BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

PHARMACY COVERAGE GUIDELINE

BIOLOGIC AND IMMUNOLOGICAL AGENTS – ORAL:
CIBINQO™ (abrocitinib)
LITFULO™ (ritlecitinib)
OLUMIANT® (baricitinib)
OTEZLA® (apremilast)
RINVOQ™ (upadacitinib)
SOTYKTU™ (deucravacitinib)
XELJANZ® (tofacitinib)
XELJANZ® XR (tofacitinib)

This Pharmacy Coverage Guideline (PCG):
- Provides information about the reasons, basis, and information sources we use for coverage decisions
- Is not an opinion that a drug (collectively "Service") is clinically appropriate or inappropriate for a patient
- Is not a substitute for a provider's judgment (Provider and patient are responsible for all decisions about appropriateness of care)
- Is subject to all provisions e.g. (benefit coverage, limits, and exclusions) in the member's benefit plan; and
- Is subject to change as new information becomes available.

Scope
- This PCG applies to Commercial and Marketplace plans
- This PCG does not apply to the Federal Employee Program, Medicare Advantage, Medicaid or members of out-of-state Blue Cross and/or Blue Shield Plans

Instructions & Guidance
- To determine whether a member is eligible for the Service, read the entire PCG.
- This PCG is used for FDA approved indications including, but not limited to, a diagnosis and/or treatment with dosing, frequency, and duration.
- Use of a drug outside the FDA approved guidelines, refer to the appropriate Off-Label Use policy.
- The "Criteria" section outlines the factors and information we use to decide if the Service is medically necessary as defined in the Member's benefit plan.
- The "Description" section describes the Service.
- The "Definition" section defines certain words, terms or items within the policy and may include tables and charts.
- The "Resources" section lists the information and materials we considered in developing this PCG
- **We do not accept patient use of samples as evidence of an initial course of treatment, justification for continuation of therapy, or evidence of adequate trial and failure.**
- Information about medications that require prior authorization is available at www.azblue.com/pharmacy. You must fully complete the request form and provide chart notes, lab workup and any other supporting documentation. The prescribing provider must sign the form. Fax the form to BCBSAZ Pharmacy Management at (602) 864-3126 or email it to Pharmacyprecert@azblue.com.

Criteria:

Section A. Applies for all indications and uses:

PHARMACY COVERAGE GUIDELINE

BIOLOGIC AND IMMUNOLOGICAL AGENTS – ORAL

- **Criteria for initial therapy:** Biologic and Immunological Agents is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

1. Prescriber is a physician specializing in or is in consultation with a Rheumatologist, Dermatologist, or Gastroenterologist, depending upon indication or use

2. Age of individual is consistent with the FDA approved product labeling

3. Meets other additional initial criteria per indication or use as described below in Sections B-I below

4. Individual does **NOT** have **ANY** of the following: **(Does not apply for Otezla)**
    a. Evidence of active serious infections including, opportunistic infections, fungal infections, tuberculosis, clinically important localized infections, sepsis, Hepatitis B, or Hepatitis C
        i. Serologic tests for hepatitis B and C (HB surface Ag, anti-HB surface Ab, anti-HB core Ab, and hepatitis C antibody tests) have been done within the previous 12 months
        ii. Screening for latent tuberculosis infection with a tuberculin skin test or blood test has been done and if positive, treatment has been initiated
    b. Concurrent use of live vaccines
    c. Severe hepatic impairment (Child-Pugh Class C)
    d. Renal dysfunction: **(Does not apply for Sotyktu)**
        i. Cibinqo: Estimated glomerular filtration (eGFR) less than 30 mL/min or end-stage renal disease (eGFR less than 15mL/min) including those on renal replacement therapy
        ii. Olumiant: eGFR less than 30 mL/min/1.73m^2
        iii. Rinvoq: End-stage renal disease
    e. Laboratory abnormalities: **(Does not apply for Sotyktu)**
        i. Absolute neutrophil count less than 1,000/mm^3 (**Does not apply for Litfulo)**
        ii. Absolute lymphocytes count less than 500/mm^3
        iii. Hemoglobin of:
            1. Less than 8 g/dL for Cibinqo, Olumiant, & Rinvoq
            2. Less than 9 g/dL for Xeljanz IR, XR, solution
        iv. Platelet count less than 150,000/mm^3 (for Cibinqo)
        v. Platelet count less than 100,000/mm^3 (for Litfulo)
    f. Pregnancy: Rinvoq only

5. There are **NO** FDA-label contraindications

6. There is no concomitant use with biologic immunomodulators or other potent immunosuppressants (e.g., Adbry, Azathioprine, Cyclosporine, Dupixent, Rituximab, Infliximab, Enbrel, Methotrexate, Otezla, Xolair, etc.) or combination use of JAK inhibitors (Cibinqo, Olumiant, Rinvoq, Xeljanz IR, XR, solution), etc.

7. There are no significant interacting drugs such as:
    a. Litfulo, Otezla, Rinvoq, Xeljanz IR, XR, solution:
        i. Strong inducers or CYP3A4 inducers (e.g., rifampin, phenobarbital, carbamazepine, phenytoin)
    b. Cibinqo:
        i. Moderate to strong inhibitors of both CYP2C19 and CYP2C9 (e.g., abiraterone, efavirenz, voriconazole, fluconazole)
        ii. Strong inducers of CYP2C19 or CYP2C9 (e.g., rifampin, phenobarbital, carbamazepine, phenytoin, aprepitant, primidone, rifapentine)

iii. Antiplatelet drugs: NSAIDS, SSRIs, etc.

- **Criteria for continuation of coverage (renewal request):** Biologic and Immunological Agents is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met **(samples are not considered for continuation of therapy)**:

1. Individual continues to be seen by a physician specializing in or is in consultation with a Rheumatologist, Dermatologist, or Gastroenterologist depending upon indication or use

2. Meets other additional continuation criteria per indication or use as described in Sections B-I below

3. Individual has been adherent with the medication

4. Individual has not developed any significant adverse drug effects that may exclude continued use including: **(Does not apply for Otezla)**
    a. Thrombosis, including deep venous thrombosis, pulmonary embolism, and arterial thrombosis
    b. Myocardial infarction or stroke (**Does not apply for Sotyktu)**
    c. Hematologic Abnormalities (**Does not apply for Sotyktu** [see Definitions section])
    d. **Additional for Olumiant, Rinvoq, Xeljanz IR, XR, solution:** Gastrointestinal perforation with
    e. **Additional for Sotyktu only:** Markedly elevated CPK levels or myopathy, unexplained muscle pain, tenderness, or weakness

5. Individual does **NOT** have **ANY** of the following: **(Does not apply for Otezla)**
    a. Evidence of active serious infections including, opportunistic infections, fungal infections, tuberculosis, clinically important localized infections, sepsis, Hepatitis B, or Hepatitis C
    b. Concurrent use of live vaccines
    c. Severe hepatic impairment (Child-Pugh Class C)
    d. Renal dysfunction: **(Does not apply for Sotyktu)**
        i. Cibinqo: Estimated glomerular filtration (eGFR) less than 30 mL/min or end-stage renal disease (eGFR less than 15mL/min) including those on renal replacement therapy
        ii. Olumiant: eGFR less than 30 mL/min/1.73m^2
        iii. Rinvoq: End-stage renal disease
    e. Laboratory abnormalities: **(Does not apply for Sotyktu)**
        i. Absolute neutrophil count less than 1,000/mm^3 (**Does not apply for Litfulo)**
        ii. Absolute lymphocytes count less than 500/mm^3
        iii. Hemoglobin of:
            1. Less than 8 g/dL for Cibinqo, Olumiant, & Rinvoq
            2. Less than 9 g/dL for Xeljanz IR, XR, solution
        iv. Platelet count less than 150,000/mm^3 (for Cibinqo)
        v. Platelet count less than 100,000/mm3 (for Litfulo)
    f. Pregnancy: **Rinvoq only**

6. There is no concomitant use with biologic immunomodulators or other potent immunosuppressants (e.g., Adbry, azathioprine, cyclosporine, Dupixent, rituximab, infliximab, Enbrel, methotrexate, Otezla, Xolair, etc.) or combination use of JAK inhibitors (Cibinqo, Olumiant, Rinvoq, Xeljanz IR, XR, solution), etc.

7. There are no significant interacting drugs such as:
    a. Litfulo, Otezla, Rinvoq, Xeljanz IR, XR, solution:

i. Strong inducers or CYP3A4 inducers (e.g., rifampin, phenobarbital, carbamazepine, phenytoin)

b. Cibinqo:
   i. Moderate to strong inhibitors of both CYP2C19 and CYP2C9 (e.g., abiraterone, efavirenz, voriconazole, fluconazole)
   ii. Strong inducers of CYP2C19 or CYP2C9 (e.g., rifampin, phenobarbital, carbamazepine, phenytoin, aprepitant, primidone, rifapentine)
   iii. Antiplatelet drugs: NSAIDS, SSRIs, etc.

Section B. Alopecia areata (AA):

- **Criteria for initial therapy:** Biologic and Immunological Agents is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met for alopecia areata (AA):

1. Request is for Litfulo (ritlecitinib), Olumiant (baricitinib)

2. Prescriber is a Dermatologist

3. Meets other initial criteria per indication or use as described in Section A above

4. Individual has a confirmed diagnosis of severe alopecia areata

5. Hair loss is described as **ALL** of the following:
   a. Chronic, relapsing disorder characterized by nonscarring asymptomatic scalp hair loss
   b. Documentation of smooth, circular, or irregular discrete areas of complete scalp hair loss that developed over a period of a few weeks with or without hair loss in other hair-bearing areas, such as the eyebrows, eyelashes, beard, and extremities
   c. Documented scalp hair loss of at least 50% for more than 6 months

6. Individual has documented failure, contraindication per FDA label, intolerance, or not a candidate for **BOTH** the following:
   a. Intralesional corticosteroid injection
   b. High potency topical corticosteroid

Approval duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Biologic and Immunological Agents is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met **(samples are not considered for continuation of therapy)**:

1. Meets other continuation criteria as described in Section A above

2. Individual's condition has responded while on therapy with response defined as the following:
   a. **With first request for continuation**: AT LEAST a 50% recovery of scalp hair

b. **With subsequent request for continuation**: Documented evidence of disease stability and/or improvement with no evidence of disease progression

Renewal Duration: 12 months

Section C. Moderately to severely active Ankylosing Spondylitis (AS):

- **Criteria for initial therapy:** Biologic and Immunological Agents is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met for moderately to severely active ankylosing spondylitis:

1. Request is for **ONE** of the following: Rinvoq, Xeljanz tab, Xeljanz XR

2. Prescriber is a Rheumatologist

3. Meets other initial criteria per indication or use as described in Section A above

4. Clinical and diagnostic imaging evidence of ankylosing spondylitis as indicated by **ALL** of the following:
   a. Back pain of 3 months or more duration with an age of onset of 45 years or younger
   b. Sacroiliitis on x-ray imaging **showing** definitive radiographic evidence of **structural damage** of sacroiliac joints
   c. Spondyloarthritis signs or symptoms as indicated by **ONE or more** of the following:
      i. Arthritis
      ii. Elevated serum C-reactive protein
      iii. Enthesitis (e.g., inflammation of Achilles tendon insertion)
      iv. HLA-B27
      v. Limited chest expansion
      vi. Morning stiffness for one hour or more
   d. A Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) of at least 4 or more, and spinal pain rated as at least 4 or more on a 0 to 10 numerical rating scale

5. Disease activity and treatment scenario as indicated by **ONE or more** of the following:
   a. Axial (spinal) disease
   b. Peripheral arthritis without axial involvement, and failure, contraindication per FDA label, or intolerance of 4 or more months of therapy with sulfasalazine

6. Individual has documented failure, contraindication per FDA label, or intolerance to **TWO or more** different NSAIDs (at maximum recommended doses) over a total period of at least 4 or more weeks of therapy

7. **Rinvoq, Xeljanz tab, Xeljanz XR** for ankylosing spondylitis: Individual has documented failure (used for > 3 consecutive months), contraindication per FDA label, or intolerance to at least **ONE** TNF inhibitor (e.g., Cimzia, Enbrel, Humira, Simponi)

Approval duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Biologic and Immunological Agents is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met **(samples are not considered for continuation of therapy)**:

  1. Meets other continuation criteria as described in Section A above

  2. Individual's condition has responded while on therapy with response defined as the following:
     a. **With first request for continuation**: AT LEAST a 20% improvement in BASDAI (see Definitions section)
     b. **With subsequent request for continuation**: Documented evidence of disease stability and/or improvement with no evidence of disease progression

  Renewal Duration: 12 months

Section D. Moderately to severely active Non-radiographic Axial Spondyloarthritis (nr-axSpA):

- **Criteria for initial therapy:** Biologic and Immunological Agents is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met for moderately to severely active non-radiographic axial spondyloarthritis:

  1. Request is for Rinvoq

  2. Prescriber is a Rheumatologist

  3. Meets other initial criteria per indication or use as described in Section A above

  4. Clinical and diagnostic imaging evidence of ankylosing spondylitis as indicated by **ALL** of the following:
     a. Back pain of 3 months or more duration and age of onset of 45 years or younger
     b. Sacroiliitis on x-ray imaging but **does not show** definitive radiographic evidence of **structural damage** of sacroiliac joints
     c. Spondyloarthritis signs or symptoms as indicated by **ONE or more** of the following:
        i. Arthritis
        ii. Elevated serum C-reactive protein
        iii. Enthesitis (e.g., inflammation of Achilles tendon insertion)
        iv. HLA-B27
        v. Limited chest expansion
        vi. Morning stiffness for one hour or more
     d. A Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) of at least 4 or more, and spinal pain rated as at least 4 or more on a 0 to 10 numerical rating scale

  5. Individual has documented failure, contraindication per FDA label, or intolerance to **TWO or more** different NSAIDs (at maximum recommended doses) over a total period of at least 4 or more weeks of therapy

  6. Individual has documented failure (used for > 3 consecutive months), contraindication per FDA label, or intolerance to at least **ONE** TNF inhibitor (e.g., Cimzia)

Approval duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Biologic and Immunological Agents is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met **(samples are not considered for continuation of therapy)**:

  1. Meets other continuation criteria as described in Section A above

  2. Individual's condition has responded while on therapy with response defined as the following:
     a. **With first request for continuation**: AT LEAST a 20% improvement in BASDAI (see Definitions section)
     b. **With subsequent request for continuation**: Documented evidence of disease stability and/or improvement with no evidence of disease progression

Renewal Duration: 12 months

Section E. Refractory, moderate to severe Atopic Dermatitis:

- **Criteria for initial therapy:** Biologic and Immunological Agents is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met for atopic dermatitis:

  1. Request is for **ONE** of the following: Cibinqo, Rinvoq

  2. Prescriber is a Dermatologist

  3. Meets other initial criteria per indication or use as described in Section A above

  4. Diagnosis of refractory, moderate to severe atopic dermatitis, as indicated by **ALL** of the following: (see Definitions section)
     a. Lesions involve at least 10% of body surface area or involve sensitive areas of the face, head, neck, hands, feet, groin, or intertriginous areas
     b. Weekly averaged Worst Daily Peak Pruritus Numeric Rating Scale (NRS) of at least 3
     c. **ONE** of the following disease intensity measures:
        i. Disease severity defined by an Investigator's Global Assessment (IGA) score of at least 7
        ii. Eczema Area and Severity Index (EASI) score of at least 7

  5. Individual has documented failure (used for > 2 consecutive months), contraindication per FDA label, intolerance, or not a candidate to **ONE** therapy from **EACH** of the following categories:
     a. Topical medium to very high potency corticosteroid
     b. Calcineurin inhibitor (Protopic (tacrolimus) or Elidel (pimecrolimus)
     c. Phosphodiesterase 4 inhibitor (Eucrisa (crisaborole))

  6. Individual has documented failure (used for ≥ 3 consecutive months), contraindication per FDA label, intolerance, or not a candidate to **ONE** systemic drug product, including biologics, for atopic dermatitis (e.g., Dupixent or Adbry)

Approval Duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Biologic and Immunological Agents is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met **(samples are not considered for continuation of therapy)**:

  1. Meets other continuation criteria as described in Section A above

  2. Individual's condition has responded while on therapy with response defined as the following:
     a. **With first request for continuation:** AT LEAST a 20% improvement in IGA or EASI scores (see Definitions section)
     b. **With subsequent request for continuation**:
        i. Documented evidence of efficacy, disease stability and/or improvement
        ii. Achieved and maintains improvement in **ONE** of the following disease intensity scores
            1. IGA of 0 or 1 (clear or almost clear)
            2. EASI-50 (improvement of at least 50% in score from baseline)
        iii. Achieved and maintains a NRS decrease of 4 or more from baseline

Renewal Duration: 12 months

Section F. Moderate to severe chronic Plaque Psoriasis (PP):

- **Criteria for initial therapy:** Biologic and Immunological Agents is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met for moderate to severe chronic plaque psoriasis:

  1. Request is for **ONE** of the following: Otezla, Sotyktu

  2. Prescriber is a Dermatologist

  3. Meets other initial criteria per indication or use as described in Section A above

  4. Diagnosis of moderate to severe plaque psoriasis, as indicated by **ALL** of the following:
     a. Individual is a candidate for photochemotherapy or phototherapy
     b. Plaque psoriasis involves ≥ 10% body surface area (BSA) **or** plaque psoriasis involves < 10% BSA but includes sensitive areas or areas that significantly impact daily function (e.g., palms, soles of feet, head/neck, or genitalia)
     c. A Psoriasis Area and Index (PASI) of at least 10

  5. Individual has documented failure (used for ≥ 3 consecutive months), contraindication per FDA label, or intolerance to a treatment regimen that includes **ALL** of the following:
     a. A trial of least **TWO** topical agents (e.g., anthralin, calcipotriene, coal tars, corticosteroids, tazarotene)
     b. A trial of **ONE** immunosuppressive treatment (e.g., cyclosporine, methotrexate)
     c. A trial of Ultraviolet Light therapy (e.g., Photochemotherapy (i.e., psoralen plus ultraviolet A therapy), Phototherapy (i.e., ultraviolet light therapy), or Excimer laser)

6. For Sotyktu, **BOTH** of the following:
    a. Individual has documented failure (used for ≥ 3 consecutive months), contraindication per FDA label, or intolerance to **THREE** of the following:
        i. Cimzia
        ii. Enbrel
        iii. Humira
        iv. Skyrizi
        v. Stelara
        vi. Tremfya
    b. Individual has documented failure (used for ≥ 3 consecutive months), contraindication per FDA label, or intolerance to Taltz

7. No concomitant use of other systemic therapy

Approval Duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Biologic and Immunological Agents is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met **(samples are not considered for continuation of therapy)**:

1. Meets other continuation criteria as described in Section A above

2. Individual's condition has responded while on therapy with response defined as the following:
    a. **With first request for continuation:** AT LEAST a 20% improvement in PASI (see Definitions section)
    b. **With subsequent request for continuation**: Documented evidence of disease stability and/or improvement with no evidence of disease progression

Renewal Duration: 12 months

Section G. Polyarticular Juvenile Idiopathic Arthritis (pJIA):

- **Criteria for initial therapy:** Biologic and Immunological Agents is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met for polyarticular juvenile idiopathic arthritis:

1. Request is for **ONE** of the following: Xeljanz tab, Xeljanz oral solution

2. Prescriber is a Rheumatologist

3. Meets other initial criteria per indication or use as described in Section A above

4. Treatment needed for disease severity, as indicated by **ONE or more** of the following:
    a. Four or fewer joints involved and has an inadequate response to **ALL** of the following:
        i. Glucocorticosteroid injection or NSAIDs
        ii. Methotrexate
    b. Five or more joints involved and has intolerance of or inadequate response to methotrexate

c. Sacroiliitis and has intolerance of or inadequate response to methotrexate
d. Uveitis and has an inadequate response to **ALL** of the following:
    i. Systemic corticosteroids
    ii. Systemic immunosuppressant (e.g., azathioprine or methotrexate)
    iii. Topical ophthalmic corticosteroids

5. **Xeljanz tab, Xeljanz oral solution** for polyarticular juvenile idiopathic arthritis: Individual has documented failure (used for ≥ 3 consecutive months), contraindication per FDA label, or intolerance to at least **ONE** TNF inhibitor (e.g., Enbrel or Humira)

Approval Duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Biologic and Immunological Agents is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met **(samples are not considered for continuation of therapy)**:

1. Meets other continuation criteria as described in Section A above

2. Individual's condition has responded while on therapy with response defined as the following:
    a. **With first request for continuation:** AT LEAST a 30% improvement in JIA Core Set (see Definitions section)
    b. **With subsequent request for continuation**: Documented evidence of disease stability and/or improvement with no evidence of disease progression

Renewal Duration: 12 months

Section H. Moderately to severely active Psoriatic Arthritis (PsA):

- **Criteria for initial therapy:** Biologic and Immunological Agents considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met for moderately to severely active psoriatic arthritis:

1. Request is for **ONE** of the following: Otezla, Rinvoq, Xeljanz tab, Xeljanz XR tab

2. Prescriber is a Rheumatologist or Dermatologist

3. Meets other initial criteria per indication or use as described in Section A above

4. Diagnosis of moderate to severe active psoriatic arthritis is identified by **ONE or more** of the following:
    a. Predominantly axial disease (i.e., sacroiliitis or spondylitis) as indicated by **ALL** of the following:
        i. Radiographic evidence of axial disease (e.g., sacroiliac joint space narrowing or erosions, vertebral syndesmophytes)
        ii. Symptoms (e.g., limited spinal range of motion, spinal morning stiffness more than 30 minutes) present for more than 3 months' duration
        iii. Failure, contraindication per FDA label, or intolerance of 1 or more different NSAIDs (at maximum recommended doses) over total period of at least 4 or more weeks of therapy

b. Predominantly non-axial disease, and failure (used for ≥ 3 consecutive months), intolerance, or contraindication per FDA label to methotrexate or NSAIDs

5. **Rinvoq, Xeljanz, Xeljanz XR** for psoriatic arthritis: Individual has documented failure (used for ≥ 3 consecutive months), contraindication per FDA label, or intolerance to at least **ONE** TNF inhibitor (e.g., Cimzia, Enbrel, Humira, Simponi)

Approval Duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Biologic and Immunological Agents is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met **(samples are not considered for continuation of therapy)**:

1. Meets other continuation criteria as described in Section A above

2. Individual's condition has responded while on therapy with response defined as the following:
   a. **With first request for continuation**: AT LEAST a 20% improvement in any of the following: ACR, CDAI, DAS28, PAS, PASII, RAPID-3, SDAI (see Definitions section)
   b. **With subsequent request for continuation**: Documented evidence of disease stability and/or improvement with no evidence of disease progression

Renewal Duration: 12 months

Section I. Moderately to severely active Rheumatoid Arthritis (RA):

- **Criteria for initial therapy:** Biologic and Immunological Agents is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met for moderately to severely active rheumatoid arthritis:

1. Request is for **ONE** of the following: Olumiant, Rinvoq, Xeljanz tab, Xeljanz XR tab

2. Prescriber is a Rheumatologist

3. Meets other initial criteria per indication or use as described in Section A above

4. Diagnosis of rheumatoid arthritis identified by **ONE** of the following:
   a. Clinical Disease Activity Index (CDAI) score greater than 10
   b. Disease Activity Score 28 (DAS28) of greater than 3.2
   c. Patient Activity Scale (PAS) of greater than 3.7
   d. Patient Activity Scale II (PASII) of greater than 3.7
   e. Routine Assessment of Patient Index Data 3 (RAPID-3) score greater than 2
   f. Simplified Disease Activity Index (SDAI) score greater than 11

5. Individual has documented failure (used for ≥ 3 consecutive months), contraindication per FDA label, or intolerance to **methotrexate**

6. Individual has documented failure (used for ≥ 3 consecutive months), contraindication per FDA label, or intolerance to **ONE** of the following: [**Note**: This criterion is waived if the individual already has tried an FDA-approved Rheumatoid Arthritis biologic.]
    a. Leflunomide
    b. Sulfasalazine

7. **Rinvoq, Xeljanz tab, Xeljanz XR** for rheumatoid arthritis: Individual has documented failure (used for > 3 consecutive months), contraindication per FDA label, or intolerance to at least ONE TNF inhibitor (e.g., Cimzia, Enbrel, Humira, Simponi)

8. **Olumiant** for rheumatoid arthritis, **ALL** of the following:
    a. Individual has documented failure (used for ≥ 3 consecutive months), contraindication per FDA label, or intolerance to **TWO** of the following:
        i. Cimzia
        ii. Enbrel
        iii. Humira
        iv. Simponi
        v. Rinvoq
        vi. Xeljanz tab or Xeljanz XR tab
    b. Individual has documented failure (used for ≥ 3 consecutive months), contraindication per FDA label, or intolerance to **BOTH** of the following: Actemra and Orencia (IV or SQ)

Approval Duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Biologic and Immunological Agents considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met **(samples are not considered for continuation of therapy)**:

1. Meets other continuation criteria as described in Section A above

2. Individual's condition has responded while on therapy with response defined as the following:
    a. **With first request for continuation**: AT LEAST a 20% improvement in any of the following: ACR, CDAI, DAS28, PAS, PASII, RAPID-3, SDAI (see Definitions section)
    b. **With subsequent request for continuation**: Documented evidence of disease stability and/or improvement with no evidence of disease progression

Renewal Duration: 12 months

Section J. Moderately to severely active Ulcerative Colitis (UC):

- **Criteria for initial therapy:** Biologic and Immunological Agents is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met for moderately to severely active ulcerative colitis (UC):

1. Request is for **ONE** of the following: Rinvoq, Xeljanz tab, Xeljanz XR tab

2. Prescriber is a Gastroenterologist

3. Meets other initial criteria per indication or use as described in Section A above

4. Diagnosis of moderate to severe active ulcerative colitis, as indicated by **ONE** of the following:
    a. American College of Gastroenterology Ulcerative Colitis activity index rating of moderate to severe disease in adults
    b. Pediatric ulcerative colitis activity index (PUCAI) greater than or equal to 35
    c. **At least 5** of the following signs and symptoms:
        i. Anemia
        ii. Bloody diarrhea or visible blood in stool
        iii. Bowel movements 4-6 or more times per day
        iv. Colicky abdominal pain
        v. Elevated fecal calprotectin
        vi. Elevated serum C-reactive protein or erythrocyte sedimentation rate
        vii. Fatigue
        viii. Fever
        ix. Tenesmus
        x. Urgency
        xi. Weight loss or delayed growth in children

5. Individual has documented failure (used for ≥ 3 consecutive months), contraindication per FDA label, or intolerance to **ONE or more** of the following: [**Note**: This criterion is waived if the individual already has tried an FDA-approved Ulcerative Colitis biologic.]
    a. 6-mercaptopurine
    b. Azathioprine
    c. Oral corticosteroids
    d. Salicylates (such as mesalamine, sulfasalazine, balsalazide, olsalazine)

6. **Rinvoq, Xeljanz tab, Xeljanz XR tab** for ulcerative colitis (UC): Individual has documented failure (used for > 3 consecutive months), contraindication per FDA label, or intolerance to at least **ONE** TNF inhibitor. (e.g., Humira, Remicade, Simponi)

Approval Duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Biologic and Immunological Agents is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met **(samples are not considered for continuation of therapy)**:

1. Meets other continuation criteria as described in Section A above

2. Individual's condition has responded while on therapy with response defined as the following:
    a. **With first request for continuation, ONE of the following:**
        i. AT LEAST a 20% improvement in signs and symptoms of ulcerative colitis
        ii. American College of Gastroenterology Ulcerative Colitis activity index rating of mild disease or disease in remission in adults
        iii. Pediatric ulcerative colitis activity index (PUCAI) of ≤ 34 in children indicating mild disease or disease remission

b. **With subsequent request for continuation**: Documented evidence of disease stability and/or improvement with no evidence of disease progression

Renewal Duration: 12 months

Section K. Behcet's Disease:

- **Criteria for initial therapy:** Otezla (apremilast) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met for oral ulcers associated with Behcet's Disease

1. Request is for Otezla
2. Prescriber is or in consultation with a Rheumatologist
3. Meets other initial criteria per indication or use as described in Section A above
4. Diagnosis is confirmed by meeting International Study Group (ISG) criteria for Behcet's Disease (see Definitions section) with **ALL** of the following:
   a. Two or more active oral ulcer without major organ involvement
   b. Oral ulcers that occurred 3 or more times in previous 12 months
   c. Does not require systemic immunosuppressants (e.g., biologics, corticosteroids, azathioprine)
   d. No concurrent therapy with topical corticosteroids
5. Individual has documented failure (used for ≥ 3 consecutive months), contraindication per FDA label or intolerance to **TWO** of the following:
   a. Oral or topical corticosteroids
   b. Nonsteroidal anti-inflammatory drugs (NSAIDs)
   c. Colchicine
   d. Immunosuppressant

Approval Duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Otezla (apremilast) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met **(samples are not considered for continuation of therapy)**:

1. Meets other continuation criteria as described in Section A above
2. Individual's condition has responded while on therapy with response defined as the following:
   a. **With first request for continuation:** AT LEAST 20% improvement in signs and symptoms of oral ulcers
   b. **With subsequent request for continuation**: Documented evidence of disease stability and/or improvement with no evidence of disease progression

Renewal duration: 12 months

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Section L. Measurement of Antibodies to Biologic/Immunologic Agents:

- Measurement of antibodies for biologic or immunologic agents in an individual receiving treatment, either alone or as a combination test, which includes the measurement of serum levels for the biologic or immunologic agents is considered ***experimental or investigational*** when any **ONE** or more of the following criteria are met:

  1. Lack of final approval from the appropriate governmental regulatory bodies (e.g., Food and Drug Administration); or
  2. Insufficient scientific evidence to permit conclusions concerning the effect on health outcomes; or
  3. Insufficient evidence to support improvement of the net health outcome; or
  4. Insufficient evidence to support improvement of the net health outcome as much as, or more than, established alternatives; or
  5. Insufficient evidence to support improvement outside the investigational setting.

  These measurements include, *but are not limited to:*
  - Anser™ ADA

Section M. Other:

- Criteria for a request for non-FDA use or indication, treatment with dosing, frequency, or duration outside the FDA-approved dosing, frequency, and duration, refer to one of the following Pharmacy Coverage Guideline:

  1. **Off-Label Use of Non-Cancer Medications**
  2. **Off-Label Use of Cancer Medications**

Definitions:

U.S. Food and Drug Administration (FDA) MedWatch Forms for FDA Safety Reporting
MedWatch Forms for FDA Safety Reporting | FDA

Adult: Age 18 years and older.

Preferred and Non-Preferred Agents:

Disease State	Preferred Agents	Non-Preferred Agents
Ankylosing Spondylitis	Cimzia* Enbrel* Humira* Rinvoq* Simponi* Simponi Aria† Xeljanz tab* Xeljanz XR tab*	Cosentyx* Taltz*

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Atopic Dermatitis	Rinvoq*	Adbry* Cibinqo* Dupixent*
Juvenile Idiopathic Arthritis	Enbrel* Humira* Simponi Aria† Xeljanz oral solution* Xeljanz tab*	Actemra (IV)† Actemra (SQ)* Orencia (IV)† Orencia (SQ)*
Non-radiographic Axial Spondyloarthritis (nr-axSpA)	Cimzia* Rinvoq*	Cosentyx* Taltz*
Psoriasis (PsO)	Cimzia* Enbrel* Humira* Otezla* Skyrizi* Stelara (IV)† Stelara (SQ)* Tremfya*	Cosentyx* Siliq* Sotyktu* Taltz*
Psoriatic Arthritis (PsA)	Cimzia* Enbrel* Humira* Otezla* Rinvoq* Simponi* Simponi Aria† Skyrizi* Stelara (IV)† Stelara (SQ)* Tremfya* Xeljanz tab* Xeljanz XR tab*	Cosentyx* Orencia (IV)† Orencia (SQ)* Taltz*
Rheumatoid Arthritis (RA)	Cimzia* Enbrel* Humira* Rinvoq* Simponi* Simponi Aria† Xeljanz tab* Xeljanz XR tab*	Actemra (IV)† Actemra (SQ)* Kevzara* Kineret* Olumiant* Orencia (IV)† Orencia (SQ)*
Ulcerative Colitis	Humira* Rinvoq* Simponi* Stelara (IV)† Stelara (SQ)* Xeljanz tab* Xeljanz XR tab*	Zeposia*
***Pharmacy Benefit:** Injectable and oral medications that can be self-administered are billed and processed through pharmacy benefit only. † **Medical Benefit:** Injectable medications that must be administered by a healthcare professional.		

Recommendations for Discontinuation of Janus Kinase Inhibitor for Laboratory Abnormalities

Laboratory Measure	Recommendation
Absolute neutrophil count (ANC) < 1,000mm^3 (tofacitinib: < 500mm^3)	Interrupt treatment, restart once ANC above this value

Absolute lymphocyte count (ALC) < 500/mm^3	Interrupt treatment, restart once ALC above this value
Hemoglobin (Hb) < 8g/dL (tofacitinib: < 9g/dL)	Interrupt treatment, restart once Hb above this value
Platelet count < 150,000/mm^3 (Cibinqo)	Interrupt treatment, follow until > 100,000/mm^3
Elevated hepatic transaminases suggesting drug-induced liver injury	Interrupt treatment until this diagnosis is excluded

Bath Ankylosing Spondylitis Disease Activity Index (BASDAI):

1. How would you describe the overall level of fatigue/tiredness you have experienced? None 0 1 2 3 4 5 6 7 8 9 10 Very Severe
2. How would you describe the overall level of ankylosing spondylitis **neck, back or hip pain** you have had? None 0 1 2 3 4 5 6 7 8 9 10 Very Severe
3. How would you describe the overall level of pain/swelling you have had in joints other than neck, back and hips? None 0 1 2 3 4 5 6 7 8 9 10 Very Severe
4. How would you describe the level of discomfort you have had from an area tender to touch or pressure? None 0 1 2 3 4 5 6 7 8 9 10 Very Severe
5. How would you describe the level of morning stiffness you have had from the time you wake up? None 0 1 2 3 4 5 6 7 8 9 10 Very Severe
6. How long does your morning stiffness last from the time you wake up? 0 hours 0 1 2 3 4 5 6 7 8 9 10 2 or more hours
Calculation of BASDAI: Compute the mean of questions 5 and 6 Calculate the sum of the values of question 1-4 and add the result to the mean of questions 5 and 6

Atopic Dermatitis Therapies:

Topical corticosteroids (TCS):

- Low-potency corticosteroids are recommended for maintenance therapy
- Intermediate and high-potency corticosteroids should be used for the treatment of clinical exacerbation over short periods of time
- Ultra-high-potency corticosteroids should be used only for very short periods (1-2 weeks) and in non-facial non-skinfold areas.
- Do not use potent fluorinated corticosteroids on the face, eyelids, genitalia, and intertriginous areas or in young infants.

Topical calcineurin inhibitors (TCI):

- Tacrolimus ointment (Protopic and generics) is indicated as second-line therapy for moderate to severe atopic dermatitis
- Pimecrolimus cream (Elidel and generics) is indicated as second line therapy for mild to moderate atopic dermatitis

Topical phosphodiesterase 4 (PDE-4) inhibitor:

- Eucrisa (crisaborole) ointment is indicated for treatment of mild to moderate atopic dermatitis

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Relative Potency of Selected Topical Corticosteroid Products:

Product	Dosage form	Strength
Category I – Very high potency		
Augmented betamethasone dipropionate	Gel, ointment	0.05
Clobetasol propionate	Ointment, gel, cream	0.05
Fluocinonide	Cream	0.1
Diflorasone diacetate	Ointment	0.05
Halobetasol propionate	Ointment, cream	0.05
Category II – High potency		
Amcinonide	Ointment, cream, lotion	0.1
Augmented betamethasone dipropionate	Cream, lotion	0.05
Betamethasone dipropionate	Ointment, cream	0.05
Betamethasone valerate	Ointment	0.1
Desoximetasone	Ointment, cream	0.25
Desoximetasone	Gel	0.05
Diflorasone diacetate	Ointment (emollient base), cream	0.05
Fluocinonide	Ointment, gel, cream	0.05
Halcinonide	Ointment, cream	0.1

Atopic Dermatitis Disease Activity Measurement Instruments:

Investigator Global Assessment Scale (IGA):
Validated-Investigator-Global-Assessment-Scale_vIGA-AD_2017.pdf (eczemacouncil.org) [Accessed May 11, 2022]

The IGA score is selected using the morphologic descriptors that best describe the overall appearance of the lesions at a given time point. It is not necessary that all characteristics under Morphological Description be present.

Score	Morphological Description
0 – Clear	No inflammatory signs of atopic dermatitis (no erythema, no induration/papulation, no lichenification, no oozing/crusting). Post-inflammatory hyperpigmentation and/or hypopigmentation may be present.
1 – Almost clear	Barely perceptible erythema, barely perceptible induration/papulation, and/or minimal lichenification. No oozing or crusting.
2 – Mild	Slight but definite erythema (pink), slight but definite induration/papulation, and/or slight but definite lichenification. No oozing or crusting.
3 – Moderate	Clearly perceptible erythema (dull red), clearly perceptible induration/papulation, and/or clearly perceptible lichenification. Oozing and crusting may be present.
4 – Severe	Marked erythema (deep or bright red), marked induration/papulation, and/or marked lichenification. Disease is widespread in extent. Oozing or crusting may be present.
Notes: 1. In indeterminate cases, use extent to differentiate between scores. For example: • Patient with marked erythema (deep or bright red), marked papulation and/or marked lichenification that is limited in extent (instead of widespread), would be considered "3 – Moderate". 2. Excoriations should not be considered when assessing disease severity	

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Eczema Area and Severity Index (EASI) score (A-E):
An EASI score is a tool used to measure the extent (area) and severity of atopic eczema. EASI score does not include a grade for dryness or scaling. Include only inflamed areas.

A. Body regions:
There are four body regions:

- Head and neck
  - Face occupies 33% (17% each side), neck 33% (17% front and back) and scalp 33% of the head and neck region
- Trunk (including genital area)
  - Front occupies 55% and back 45% of the trunk
- Upper limbs
  - Each arm occupies 50% of the upper limbs region (front or back of one arm is 25%)
- Lower limbs (including buttocks)
  - Each leg occupies 45% (front or back of one leg is 22.5%) and buttocks 10% of the lower limbs region

B. Area score:
Area score is recorded for each of the four regions of the body. The area score is the percentage of skin affected by eczema for each body region.

Area score	Percentage of skin affected by eczema in each region
0	No active eczema in this region
1	1-9
2	10-29
3	30-49
4	50-69
5	70-89
6	90-100: the entire region is affected by eczema

C. Severity score:
Severity score is recorded for each of the four regions of the body. The severity score is the sum of the intensity scores for four signs. The four signs are:

1. Redness (erythema, inflammation)
2. Thickness (induration, papulation, swelling—acute eczema)
3. Scratching (excoriation)
4. Lichenification (lined skin, furrowing, prurigo nodules—chronic eczema).

The *average* intensity of each sign in each body region is assessed as: none (0), mild (1), moderate (2) and severe (3). Half scores are allowed. It may be difficult to assess redness in dark skin. If in doubt, increase the average redness score by one level.

Score	Intensity of redness, thickness/swelling, scratching. lichenification
0	None, absent
1	Mild (just perceptible)
2	Moderate (obvious)

3	Severe

D. Calculations:
For each region, record the intensity for each of four signs and calculate the severity score.

- Severity score = redness intensity + thickness intensity + scratching intensity + lichenification intensity

For each region, multiple the severity score by the area score and by a multiplier. The multiplier is different for each body site.

- Head and neck: severity score x area score x 0.1 (in children 0–7 years, x 0.2)
- Trunk: severity score x area score x 0.3
- Upper limbs: severity score x area score x 0.2
- Lower limbs: severity score x area score x 0.4 (in children 0–7 years, x 0.3)

Add up the total scores for each region to determine the final EASI score. The minimum EASI score is 0 and the maximum EASI score is 72.

E. Interpretation:
The suggested severity levels for the EASI are as follows:

0	Clear
0.1-1.0	Almost clear
1.1-7.0	Mild
7.1-21.0	Moderate
21.1-50.0	Severe
50.1-72.0	Very severe

Pruritus Numerical Rating Scale (NRS):
Numerical Rating Scale - Pruritus Resources (pruritussymposium.de) [Accessed October 09, 2021]

The NRS is comprised of one item and is represented by numbers 0 (“no itch”) to 10 (“worst imaginable itch”). Patients are asked to rate the intensity of their itch using this scale. It features high reliability and concurrent validity and is a popular choice for all patients due to its simple format. Time needed for completion: 1 minute. It has been validated in several languages.

- It can be interpreted as follows:
  - NRS 0 - no pruritus
  - NRS < 3 - mild pruritus
  - NRS ≥ 3 < 7 - moderate pruritus
  - NRS ≥ 7 < 9 - severe pruritus
  - NRS ≥ 9 - very severe pruritus

On a scale from 0 (no itch) to 10 (worst imaginable itch), how would you rate your itch overall (on average) during the past 24-hour? (Select number)										
0	1	2	3	4	5	6	7	8	9	10

Diagnostic criteria for Behcet’s syndrome:

Criterion	Required features
Recurrent oral ulceration	Aphthous (idiopathic) ulceration, observed by clinician or patient, with at least three episodes in any 12-month period
Plus any two of the following:	
Recurrent genital ulceration	Aphthous ulceration or scarring, observed by clinician or patient

Eye lesions	Anterior or posterior uveitis cells in vitreous in slit-lamp examination; or retinal vasculitis documented by ophthalmologist
Skin lesions	Erythema nodosum-like lesions observed by clinician or patient; papulopustular skin lesions or pseudofolliculitis with characteristic acneiform nodules observed by clinician
Pathergy test	Interpreted at 24 to 48 hours by clinician
Adapted from International Study Group for Behcet's Disease. Criteria for diagnosis of Behcet's disease. Lancet 1990; 335:1078.	

Psoriasis Area and Severity Index (PASI):

	Head	Upper Extremities	Trunk	Lower extremities
1. Redness[1]				
2. Thickness[1]				
3. Scale[1]				
4. Sum of rows 1,2 and 3				
5. Area score[2]				
6. Score of row 4 x row 5 x the area multiplier	row 4 x row 5 x 0.1	row 4 x row 5 x 0.2	Row 4 x row 5 x 0.3	Row 4 x row 5 x 0.4
7. Sum row 6 for each column for PASI score				

Steps in generating PASI score:
(a) Divide body into four areas: head, arms, trunk to groin, and legs to top of buttocks.
(b) Generate an average score for the erythema, thickness, and scale for each of the 4 areas (0 = clear; 1–4 = increasing severity)[1].
(c) Sum scores of erythema, thickness, and scale for each area.
(d) Generate a percentage for skin covered with psoriasis for each area and convert that to a 0–6 scale (0 = 0%; 1 = <10%; 2 = 10–<30%; 3 = 30–<50%; 4 = 50–<70%; 5 = 70–<90%; 6 = 90–100%).
(e) Multiply score of item (c) above times item (d) above for each area and multiply that by 0.1, 0.2, 0.3, and 0.4 for head, arms, trunk, and legs, respectively.
(f) Add these scores to get the PASI score.

[1] Erythema, induration and scale are measured on a 0–4 scale (none, slight, mild, moderate, severe)
[2] Area scoring criteria (score: % involvement)
0: 0 (clear)
1: <10%
2: 10–<30%
3: 30–<50%
4: 50–<70%
5: 70–<90%
6: 90–<100%

Feldman, SR and Krueger, GG. Psoriasis assessment tools in clinical trials. Ann Rheum Dis 2005; 64 (Suppl III): ii65-ii68.

JIA Core Set 30%:

At least 30 percent improvement in at least 3 of the 6 core set variables with no more than 1 remaining variable worsening by > 30%
1. Physician's global assessment of overall disease activity measured on a visual analog scale (VAS)
2. Parent or patient global assessment of overall well-being measured on VAS
3. Functional ability
4. Number of joints with active arthritis
5. Number of joints with limited range of motion
6. Erythrocyte sedimentation rate (ESR)
Giannini, EH, Ruperto, N, Ravelli A, et al. Preliminary Definition of Improvement in Juvenile Arthritis. Arthritis & Rheumatism 1997

BIOLOGIC AND IMMUNOLOGICAL AGENTS – ORAL

Rheumatoid Arthritis Disease Activity Measurement Instruments:

Instrument	Threshold of Disease Activity
Clinical Disease Activity Index (CDAI)	Range: 0 to 76 Remission: ≤ 2.8 Low activity: >2.8 to ≤ 10 Moderate activity: >10 to ≤ 22 High activity: >22
Disease Activity Score 28 (DAS28)	Range: 0.5 to 9 Remission: < 2.6 Low activity: > 2.6 to ≤ 3.2 Moderate activity: > 3.2 to ≤ 5.1 High activity: > 5.1
Patient Activity Scale (PAS) Patient Activity Scale II (PASII)	Range 0 to 10 Remission: 0 to 0.25 Low activity: >0.25 to 3.7 Moderate activity: > 3.7 to < 8.0 High activity: ≥ 8.0
Routine Assessment of Patient Index Data 3 (RAPID-3)	Range: 0 to 10 Remission: 0 to 1.0 Low activity: > 1.0 to 2.0 Moderate activity: > 2.0 to 4.0 High activity: > 4.0 to 10
Simplified Disease Activity Index (SDAI)	Range: 0 to 90 Remission: ≤ 3.3 Low activity: > 3.3 to ≤ 11.0 Moderate activity: > 11.0 to ≤ 26 High activity: > 26

American College of Rheumatology 20 Percent Improvement Criteria (ACR20):

At least 20 percent improvement in the following:
1. Swollen joint count
2. Tender joint count
And three of the following five variables:
3. Patient-assessed global disease activity (e.g., by VAS)
4. Evaluator-assessed global disease activity (e.g., by VAS)
5. Patient pain assessment (e.g., by VAS)
6. Functional disability (e.g., by HAQ)
7. Acute phase response (ESR or CRP)
A 50 and 70 percent ACR response (ACR50 and ACR70, respectively) represents respective improvement of at least 50 or 70 percent[1].
 1. *Felson DT, Anderson JJ, Lange ML, et al. Should improvement in rheumatoid arthritis clinical trials be defined as fifty percent or seventy percent improvement in core set measures, rather than twenty percent?. Arthritis Rheum 1998; 41:1564.* 2. *Felson DT, Anderson JJ, Boers M, et al. American College of Rheumatology preliminary definition of improvement in rheumatoid arthritis. Arthritis Rheum 1995; 38:727.*

Ulcerative Colitis Activity (Adults):

American College of Gastroenterology Ulcerative Colitis Activity Index				
	Remission	Mild	Moderate-severe	Fulminant
Stools (no./d)	Formed	< 4	> 6	> 10
Blood in stools	None	Intermittent	Frequent	Continuous
Urgency	None	Mild, occasional	Often	Continuous
Hemoglobin	Normal	Normal	< 75% of normal	Transfusion needed

ESR	< 30	< 30	> 30	> 30
CRP (mg/L)	Normal	Elevated	Elevated	Elevated
Fecal calprotectin (mg/g)	< 150-200	> 150-200	> 150-200	> 150-200
Endoscopy (Mayo sub-score)	0-1	1	2-3	3
UCEIS	0-1	2-4	5-8	7-8
The above factors are general guides for disease activity. With the exception of remission, a patient does not need to have all the factors to be considered in a specific category. CRP, C-reactive protein; ESR, erythrocyte sedimentation rate; UCEIS, Ulcerative Colitis Endoscopic Index of Severity.				

Endoscopic Assessment of Disease Activity		
Endoscopic Features	UCEIS Score	Mayo Score
Normal	0	0
Erythema, decreased vascular pattern, mild friability	1-3	1
Marked erythema, absent vascular pattern, friability, erosions	4-6	2
Spontaneous bleeding, ulceration	7-8	3

Pediatric ulcerative colitis activity index (PUCAI)

Abdominal pain	No pain	0 points
	Pain can be ignored	5 points
	Pain cannot be ignored	10 points
Rectal Bleeding	None	0 points
	Small amount only, in <50% of stools	10 points
	Small amount with most stools	20 points
	Large amount (>50% of the stool content)	30 points
Stool consistency of most stools	Formed	0 points
	Partially formed	5 points
	Completely unformed	10 points
Number of stools er 24 hours	0 to 2	0 points
	3 to 5	5 points
	6 to 8	10 points
	>8	15 points
Nocturnal stools (any episode causing wakening)	No	0 points
	Yes	10 points
Activity level	No limitation of activity	0 points
	Occasional limitation of activity	5 points
	Severe restricted activity	10 points
Sum (0-85) PUCAI scores are interpreted as follows: 0 to 9 – Remission 10 to 34 – Mild disease 35 to 64 – Moderate disease 65 to 85 – Severe disease		

Resources:

Cibinqo (abrocitinib) product information, revised by Pfizer Laboratories Div Pfizer Inc. 02-2023. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed February 14, 2023.

Litfulo (ritlecitinib) product information, revised by Pfizer Laboratories Div Pfizer Inc. 06-2023. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed August 07, 2023.

Olumiant (baricitinib) product information, revised by Eli Lilly and Company 06-2022. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed February 8, 2023.

Otezla (apremilast) product information, revised by Amgen Inc. 12-2021. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed February 8, 2023.

Rinvoq (upadacitinib) product information, revised by AbbVie Inc. 10-2022. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed February 8, 2023.

Sotyktu (deucravacitinib) product information, revised by E. R. Squibb & Sons, LLC. 09-2022. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed February 8, 2023.

Xeljanz (tofacitinib) tab, Xeljanz (tofacitinib) oral solution, and Xeljanz XR (tofacitinib) tab product information, revised by Pfizer Laboratories Div Pfizer Inc. 12-2021. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed February 8, 2023.

Yu DT, van Tubergen A. Diagnosis and differential diagnosis of axial spondyloarthritis (ankylosing spondylitis and nonradiographic axial spondylarthritis) in adults. In: UpToDate, Sieper J, Seo P (Eds), UpToDate, Waltham, MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through January 2023. Topic last updated February 28, 2022. Accessed February 8, 2023.

Yu DT, van Tubergen A. Treatment of axial spondylarthritis (ankylosing spondylitis and nonradiographic axial spondyloarthritis in adults. In: UpToDate, Sieper J, Seo P (Eds), UpToDate, Waltham, MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through January 2023. Topic last updated January 20, 2023. Accessed February 8, 2023.

Howe W. Treatment of atopic dermatitis (eczema). In: UpToDate, Dellavalle RP, Levy ML, Fowler J, Corona R (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through January 2023. Topic last updated February 7, 2023. Accessed February 8, 2023.

Weston WL, Howe W. Atopic dermatitis (eczema): Pathogenesis, clinical manifestations, and diagnosis. In: UpToDate, Dellavalle RP, Levy ML, Fowler J, Corona R (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through January 2023. Topic last updated September 28, 2022. Accessed February 8, 2023.

Spergel JM, Lio PA. Management of severe atopic dermatitis (eczema) in children. In: UpToDate, Dellavalle RP, Levy ML, Fowler J, Corona R (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through January 2023. Topic last updated June 28, 2022. Accessed February 8, 2023.

Armstrong AW. Treatment Selection for moderate to severe plaque psoriasis in special populations. In UpToDate, Duffin KC, Ofori AO (Eds), UpToDate, Waltham, MA. : UpToDate Inc. Available at http://uptodate.com. Literature current through January 2023. Topic last updated May 1, 2020. Accessed February 8, 2023.

Weiss PF. Polyarticular juvenile idiopathic arthritis: Clinical manifestations, diagnosis, and complications. In: UpToDate, Klein-Gitelman M, TePas E (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through January 2023. Topic last updated February 15, 2022. Accessed February 8, 2023.

Weiss PF. Polyarticular juvenile idiopathic arthritis: Treatment. In: UpToDate, Klein-Gitelman M, TePas E (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through January 2023. Topic last updated January 19, 2022. Accessed February 8, 2023.

Feldman SR. Treatment of psoriasis in adults. In: UpToDate, Dellavalle RP, Duffin KC, Ofori, AO (Eds), UpToDate, Waltham, MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through January 2023. Topic last updated October, 12, 2022. Accessed February 8, 2023.

Gladman DD, Ritchlin C. Clinical manifestations and diagnosis of psoriatic arthritis. In UpToDate, Sieper J, Seo P (Eds), UpToDate, Waltham, MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through January 2023. Topic last updated September 28, 2022. Accessed February 8, 2023.

Gladman DD, Ritchlin C. Treatment of psoriatic arthritis. In UpToDate, Sieper J, Seo P (Eds), UpToDate, Waltham, MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through January 2023. Topic last updated September 28, 2022. Accessed February 8, 2023.

Moreland LW, Cannella A. General principles and overview of management of rheumatoid arthritis in adults. In: UpToDate, O'Dell JR, Seo P (Eds), UpToDate, Waltham, MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through January 2023. Topic last updated April 19, 2022. Accessed February 8, 2023.

Cohen S, Mikuls TR. Initial treatment of rheumatoid arthritis in adults. In: UpToDate, O'Dell JR, Seo P (Eds), UpToDate, Waltham, MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through January 2023. Topic last updated May 4, 2022. Accessed February 8, 2023.

Smolen JS, Aletaha D. Assessment of rheumatoid arthritis disease activity and physical function. In: UpToDate, St Clair EW, Seo P (Eds), UpToDate, Waltham, MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through January 2023. Topic last updated November 22, 2022. Accessed February 8, 2023.

Cohen S, Cannella A. Treatment of rheumatoid arthritis in adults resistant to initial conventional (nonbiologic) DMARD therapy. In: UpToDate, O'Dell JR, Seo P (Eds), UpToDate, Waltham, MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through January 2023. Topic last updated July 1, 2022. Accessed February 8, 2023.

Setty M, Moran CJ, Bousvaros A. Clinical manifestations and complications of inflammatory bowel disease in children and adolescents. In: UpToDate, Motil KJ, Heyman MB, Hoppin AG (Eds), UpToDate, Waltham, MA. : UpToDate Inc. Available at http://uptodate.com. Literature current through January 2023. Topic last updated July 19, 2022. Accessed February 8, 2023.

Bousvaros A, Setty M, Kaplan JL. Management of mild to moderate ulcerative colitis in children and adolescents. In: UpToDate, Heyman MB, Hoppin AG (Eds), UpToDate, Waltham, MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through January 2023. Topic last updated March 31, 2022. Accessed February 8, 2023.

Bousvaros A, Setty M, Kaplan JL. Management of severe or refractory ulcerative colitis in children and adolescents. In: UpToDate, Heyman MB, Hoppin AG (Eds), UpToDate, Waltham, MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through January 2023. Topic last updated April 21, 2021. Accessed February 8, 2023.

Peppercorn MA, Kane SV. Clinical manifestations, diagnosis, and prognosis of ulcerative colitis in adults. In: UpToDate, Lamont JT, Robson KM (Eds), UpToDate, Waltham, MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through January 2023. Topic last updated March 21, 2022. Accessed February 8, 2023.

Cohen RD, Stein AC. Management of moderate to severe ulcerative colitis in adults. In: UpToDate, Kane SV, Robson KM (Eds), UpToDate, Waltham, MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through January 2023. Topic last updated June 23, 2022. Accessed February 8, 2023.

Smith EL, Yazici Y. Clinical manifestations and diagnosis of Behcet syndrome. In: UpToDate, Merkel PA, Seo P (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through January 2023. Topic last updated October 13, 2022 Accessed February 8, 2023.

Smith EL, Yazici Y. Treatment of Behcet syndrome. In: UpToDate, Merkel PA, Seo P (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through January 2023. Topic last updated November 4, 2022. Accessed February 8, 2023.

Messenger AG. Alopecia areata: management. In: UpToDate, Dellavalle RP, Hordinsky M, Ofori AO (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through January 2023. Topic last updated December 8, 2022. Accessed February 8, 2023.

Messenger AG. Alopecia areata: clinical manifestations and diagnosis. In: UpToDate, Dellavalle RP, Hordinsky M, Ofori AO (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through January 2023. Topic last updated April 6, 2021. Accessed February 8, 2023.