SC, or IM <br><br>**RA** <br>7.5 mg/week PO, SC, or IM or 2.5 mg PO Q12 hr for 3 doses/week <br><br>**PsO** | 30 mg/week |

| Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose |
|---|---|---|
| | 10 to 25 mg/week IM, SC or PO or 2.5 mg PO Q12 hr for 3 doses/week | |
| NSAIDs (e.g., indomethacin, ibuprofen, naproxen, celecoxib) | **AS, nr-axSpA**<br>Varies | Varies |
| Pentasa® (mesalamine) | **CD**<br>1,000 mg PO QID | 4 g/day |
| Ridaura® (auranofin) | **RA**<br>6 mg PO QD or 3 mg PO BID | 9 mg/day (3 mg TID) |
| sulfasalazine (Azulfidine®) | **PJIA***<br>30-50 mg/kg/day PO divided BID<br><br>**RA**<br>Initial dose:<br>500 mg to 1,000 mg PO QD for the first week. Increase the daily dose by 500 mg each week up to a maintenance dose of 2 g/day.<br>Maintenance dose:<br>2 g/day PO in divided doses | PJIA: 2 g/day<br><br>RA: 3 g/day |
| tacrolimus (Prograf®) | **CD***<br>0.27 mg/kg/day PO in divided doses or 0.15 – 0.29 mg/kg/day PO | N/A |
| Actemra® (tocilizumab) | **pJIA**<br>• Weight < 30 kg: 10 mg/kg IV every 4 weeks or 162 mg SC every 3 weeks<br>• Weight ≥ 30 kg: 8 mg/kg IV every 4 weeks or 162 mg SC every 2 weeks<br><br>**RA**<br>IV: 4 mg/kg every 4 weeks followed by an increase to 8 mg/kg every 4 weeks based on clinical response<br><br>SC:<br>Weight < 100 kg: 162 mg SC every other week, followed by an increase to every week based on clinical response<br>Weight ≥ 100 kg: 162 mg SC every week | PJIA:<br>• IV: 10 mg/kg every 4 weeks<br>• SC: 162 mg every 2 weeks<br><br>RA:<br>• IV: 800 mg every 4 weeks<br>• SC: 162 mg every week |
| Hadlima (adalimumab-bwwd), Simlandi | **RA, AS, PsA**<br>40 mg SC every other week | 40 mg every other week |

| Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose |
|---|---|---|
| (adalimumab-ryvk), Yusimry (adalimumab-aqvh), adalimumab-aaty (Yuflyma®), adalimumab-adaz (Hyrimoz®), adalimumab-fkjp (Hulio®), adalimumab-adbm (Cyltezo®) | **PsO**<br>Initial dose:<br>80 mg SC<br><br>Maintenance dose:<br>40 mg SC every other week starting one week after initial dose<br><br>**CD**<br>Initial dose:<br>160 mg SC on Day 1, then 80 mg SC on Day 15<br><br>Maintenance dose:<br>40 mg SC every other week starting on Day 29<br><br>**pJIA**<br>**Cyltezo, Hadlima, Hyrimoz:**<br>Weight 10 kg (22 lbs) to < 15 kg (33 lbs): 10 mg SC every other week<br><br>**Cyltezo, Hadlima, Hulio, Yuflyma:**<br>Weight 15 kg (33 lbs) to < 30 kg (66 lbs): 20 mg SC every other week<br><br>**Cyltezo, Hadlima, Hulio, Hyrimoz, Simlandi, Yuflyma, Yusimry:**<br>Weight ≥ 30 kg (66 lbs): 40 mg SC every other week | |
| Otezla® (apremilast) | **PsA**<br>Initial dose:<br>Day 1: 10 mg PO QAM<br>Day 2: 10 mg PO QAM and 10 mg PO QPM<br>Day 3: 10 mg PO QAM and 20 mg PO QPM<br>Day 4: 20 mg PO QAM and 20 mg PO QPM<br>Day 5: 20 mg PO QAM and 30 mg PO QPM<br><br>Maintenance dose:<br>Day 6 and thereafter: 30 mg PO BID | 60 mg/day |
| Otulfi® (ustekinumab-aauz), Pyzchiva® (ustekinumab-ttwe), | **CD**<br>Weight based dosing IV at initial dose:<br>Weight ≤ 55 kg: 260 mg<br>Weight > 55 kg to 85 kg: 390 mg | CD:<br>90 mg every 8 weeks |

| Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose |
|---|---|---|
| Steqeyma® (ustekinumab-stba), Yesintek™ (ustekinumab-kfce) | Weight > 85 kg: 520 mg<br><br>Maintenance dose:<br>90 mg SC every 8 weeks<br><br>**PsO**<br>Weight based dosing SC at weeks 0 and 4, followed by maintenance dose every 12 weeks<br><br>*Adult:*<br>Weight ≤ 100 kg: 45 mg<br>Weight > 100 kg: 90 mg<br><br>*Pediatrics (age 6 years to 17 years):*<br>**Otulfi, Pyzchiva, Yesintek:**<br>Weight < 60 kg: 0.75 mg/kg<br><br>**Otulfi, Pyzchiva, Steqeyma, Yesintek:**<br>Weight 60 to 100 kg: 45 mg<br>Weight > 100 kg: 90 mg<br><br>**PsA**<br>Weight based dosing SC at weeks 0 and 4, followed by maintenance dose every 12 weeks<br><br>*Adult:*<br>45 mg SC at weeks 0 and 4, followed by 45 mg every 12 weeks<br><br>*Pediatrics (age 6 years to 17 years):*<br>Weight based dosing SC at weeks 0 and 4, then every 12 weeks thereafter<br><br>**Otulfi, Pyzchiva, Yesintek:**<br>Weight < 60 kg: 0.75 mg/kg<br><br>**Otulfi, Pyzchiva, Steqeyma, Yesintek:**<br>Weight ≥ 60 kg: 45 mg | PsO:<br>90 every 12 weeks<br><br>PsA:<br>45 mg every 12 weeks |
| Taltz® (ixekizumab) | **PsA, AS**<br>Initial dose: 160 mg (two 80 mg injections) SC at week 0 | 80 mg every 4 weeks |

| Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose |
|---|---|---|
| | Maintenance dose:<br>80 mg SC every 4 weeks<br><br>**nr-axSpA**<br>80 mg SC every 4 weeks<br><br>**PsO**<br>Initial dose:<br>160 mg (two 80 mg injections) SC at week 0, then 80 mg SC at weeks 2, 4, 6, 8, 10, and 12<br>Maintenance dose:<br>80 mg SC every 4 weeks | |
| Xeljanz®<br>(tofacitinib) | **PsA, RA**<br>5 mg PO BID<br><br>**pJIA**<br>• 10 kg ≤ body weight < 20 kg: 3.2 mg (3.2 mL oral solution) PO BID<br>• 20 kg ≤ body weight < 40 kg: 4 mg (4 mL oral solution) PO BID<br>• Body weight ≥ 40 kg: 5 mg PO BID | 10 mg/day |
| Xeljanz XR®<br>(tofacitinib extended-release) | **PsA, RA**<br>11 mg PO QD | 11 mg/day |

*sTherapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.*
**Off-label*

*Appendix C: Contraindications/Boxed Warnings*

- Contraindication(s): none reported
- Boxed warning(s):
  - There is an increased risk of serious infections leading to hospitalization or death including tuberculosis (TB), bacterial sepsis, invasive fungal infections (such as histoplasmosis), and infections due to other opportunistic pathogens.
  - Cimzia should be discontinued if a patient develops a serious infection or sepsis.
  - Perform test for latent TB; if positive, start treatment for TB prior to starting Cimzia
  - Monitor all patients for active TB during treatment, even if initial latent TB test is negative
  - Lymphoma and other malignancies have been observed.
  - Epstein Barr Virus-associated post-transplant lymphoproliferative disorder has been observed.

*Appendix D: General Information*

- Definition of failure of MTX or DMARDs
  - Child-bearing age is not considered a contraindication for use of MTX. Each drug has

risks in pregnancy. An educated patient and family planning would allow use of MTX in patients who have no intention of immediate pregnancy.
    - Social use of alcohol is not considered a contraindication for use of MTX. MTX may only be contraindicated if patients choose to drink over 14 units of alcohol per week. However, excessive alcohol drinking can lead to worsening of the condition, so patients who are serious about clinical response to therapy should refrain from excessive alcohol consumption.
- Examples of positive response to therapy may include, but are not limited to:
    - Reduction in joint pain/swelling/tenderness
    - Improvement in ESR/CRP levels
    - Improvements in activities of daily living
- The following may be considered for medical justification supporting inability to use an immunomodulator for Crohn's disease:
    - Inability to induce short-term symptomatic remission with a 3-month trial of systemic glucocorticoids
    - High-risk factors for intestinal complications may include:
        - Initial extensive ileal, ileocolonic, or proximal GI involvement
        - Initial extensive perianal/severe rectal disease
        - Fistulizing disease (e.g., perianal, enterocutaneous, and rectovaginal fistulas)
        - Deep ulcerations
        - Penetrating, structuring or stenosis disease and/or phenotype
        - Intestinal obstruction or abscess
    - High risk factors for postoperative recurrence may include:
        - Less than 10 years duration between time of diagnosis and surgery
        - Disease location in the ileum and colon
        - Perianal fistula
        - Prior history of surgical resection
        - Use of corticosteroids prior to surgery
- TNF blockers:
    - Etanercept (Enbrel®), adalimumab (Humira®) and its biosimilars, infliximab (Remicade®) and its biosimilars (Avsola™, Renflexis™, Inflectra®), certolizumab pegol (Cimzia®), and golimumab (Simponi®, Simponi Aria®)

*Appendix E: The 2010 ACR Classification Criteria for RA*
Add score of categories A through D; a score of ≥ 6 out of 10 is needed for classification of a patient as having definite RA.

| | | |
|---|---|---|
| **A** | **Joint involvement** | Score |
| | 1 large joint | 0 |
| | 2-10 large joints | 1 |
| | 1-3 small joints (with or without involvement of large joints) | 2 |
| | 4-10 small joints (with or without involvement of large joints) | 3 |
| | > 10 joints (at least one small joint) | 5 |
| **B** | **Serology (at least one test result is needed for classification)** | |
| | Negative rheumatoid factor (RF) *and* negative anti-citrullinated protein antibody (ACPA) | 0 |

| | | |
|---|---|---|
| | Low positive RF *or* low positive ACPA<br>* *Low: < 3 x upper limit of normal* | 2 |
| | High positive RF *or* high positive ACPA<br>* *High: ≥ 3 x upper limit of normal* | 3 |
| **C** | **Acute phase reactants (at least one test result is needed for classification)** | |
| | Normal C-reactive protein (CRP) and normal erythrocyte sedimentation rate (ESR) | 0 |
| | Abnormal CRP or abnormal ESR | 1 |
| **D** | **Duration of symptoms** | |
| | < 6 weeks | 0 |
| | ≥ 6 weeks | 1 |

*Appendix F: Clinical Disease Activity Index (CDAI) Score*
The Clinical Disease Activity Index (CDAI) is a composite index for assessing disease activity in RA. CDAI is based on the simple summation of the count of swollen/tender joint count of 28 joints along with patient and physician global assessment on VAS (0–10 cm) Scale for estimating disease activity. The CDAI score ranges from 0 to 76.

| CDAI Score | Disease state interpretation |
|---|---|
| ≤ 2.8 | Remission |
| > 2.8 to ≤ 10 | Low disease activity |
| > 10 to ≤ 22 | Moderate disease activity |
| > 22 | High disease activity |

*Appendix G: Routine Assessment of Patient Index Data 3 (RAPID3) Score*
The Routine Assessment of Patient Index Data 3 (RAPID3) is a pooled index of the three patient-reported ACR core data set measures: function, pain, and patient global estimate of status. Each of the individual measures is scored 0 – 10, and the maximum achievable score is 30.

| RAPID3 Score | Disease state interpretation |
|---|---|
| ≤ 3 | Remission |
| 3.1 to 6 | Low disease activity |
| 6.1 to 12 | Moderate disease activity |
| > 12 | High disease activity |

*Appendix H: Polyarticular Juvenile Idiopathic Arthritis Disease Activity*
According to 2019 American College of Rheumatology/Arthritis Foundation Guideline for the Treatment of Juvenile Idiopathic Arthritis, disease activity (moderate/high and low) as defined by the clinical Juvenile Disease Activity score based on 10 joints (cJADAS-10) is provided as a general parameter and should be interpreted within the clinical context.
The cJADAS10 is a continuous disease activity score specific to JIA and consisting of the following three parameters totaling a maximum of 30 points:

- Physician's global assessment of disease activity measured on a 0-10 visual analog scale (VAS), where 0 = no activity and 10 = maximum activity;
- Parent global assessment of well-being measured on a 0-10 VAS, where 0 = very well and 10 = very poor;
    - Count of joints with active disease to a maximum count of 10 active joints*

**ACR definition of active joint: presence of swelling (not due to currently inactive synovitis or to bony enlargement) or, if swelling is not present, limitation of motion accompanied by pain, tenderness, or both*

| cJADAS-10 | Disease state interpretation |
|---|---|
| ≤ 1 | Inactive disease |
| 1.1 to 2.5 | Low disease activity |
| 2.51 to 8.5 | Moderate disease activity |
| > 8.5 | High disease activity |

## V.Dosage and Administration

| Indication | Dosing Regimen | Maximum Dose |
|---|---|---|
| CD | Initial dose: 400 mg SC at 0, 2, and 4 weeks<br>Maintenance dose: 400 mg SC every 4 weeks | 400 mg every 4 weeks |
| RA, PsA, AS, nr-axSpA | Initial dose: 400 mg SC at 0, 2, and 4 weeks<br>Maintenance dose: 200 mg SC every other week (or 400 mg SC every 4 weeks) | 400 mg every 4 weeks |
| PsO | 400 mg SC every other week. For some patients (with body weight ≤ 90 kg), a dose of 400 mg SC at 0, 2 and 4 weeks, followed by 200 mg SC every other week may be considered. | 400 mg every other week |
| pJIA | Loading dose:<br>• Weight 10 kg (22 lbs) to < 20 kg (44 lbs): 100 mg SC at week 0, 2, and 4<br>• Weight 20 kg (44 lbs) to < 40 kg (88 lbs): 200 mg SC at week 0, 2, and 4<br>• Weight ≥ 40 kg (88 lbs): 400 mg SC at week 0, 2, and 4<br><br>Maintenance dose:<br>• Weight 10 kg (22 lbs) to < 20 kg (44 lbs): 50 mg SC at week 6 and every 2 weeks thereafter<br>• Weight 20 kg (44 lbs) to < 40 kg (88 lbs): 100 mg SC at week 6 and every 2 weeks thereafter<br>• Weight ≥ 40 kg (88 lbs): 200 mg SC at week 6 and every 2 weeks thereafter | 200 mg every 2 weeks |

## VI.Product Availability

- Single-use vial: 200 mg
- Single-use prefilled syringe: 200 mg/mL

## VII. References

1. Cimzia Prescribing Information. Smyrna, GA: UCB, Inc.; September 2024. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/125160s275lbl.pdf. Accessed February 27, 2025.
2. Fraenkel L, Bathon JM, Engglanд BR, et al. 2021 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. Arthritis Care & Research. 2021; 73(7):924-939. DOI 10.1002/acr.24596.
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;80:1029-72. Doi:10.1016/j.aad.201811.057.
4. Singh JA, Guyatt G, Ogdie A, et al. 2018 American College of Rheumatology/National Psoriasis Foundation Guideline for the treatment of psoriatic arthritis. *American College of Rheumatology*. 2019; 71(1):5-32. Doi: 10.1002/art.40726.
5. Smolen JS, Landewe RB, Dergstra SA, et al. 2022 update of the EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs. Arthritis Rheumatology. 2023 January; 32:3-18. DOI:10.1136/ard- 2022-223356.
6. Gossec L, Baraliakos X, Kerschbaumer A, et al. EULAR recommendations for the management of psoriatic arthritis with pharmacological therapies: 2019 update. *Ann Rheum Dis.* 2020;79:700–712. Doi:10.1136/annrheumdis-2020-217159.
7. Ward MM, Deodhar A, Gensler L, et al. 2019 Update of the American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network recommendations for the treatment of anklyosing spondylitis and nonradiographic axial spondyloarthritis. *Arthritis & Rheumatology*. 2019; 71(10):1599-1613. DOI 10.1002/ART.41042.
8. Ramiro S, Nikiphorou E, Sepriano A, et al. ASAS-EULAR recommendations for the management of axial spondyloarthritis: 2022 update. Ann Rheum Dis. 2023 Jan;82(1):19-34. doi: 10.1136/ard-2022-223296.
9. 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; 160:2496-2508. https://doi.org/10.1053/j.gastro.2021.04.022.
10. Lichtenstein GR, Loftus EV, Isaacs KL et al. ACG Clinical Guideline: Management of Crohn's Disease in Adults. Am J Gastroenterol. 2018 Apr;113(4):481-517. doi: 10.1038/ajg.2018.27.
11. Clowse MEB, Forger F, Hwang C, et al. Minimal to no transfer of certolizumab pegol into breast milk: results from CRADLE, a prospective, postmarketing, multicenter, pharmacokinetic study. *Ann Rheum Dis.* 2017;76:1980-1896. Doi:10.1136/annrheumdis- 2017-211384.
12. 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 Care and Research. 2019:71(6):717-734. DOI 10.1002/acr.23870.

**Coding Implications**
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

| HCPCS Codes | Description |
|---|---|
| J0717 | Injection, certolizumab pegol, 1 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered) |

| Reviews, Revisions, and Approvals | Date |
|---|---|
| Policy created | 10/2025 |