LifeWise
Health Plan of Washington

PHARMACY / MEDICAL POLICY – 5.01.645

Pharmacologic Treatment of Psoriatic Arthritis

Effective Date:	**Jan. 1, 2027***
Last Revised:	Sep. 8, 2026
Replaces:	N/A
*View the current policy here.	

RELATED MEDICAL POLICIES:

5.01.550	Pharmacotherapy of Arthropathies
5.01.563	Pharmacotherapy of Inflammatory Bowel Disorder
5.01.564	Pharmacotherapy of Miscellaneous Autoimmune Diseases
5.01.607	Continuity of Coverage for Maintenance Medications
5.01.628	Pharmacologic Treatment of Atopic Dermatitis
5.01.629	Pharmacologic Treatment of Psoriasis
5.01.647	Medical Necessity Criteria for Custom Open Formulary
11.01.523	Site of Service: Infusion Drugs and Biologic Agents

The Site of Service Medical Necessity criteria within this policy DO NOT apply to Alaska fully-insured members; refer to the infusion and injection drug Medical Necessity criteria only.

Site of Service *and* the infusion and injection drug Medical Necessity criteria apply to all other plan members.

Please contact Customer Service for more information.

Select a hyperlink below to be directed to that section.

POLICY CRITERIA | DOCUMENTATION REQUIREMENTS | CODING
RELATED INFORMATION | EVIDENCE REVIEW | REFERENCES | HISTORY

∞ Clicking this icon returns you to the hyperlinks menu above.

Introduction

Psoriatic arthritis is an inflammatory disease of the joints and areas where tendons and ligaments connect to bone. The most common symptoms are joint pain and stiffness, skin rashes, and changes in your fingernails and toenails. This policy discusses when biologics and other drugs are considered medically necessary for the treatment of psoriatic arthritis.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

Site of Service (SOS) Medical Necessity criteria applies ONLY to medical benefit reviews.

Site of Service (SOS) Medical Necessity criteria does NOT apply to Alaska fully-insured members; refer to the infusion and injection drug Medical Necessity criteria only.

Please contact Customer Service for more information.

We will review specific intravenous (IV) and injectable drugs for medical necessity for all ages.

For those age 13 and older, we also will review the site of service for medical necessity. Site of service is defined as the location where the drug is administered, such as a hospital-based outpatient setting, an infusion center, a physician's office, or at home. Click **here** to be directed to the site of service review criteria.

Drugs subject to site of service review addressed in this policy are:

- Avsola (infliximab-axxq) IV
- Cosentyx (secukinumab) IV
- Inflectra (infliximab-dyyb) IV
- Infliximab (Janssen – unbranded) IV
- Orencia (abatacept) IV
- Remicade (infliximab) IV
- Renflexis (infliximab-abda) IV
- Simponi Aria (golimumab) IV

Site of Service Administration	Medical Necessity
Medically necessary sites of service • **Physician's office** • **Infusion center** • **Home infusion**	**IV infusion and injection therapy of various medical or biologic agents will be covered in the most appropriate, safe and cost-effective site:** • These are the preferred **medically necessary** sites of service for specified drugs.
Hospital-based outpatient setting • **Outpatient hospital IV infusion department** • **Hospital-based outpatient clinical level of care**	**IV infusion and injection therapy of various medical or biologic agents will be covered in the most appropriate, safe and cost-effective site.** **This site is considered medically necessary for the first 90 days for the following:** • The initial course of infusion or injection of a pharmacologic or biologic agent **OR** • Re-initiation of an agent after 6 months or longer following discontinuation of therapy* *This does not include when standard dosing between infusions or injections is 6 months or longer **This site is considered medically necessary when there is no outpatient infusion center within 50 miles of the individual's home and there is no contracted home infusion agency that will travel to their home, or a hospital is the only place that offers infusions or injections of this drug.** **This site is considered medically necessary only when the individual has a clinical condition which puts him or her at increased risk of complications for infusions or injections, including any 1 of the following:** • Known cardiac condition (e.g., symptomatic cardiac arrhythmia) or pulmonary condition (e.g., significant respiratory disease, serious obstructive airway disease, %FVC less than or equal to 40%) that may increase the risk of an adverse reaction

Site of Service Administration	Medical Necessity
	• Unstable renal function which decreases the ability to respond to fluids • Difficult or unstable vascular access • Acute mental status changes or cognitive conditions that impact the safety of infusion or injection therapy • A known history of severe adverse drug reactions and/or anaphylaxis to prior treatment with a related or similar drug **This site is considered medically necessary when the individual has cytokine release syndrome (CRS) and all the following are met:** • CRS is grade 3 or 4 as evidenced by ALL the following: ○ Temperature at least 38 °C ○ Hypotension that requires 1 or more vasopressors ○ Hypoxia that requires oxygen through a high-flow nasal cannula, face mask, non-rebreather mask, or Venturi mask OR positive pressure (continuous positive airway pressure [CPAP], bilevel positive airway pressure [BiPAP], intubation, or mechanical ventilation) **AND** • The individual will be admitted into an inpatient setting as soon as possible
Hospital-based outpatient setting • **Outpatient hospital IV infusion department** • **Hospital-based outpatient clinical level of care**	**These sites are considered not medically necessary for infusion and injectable therapy services of various medical and biologic agents when the site-of-service criteria in this policy are not met.**

Step therapy tiers are listed below; please refer to the Policy section for details.

Psoriatic Arthritis – First Line					
TNF-α Inhibitors	**IL-17 Inhibitor**	**IL-12/23 Inhibitors**	**IL-23 Inhibitors**	**Janus Kinase Inhibitors**	**PDE-4 Inhibitor**
• Avsola (IV)			• Skyrizi (SC)		

• Immgolis Intri (IV) • Inflectra (IV) • Renflexis (IV) • Simponi Aria (IV)	• Taltz (SC)	• Steqeyma (SC) • Yesintek (SC)	• Tremfya (SC) [pen, syringe, and injector]	• Rinvoq / Rinvoq LQ (oral) • Tofacitinib/ Tofacitinib XR (oral) • Xeljanz / Xeljanz XR (oral)	• Otezla / Otezla XR (oral)
• Adalimumab-aaty (SC) • Adalimumab-adaz (SC) • Adalimumab-adbm [NDCs starting with 00597] (SC) • Enbrel (SC)					

Psoriatic Arthritis – Second Line			
TNF-α Inhibitors	**IL-17 Inhibitors**	**IL-12/23 Inhibitors**	**T-Cell Costimulation Modulator**
• Infliximab (Janssen – unbranded) (IV) • Remicade (IV)	• Bimzelx (SC) • Cosentyx (IV/SC)	• Imuldosa (SC) • Otulfi (SC) • Pyzchiva (SC) • Selarsdi (SC) • Starjemza (SC) • Stelara (SC) • Brand ustekinumab (SC) • Brand ustekinumab-aekn (SC)	• Orencia (IV/SC)
• Cimzia (SC) • Immgolis (SC) • Simponi (SC)			
• Abrilada (SC) • Adalimumab-aacf (SC) • Adalimumab-adbm [NDCs starting with 82009] (SC) • Adalimumab-bwwd (SC) • Adalimumab-fkjp (SC) • Adalimumab-ryvk (SC) • Amjevita (SC)			

• Cyltezo (SC) • Hadlima (SC) • Hulio (SC) • Humira (SC) • Hyrimoz (SC) • Simlandi (SC) • Yusimry (SC)		• Brand ustekinumab-aauz (SC) • Brand ustekinumab-ttwe (SC) • Wezlana (SC)	

TNF-α Antagonists – First Line	
Agent	**Medical Necessity, Psoriatic Arthritis**
• **Adalimumab-aaty SC** • **Adalimumab-adaz SC** • **Adalimumab-adbm [NDCs starting with 00597] SC**	**Adalimumab-aaty, adalimumab-adaz, and adalimumab-adbm [NDCs starting with 00597] may be considered medically necessary for the treatment of active psoriatic arthritis when:** • The individual is aged 18 years or older **AND** • Medication is being prescribed by or in consultation with a rheumatologist or dermatologist **Note:** This medical necessity criteria does not apply to one Open formulary (Formulary ID: 6062; Rx Plan F1). The criteria for members with this custom Open formulary plan can be found in policy **5.01.647 Medical Necessity Criteria for Custom Open Formulary**. Please check the member Plan booklet or member ID card to determine whether this policy criteria applies.
• **Avsola (infliximab-axxq) IV** • **Inflectra (infliximab-dyyb) IV** • **Renflexis (infliximab-abda) IV**	**Avsola (infliximab-axxq), Inflectra (infliximab-dyyb), and Renflexis (infliximab-abda) are subject to review for site of service administration.** **Avsola (infliximab-axxq), Inflectra (infliximab-dyyb), and Renflexis (infliximab-abda) may be considered medically necessary for the treatment of active psoriatic arthritis when:** • The individual is aged 18 years or older **AND** • Medication is being prescribed by or in consultation with a rheumatologist or dermatologist

Enbrel (etanercept) SC	**Enbrel (etanercept) may be considered medically necessary for the treatment of active psoriatic arthritis when:** • The individual is aged 18 years or older **AND** • Medication is being prescribed by or in consultation with a rheumatologist or dermatologist
• **Immgolis Intri (golimumab-sldi) IV** • **Simponi Aria (golimumab) IV**	**Simponi Aria (golimumab) IV is subject to review for site of service administration.** **Immgolis Intri (golimumab-sldi) IV and Simponi Aria (golimumab) may be considered medically necessary for the treatment of active psoriatic arthritis when:** • The individual is aged 2 years or older **AND** • Medication is being prescribed by or in consultation with a rheumatologist or dermatologist
IL-17 Inhibitor - First Line	
Taltz (ixekizumab) SC	**Taltz (ixekizumab) SC may be considered medically necessary for the treatment of active psoriatic arthritis when:** • The individual is aged 18 years or older **AND** • Medication is being prescribed by or in consultation with a rheumatologist or dermatologist
IL-12/23 Inhibitor - First Line	
• **Steqeyma (ustekinumab-stba) SC** • **Yesintek (ustekinumab-kfce) SC**	**Steqeyma (ustekinumab-stba) SC and Yesintek (ustekinumab-kfce) SC may be considered medically necessary for the treatment of active psoriatic arthritis when:** • The individual is aged 6 years or older **AND** • Medication is being prescribed by or in consultation with a rheumatologist or dermatologist
IL-23 Inhibitors - First Line	
Tremfya (guselkumab) SC (pen, syringe, and injector)	**Tremfya (guselkumab) may be considered medically necessary for the treatment of active psoriatic arthritis when:** • The individual is aged 6 years or older and weighs at least 40 kg **AND**

	• Medication is being prescribed by or in consultation with a dermatologist or a rheumatologist
Skyrizi (risankizumab-rzaa) SC	**Skyrizi (risankizumab-rzaa) SC may be considered medically necessary for the treatment of active psoriatic arthritis when:** • The individual is aged 6 years or older **AND** • Medication is being prescribed by or in consultation with a dermatologist or a rheumatologist
Janus Kinase Inhibitors - First Line	
• **Rinvoq (upadacitinib) oral** • **Rinvoq LQ (upadacitinib) oral**	**Rinvoq (upadacitinib) and Rinvoq LQ (upadacitinib) may be considered medically necessary for the treatment of active psoriatic arthritis when:** • The individual is aged 2 years or older **AND** • The individual has had an inadequate response or intolerance to 1 or more TNF blockers **AND** • Medication is being prescribed by or in consultation with a rheumatologist or dermatologist
• **Tofacitinib oral** • **Tofacitinib extended-release oral** • **Xeljanz (tofacitinib) oral** • **Xeljanz XR (tofacitinib extended-release) oral**	**Tofacitinib and Xeljanz (tofacitinib) may be considered medically necessary for the treatment of active psoriatic arthritis when:** • The individual is aged 2 years or older **AND** • Has had an inadequate response or intolerance to 1 or more TNF blockers **AND** • Medication is being prescribed by or in consultation with a rheumatologist or dermatologist **Tofacitinib extended-release and Xeljanz XR (tofacitinib extended-release) may be considered medically necessary for the treatment of active psoriatic arthritis when:** • The individual is aged 18 years or older **AND** • Has had an inadequate response or intolerance to 1 or more TNF blockers **AND**

	• Medication is being prescribed by or in consultation with a rheumatologist or dermatologist
PDE4 Inhibitor - First Line	
• **Otezla (apremilast) oral** • **Otezla XR (apremilast extended-release) oral**	**Otezla (apremilast) may be considered medically necessary for the treatment of active psoriatic arthritis when:** • The individual is aged 6 years or older and weighs at least 20 kg **AND** • Medication is being prescribed by or in consultation with a rheumatologist or dermatologist **Otezla XR (apremilast extended-release) may be considered medically necessary for the treatment of active psoriatic arthritis when:** • The individual is aged 6 years or older and weighs at least 50 kg **AND** • Medication is being prescribed by or in consultation with a rheumatologist or dermatologist
Tyrosine Kinase 2 (TYK2) Inhibitors – First Line	
Sotyktu (deucravacitinib) oral	**Sotyktu (deucravacitinib) may be considered medically necessary for the treatment of active psoriatic arthritis when:** • The individual is aged 18 years or older **AND** • Medication is being prescribed by or in consultation with a rheumatologist or dermatologist
TNF-α Antagonists – Second Line	
• **Abrilada (adalimumab-afzb) SC** • **Adalimumab-aacf SC** • **Adalimumab-adbm [NDCs starting with 82009] SC** • **Adalimumab-bwwd SC** • **Adalimumab-fkjp SC** • **Adalimumab-ryvk SC** • **Amjevita (adalimumab-atto) SC**	**Abrilada (adalimumab-afzb), adalimumab-aacf, adalimumab-adbm [NDCs starting with 82009], adalimumab-bwwd, adalimumab-fkjp, adalimumab-ryvk, Amjevita (adalimumab-atto), Cyltezo (adalimumab-adbm), Hadlima (adalimumab-bwwd), Hulio (adalimumab-fkjp), Humira (adalimumab), Hyrimoz (adalimumab-adaz), Simlandi (adalimumab-ryvk), and Yusimry (adalimumab-aqvh) may be considered medically necessary for the treatment of active psoriatic arthritis when:** • The individual is aged 18 years or older **AND**

• **Cyltezo (adalimumab-adbm) SC** • **Hadlima (adalimumab-bwwd) SC** • **Hulio (adalimumab-fkjp) SC** • **Humira (adalimumab) SC** • **Hyrimoz (adalimumab-adaz) SC** • **Simlandi (adalimumab-ryvk) SC** • **Yusimry (adalimumab-aqvh) SC**	• Has had an inadequate response or intolerance to ALL the following agents: ○ Adalimumab-aaty ○ Adalimumab-adaz ○ Adalimumab-adbm [NDCs starting with 00597] **AND** • Medication is being prescribed by or in consultation with a dermatologist or a rheumatologist **Note:** This medical necessity criteria does not apply to one Open formulary (Formulary ID: 6062; Rx Plan F1). The criteria for members with this custom Open formulary plan can be found in policy **5.01.647 Medical Necessity Criteria for Custom Open Formulary**. Please check the member Plan booklet or member ID card to determine whether this policy criteria applies.
• **Cimzia (certolizumab pegol) SC** • **Immgolis (golimumab-sldi) SC** • **Simponi (golimumab) SC**	**Cimzia (certolizumab pegol), Immgolis (golimumab-sldi) SC, and Simponi (golimumab) SC may be considered medically necessary for the treatment of active psoriatic arthritis when:** • The individual is aged 18 years or older **AND** • Has had an inadequate response or intolerance to 2 of the following agents: ○ Enbrel (etanercept) ○ Adalimumab-aaty **OR** adalimumab-adaz **OR** adalimumab-adbm [NDCs starting with 00597] ○ Otezla (apremilast) **OR** Otezla XR (apremilast extended-release) ○ Rinvoq (upadacitinib) **OR** Rinvoq LQ (upadacitinib) ○ Skyrizi (risankizumab-rzaa) SC ○ Sotyktu (deucravacitinib) ○ Steqeyma (ustekinumab-stba) SC **OR** Yesintek (ustekinumab-kfce) SC ○ Taltz (ixekizumab) ○ Tremfya (guselkumab) ○ Tofacitinib **OR** tofacitinib extended-release **OR** Xeljanz (tofacitinib) **OR** Xeljanz XR (tofacitinib extended-release) **AND**

	• Medication is being prescribed by or in consultation with a dermatologist or a rheumatologist **Note:** This medical necessity criteria does not apply to one Open formulary (Formulary ID: 6062; Rx Plan F1). The criteria for members with this custom Open formulary plan can be found in policy **5.01.647 Medical Necessity Criteria for Custom Open Formulary**. Please check the member Plan booklet or member ID card to determine whether this policy criteria applies.
• **Infliximab (Janssen – unbranded) IV** • **Remicade (infliximab) IV**	**Infliximab (Janssen – unbranded) and Remicade (infliximab) are subject to review for site of service administration.** **Infliximab (Janssen – unbranded) and Remicade (infliximab) may be considered medically necessary for the treatment of active psoriatic arthritis when:** • The individual is aged 18 years or older **AND** • Has had a documented trial and treatment failure with Avsola (infliximab-axxq), Inflectra (infliximab-dyyb), **AND** Renflexis (infliximab-abda)[1] **AND** • Medication is being prescribed by or in consultation with a rheumatologist or dermatologist [1]**Note:** Only applies to individuals not previously treated with requested therapy.
IL-12/23 Inhibitors - Second Line	
• **Imuldosa (ustekinumab-srlf) SC** • **Otulfi (ustekinumab-aauz) SC** • **Pyzchiva (ustekinumab-ttwe) SC** • **Selarsdi (ustekinumab-ackn) SC** • **Starjemza (ustekinumab-hmny) SC** • **Stelara (ustekinumab) SC** • **Ustekinumab SC**	**Imuldosa (ustekinumab-srlf) SC, Otulfi (ustekinumab-aauz) SC, Pyzchiva (ustekinumab-ttwe) SC, Selarsdi (ustekinumab-ackn) SC, Starjemza (ustekinumab-hmny) SC, Stelara (ustekinumab) SC, ustekinumab SC, ustekinumab-aauz SC, ustekinumab-aekn SC, ustekinumab-ttwe SC, and Wezlana (ustekinumab-auub) SC may be considered medically necessary for the treatment of active psoriatic arthritis when:** • The individual is aged 6 years or older **AND** • Has had an inadequate response or intolerance to ALL the following agents:

• **Ustekinumab-aauz SC** • **Ustekinumab-aekn SC** • **Ustekinumab-ttwe SC** • **Wezlana (ustekinumab-auub) SC**	○ Steqeyma (ustekinumab-stba) SC ○ Yesintek (ustekinumab-kfce) SC **AND** • Medication is being prescribed by or in consultation with a dermatologist or a rheumatologist
IL-17 Inhibitors - Second Line	
Bimzelx (bimekizumab-bkzx) SC	**Bimzelx (bimekizumab-bkzx) may be considered medically necessary for the treatment of active psoriatic arthritis when:** • The individual is aged 18 years or older **AND** • Has had an inadequate response or intolerance to 1 of the following agents: ○ Enbrel (etanercept) ○ Adalimumab-aaty **OR** adalimumab-adaz **OR** adalimumab-adbm [NDCs starting with 00597] ○ Otezla (apremilast) **OR** Otezla XR (apremilast extended-release) ○ Skyrizi (risankizumab-rzaa) ○ Sotyktu (deucravacitinib) ○ Steqeyma (ustekinumab-stba) SC **OR** Yesintek (ustekinumab-kfce) SC ○ Taltz (ixekizumab) ○ Tremfya (guselkumab) **AND** • Medication is being prescribed by or in consultation with a dermatologist or a rheumatologist **Note:** This medical necessity criteria does not apply to one Open formulary (Formulary ID: 6062; Rx Plan F1). The criteria for members with this custom Open formulary plan can be found in policy **5.01.647 Medical Necessity Criteria for Custom Open Formulary**. Please check the member Plan booklet or member ID card to determine whether this policy criteria applies.
Cosentyx (secukinumab) IV/SC	**Cosentyx (secukinumab) IV is subject to review for site of service administration.** **Cosentyx (secukinumab) may be considered medically necessary for the treatment of active psoriatic arthritis when:**

	• The individual is aged 2 years or older **AND** • Has had an inadequate response or intolerance to 2 of the following agents: ○ Enbrel (etanercept) ○ Adalimumab-aaty **OR** adalimumab-adaz **OR** adalimumab-adbm [NDCs starting with 00597] ○ Otezla (apremilast) **OR** Otezla XR (apremilast extended-release) ○ Rinvoq (upadacitinib) **OR** Rinvoq LQ (upadacitinib) ○ Skyrizi (risankizumab-rzaa) ○ Sotyktu (deucravacitinib) ○ Steqeyma (ustekinumab-stba) SC **OR** Yesintek (ustekinumab-kfce) SC ○ Taltz (ixekizumab) ○ Tremfya (guselkumab) ○ Tofacitinib **OR** tofacitinib extended-release **OR** Xeljanz (tofacitinib) **OR** Xeljanz XR (tofacitinib extended-release) **AND** • Medication is being prescribed by or in consultation with a dermatologist or a rheumatologist **Note:** This medical necessity criteria does not apply to one Open formulary (Formulary ID: 6062; Rx Plan F1). The criteria for members with this custom Open formulary plan can be found in policy **5.01.647 Medical Necessity Criteria for Custom Open Formulary**. Please check the member Plan booklet or member ID card to determine whether this policy criteria applies.
T-Cell Costimulation Modulators – Second Line	
Orencia (abatacept) IV/SC	**Orencia (abatacept) IV is subject to review for site of service administration.** **Orencia (abatacept) IV/SC may be considered medically necessary for the treatment of adults with active psoriatic arthritis when:** • The individual is aged 18 years or older **AND**

	• Has had an inadequate response or intolerance to 2 of the following agents: ○ Enbrel (etanercept) ○ Adalimumab-aaty **OR** adalimumab-adaz **OR** adalimumab-adbm [NDCs starting with 00597] ○ Otezla (apremilast) **OR** Otezla XR (apremilast extended-release) ○ Rinvoq (upadacitinib) **OR** Rinvoq LQ (upadacitinib) ○ Skyrizi (risankizumab-rzaa) ○ Sotyktu (deucravacitinib) ○ Steqeyma (ustekinumab-stba) SC **OR** Yesintek (ustekinumab-kfce) SC ○ Taltz (ixekizumab) ○ Tremfya (guselkumab) ○ Tofacitinib **OR** tofacitinib extended-release **OR** Xeljanz (tofacitinib) **OR** Xeljanz XR (tofacitinib extended-release) **OR** • Has heart failure, a previously treated lymphoproliferative disorder, a previous serious infection, or a demyelinating disorder **AND** • Medication is being prescribed by or in consultation with a dermatologist or a rheumatologist **Note:** This medical necessity criteria does not apply to one Open formulary (Formulary ID: 6062; Rx Plan F1). The criteria for members with this custom Open formulary plan can be found in policy **5.01.647 Medical Necessity Criteria for Custom Open Formulary**. Please check the member Plan booklet or member ID card to determine whether this policy criteria applies. **Orencia (abatacept) SC may be considered medically necessary for the treatment of pediatric individuals with active psoriatic arthritis when:** • The individual is aged 2 years or older **AND** • Has had an inadequate response or intolerance to 1 of the following agents:

	○ Enbrel (etanercept) ○ Rinvoq (upadacitinib) **OR** Rinvoq LQ (upadacitinib) ○ Steqeyma (ustekinumab-stba) SC **OR** Yesintek (ustekinumab-kfce) SC **OR** • Has heart failure, a previously treated lymphoproliferative disorder, a previous serious infection, or a demyelinating disorder **AND** • Medication is being prescribed by or in consultation with a dermatologist or a rheumatologist

Drug	Investigational
As listed	**The medications listed in this policy are subject to the product's US Food and Drug Administration (FDA) dosage and administration prescribing information.** **All other uses of the above-named agents when used in combination with each other or for conditions not outlined in this policy or Related Medical Policies are considered investigational.**

Drug	Not Medically Necessary
As listed	**All other uses of the drugs for approved conditions listed in this policy are considered not medically necessary.**

Length of Approval	
Approval	**Criteria**
Initial authorization	**All drugs listed in the policy may be approved up to 12 months.**
Re-authorization criteria	**All drugs listed in the policy may be approved up to 12 months as long as the drug-specific coverage criteria are met, and chart notes demonstrate that the individual continues to show a positive clinical response to therapy.**

Documentation Requirements

The individual's medical records submitted for review for all conditions should document that medical necessity criteria are met. The record should include the following:

- Office visit notes that contain the diagnosis, relevant history, physical evaluation and medication history

Coding

Code	Description
HCPCS	
J0129	Injection, abatacept (Orencia), 10 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)
J0139	Injection, adalimumab (Humira), 1 mg
J0717	Injection, certolizumab pegol (Cimzia), 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)
J1438	Injection, etanercept (Enbrel), 25mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)
J1602	Injection, golimumab (Simponi Aria), 1 mg, for intravenous use
J1628	Injection, guselkumab (Tremfya), 1 mg
J1745	Injection, infliximab, excludes biosimilar (Remicade or Janssen unbranded), 10mg
J3247	Injection, secukinumab, intravenous, (Cosentyx) 1 mg
J3357	Injection, ustekinumab, subcutaneous injection (Stelara), 1mg
J3590	Unclassified biologics (use to report: Abrilada, Adalimumab-adaz HCF, Amjevita, Bimzelx, Cyltezo, Hadlima, Hulio, Hyrimoz LCF, Hyrimoz HCF, Immgolis, Imgolis Intri, Imuldosa, Kevzara, Kineret, Sandoz (unbranded), Simponi, Skyrizi, Starjemza, Taltz, Yuflyma, Yusimry)
Q5098	Injection, ustekinumab-srlf (Imuldosa), biosimilar, 1 mg
Q5099	Injection, ustekinumab-stba (Steqeyma), biosimilar, 1 mg
Q5100	Injection, ustekinumab-kfce (Yesintek), biosimilar, 1 mg

Code	Description
Q5103	Injection, infliximab-dyyb, biosimilar (Inflectra), 10 mg
Q5104	Injection, infliximab-abda, biosimilar (Renflexis), 10 mg
Q5121	Injection, infliximab-axxq, biosimilar (Avsola), 10 mg
Q5137	Injection, ustekinumab-auub, subcutaneous injection (Wezlana), biosimilar, 1 mg
Q5138	Injection, ustekinumab-auub, intravenous (Wezlana), biosimilar, 1 mg
Q5140	Injection, adalimumab-fkjp (Hulio), biosimilar, 1 mg
Q5141	Injection, adalimumab-aaty (Yuflyma), biosimilar, 1 mg
Q5142	Injection, adalimumab-ryvk biosimilar (Simlandi), 1 mg
Q5143	Injection, adalimumab-adbm, biosimilar (Cyltezo), 1 mg
Q5144	Injection, adalimumab-aacf (Idacio), biosimilar, 1 mg
Q5145	Injection, adalimumab-afzb (Abrilada), biosimilar, 1 mg
Q5164	Injection, ustekinumab-hmny (Starjemza), biosimilar, 1 mg (new code effective 07/01/26)
Q9996	Injection, ustekinumab-ttwe, (Pyzchiva), subcutaneous, 1 mg
Q9997	Injection, ustekinumab-ttwe, (Pyzchiva), intravenous, 1 mg
Q9998	Injection, ustekinumab-aekn (Selarsdi), 1 mg
Q9999	Injection, ustekinumab-aauz (Otulfi), biosimilar, 1 mg

Note: CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).

Related Information

Consideration of Age

Age limits specified in this policy are determined according to FDA-approved indications, where applicable.

For site of service for medical necessity the age described in this policy is 13 years of age or older. Site of service is defined as the location where the drug is administered, such as a

hospital-based outpatient setting, an infusion center, a physician's office, or at home. The age criterion for site of service for medical necessity is based on the following: Pediatric individuals are not small adults. Pediatric individuals differ physiologically, developmentally, cognitively, and emotionally from adult individuals, and vary by age groups from infancy to teen. Children often require smaller doses than adults, lower infusion rates, appropriately sized equipment, the right venipuncture site determined by therapy and age, and behavioral management during administration of care. Specialty infusion training is therefore necessary for pediatric IV insertions and therapy. Due to pediatrics unique physiology and psychology, site of service review is limited to individuals above the age of 13.

Evidence Review

Psoriatic Arthritis

Psoriatic Arthritis (PsA) is characterized as a spondyloarthropathy associated with psoriasis. The true incidence is unknown and is variably reported to occur in 6-42% (25% is considered a reasonable estimate) of individuals with psoriasis, an immunologic skin disease which occurs in 2-3% of the general population. There is similarity in the histopathogenesis of PsA and rheumatoid arthritis (RA), including the role of cytokines such as tumor necrosis factor alpha (TNF- α), although there are important differences as well. Several subsets of PsA have also been described. PsA is characterized by stiffness - both peripheral and spine inflammation and pain - joint deformities related to joint destruction, dactylitis, enthesitis (inflammation at insertion sites of tendons, ligaments, and joint capsule fibers), and psoriasis skin plaques. The course of PsA is variable, but the majority of individuals develop a chronic progressive form of the disease resulting in joint destruction, unless treated effectively. Although less well characterized than in RA, similar levels of disability, decreased quality of life, increased co-morbidities, and premature mortality are now being noted in long term registry studies.

Pharmacologic therapy combined with a physical rehabilitation program is the most effective available treatment for psoriatic arthritis (PsA). As with RA, early initiation of pharmacologic therapy is needed to avoid joint damage and disability.

NSAIDs have customarily been used in milder disease along with corticosteroids or traditional DMARDs. Moderate to severe disease requires the use of traditional DMARDs such as methotrexate, sulfasalazine, or the anti-TNF agents. Azathioprine and cyclosporine are rarely used. Retinoids, phototherapy, and topical and systemic corticosteroids have also been used to

treat the skin manifestations of PsA. In January 2002, etanercept, a TNF-α inhibitor became the first therapy to be approved for the indication. Adalimumab has also recently received FDA-approval for this indication. Additionally, infliximab has been demonstrated effective for this condition in at least one randomized, double-blind, controlled clinical trial. FDA has since approved the newer TNF-α inhibitors certolizumab pegol and golimumab for this indication. More recently, the IL12/IL23 inhibitor ustekinumab and the phosphodiesterase four inhibitor apremilast are now approved.

2025 Update

Moved psoriatic arthritis criteria for the infliximab products, adalimumab products, Simponi Aria, Enbrel, Taltz, Stelara, Skyrizi, Tremfya, Rinvoq, Rinvoq LQ, Xeljanz, Xeljanz XR, Otezla, Cimzia, Simponi, Bimzelx, Cosentyx, and Orencia from Policy 5.01.550 to 5.01.645. Added coverage criteria for Imuldosa (ustekinumab-srlf), Otulfi (ustekinumab-aauz), Pyzchiva (ustekinumab-ttwe), Selarsdi (ustekinumab-ackn), Starjemza (ustekinumab-hmny), Steqeyma (ustekinumab-stba), ustekinumab (Stelara unbranded), ustekinumab-aekn (Selarsdi unbranded), ustekinumab-ttwe (Pyzchiva unbranded), Yesintek (ustekinumab-kfce), and Wezlana (ustekinumab-auub). Added the following to note to select criteria for Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab pegol), Cosentyx (secukinumab) IV/SC, Orencia (abatacept) IV/SC, and Simponi (golimumab) SC: This medical necessity criteria does not apply to one Open formulary (Formulary ID: 6062; Rx Plan F1) and one Preferred formulary (Formulary ID: 6064; Rx Plan G3). The criteria for members with these custom Open and Preferred formulary plans can be found in policy 5.01.647 Medical Necessity Criteria for Custom Open and Preferred Formularies. Updated Tremfya (guselkumab) coverage criteria age requirement from 18 years or older to 6 years or older. Removed reference to the Preferred formulary (Formulary ID: 6064; Rx Plan G3) as it is no longer available. Clarified that Section 2 of this policy applies to plans with the High Cost Low Value (HCLV) drug list. Updated Otezla (apremilast) coverage criteria age requirement from 18 years or older to 6 years or older. Updated Xeljanz (tofacitinib) coverage criteria age requirement from 18 years or older to 2 years or older.

2026 Update

Reviewed prescribing information for all drugs in policy. Updated Enbrel and Simponi Aria removing note: This medical necessity criteria does not apply to one Open formulary (Formulary ID: 6062; Rx Plan F1). The criteria for members with this custom Open formulary plan can be found in policy 5.01.647 Medical Necessity Criteria for Custom Open Formulary. Please check the

member Plan booklet or member ID card to determine whether this policy criteria applies. Updated coverage criteria for Otezla (apremilast) specifying individual weighs at least 20 kg. Added coverage criteria for Otezla XR (apremilast extended-release) for the treatment of psoriatic arthritis. Added Otezla XR to list of preferred alternatives for Cimzia, Simponi, Bimzelx, Cosentyx, and Orencia. Updated Simponi Aria (golimumab) coverage criteria age requirement from 18 years or older to 2 years or older. Updated Tremfya (guselkumab) coverage criteria to include individuals weigh at least 40 kg.

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10. Avsola (infliximab-axxq). Prescribing Information. Amgen, Inc; Thousand Oaks, CA. Revised August 2025.
11. Enbrel (etanercept). Prescribing Information. Immunex Corporation; Thousand Oaks, CA. Revised September 2024.
12. Hyrimoz (adalimumab-adaz). Prescribing Information. Sandoz Inc; Princeton, NJ. Revised October 2025.
13. Inflectra (infliximab-dyyb). Prescribing Information. Celltrion, Inc.; New York, NY. Revised September 2025.
14. Cyltezo (adalimumab-adbm). Prescribing Information. Boehringer Ingelheim Pharmaceuticals, Inc; Ridgefield, CT. Revised October 2025.
15. Hadlima (adalimumab-bwwd). Prescribing Information. Merck Sharp & Dohme Corp; Whitehouse Station, NJ. Revised October 2025.
16. Abrilada (adalimumab-afzb). Prescribing Information. Pfizer Inc; New York, NY. Revised December 2025.

17. Hulio (adalimumab-fkjp). Prescribing Information. Mylan Pharmaceuticals Inc; Morgantown, WV. Revised February 2025.
18. Yusimry (adalimumab-aqvh). Prescribing Information. Coherus BioSciences, Inc., Redwood City, California. Revised November 2025.
19. Cosentyx (secukinumab). Prescribing Information. Novartis Pharmaceuticals Corporation, East Hanover, NJ. Revised August 2025.
20. Stelara (ustekinumab). Prescribing Information. Janssen Biotech, Inc. Horsham, PA. Revised November 2025.
21. Orencia (abatacept). Prescribing Information. Bristol-Myers Squibb. Princeton, NJ. Revised May 2024.
22. Simlandi (adalimumab-ryvk). Prescribing Information. Teva Pharmaceuticals. Parsippany, NJ. Revised October 2025.
23. Cimzia (certolizumab pegol). Prescribing Information. UCB, Inc. Smyrna, GA. Revised September 2025.
24. Bimzelx (bimekizumab-bkzx). Prescribing Information. UCB, Inc. Smyrna, GA. Revised November 2024.
25. Simponi Aria (golimumab). Prescribing Information. Janssen Biotech, Inc.; Horsham, PA. Revised April 2025.
26. Taltz (ixekizumab). Prescribing Information. Eli Lilly and Company; Indianapolis, IN. Revised August 2024.
27. Steqeyma (ustekinumab-stba). Prescribing Information. Celltrion, Inc.; Jersey City, NJ. Revised December 2025.
28. Yesintek (ustekinumab-kfce). Prescribing Information. Biocon Biologics Inc.; Cambridge, MA. Revised January 2026.
29. Tremfya (guselkumab). Prescribing Information. Janssen Biotech, Inc.; Horsham, PA. Revised September 2025.
30. Skyrizi (Risankizumab-rzaa). Prescribing Information. AbbVie Inc.; North Chicago, IL. Revised September 2025.
31. Rinvoq (upadacitinib). Prescribing Information. AbbVie Inc.; North Chicago, IL. Revised October 2025.
32. Xeljanz (tofacitinib). Prescribing Information. Pfizer. New York, NY. Revised October 2025.
33. Sotyktu (deucravacitinib). Prescribing Information. Bristol-Myers Squibb Company. Princeton, NJ. Revised March 2026.
34. Immgolis (golimumab-sldi). Prescribing Information. Accord BioPharma, Inc.; Raleigh, NC. Revised May 2026.

History

Date	Comments
07/01/25	New policy, approved June 10, 2025. Moved psoriatic arthritis criteria for the infliximab products, adalimumab products, Simponi Aria, Enbrel, Taltz, Stelara, Skyrizi, Tremfya, Rinvoq, Rinvoq LQ, Xeljanz, Xeljanz XR, Otezla, Cimzia, Simponi, Bimzelx, Cosentyx, and Orencia from Policy 5.01.550 to 5.01.645. Added coverage criteria for Imuldosa (ustekinumab-srlf), Otulfi (ustekinumab-aauz), Pyzchiva (ustekinumab-ttwe), Selarsdi (ustekinumab-ackn), Steqeyma (ustekinumab-stba), ustekinumab (Stelara unbranded), ustekinumab-aekn (Selarsdi unbranded), ustekinumab-ttwe (Pyzchiva unbranded), Yesintek (ustekinumab-kfce), and Wezlana (ustekinumab-auub). Added the following to note to select criteria for Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab pegol), Cosentyx (secukinumab) IV/SC, Orencia (abatacept) IV/SC, and Simponi (golimumab) SC: This medical necessity criteria does not apply to one Open formulary (Formulary ID: 6062; Rx Plan F1) and one Preferred formulary (Formulary ID: 6064; Rx Plan G3). The criteria for members with these custom Open and Preferred formulary plans can be found in policy 5.01.647 Medical Necessity Criteria for Custom Open and Preferred

Date	Comments
	Formularies. Added HCPCS code Q9999. Also added HCPCS codes Q5137 and Q5138 for Wezlana, Q9996 and Q9998 for Steqeyma. Also added new HCPCS codes Q5098 for Imuldosa and Q5099 for Otulfi and Q5100 for Yesintek. The following policy changes are effective October 3, 2025, following 90-day provider notification. Clarified that the Site of Service Medical Necessity criteria can apply to injection drugs. Updated Stelara (ustekinumab) coverage criteria to require trial with Steqeyma (ustekinumab-aauz) and Yesintek (ustekinumab-kfce) for individuals not previously treated. New policy sections for Metallic (individual/small group/student ISHIP) formulary plans, Essentials formulary plans, and Open/Preferred/Select formulary plans and plans with no pharmacy benefit coverage. Added different coverage criteria for Metallic (individual/small group/student ISHIP) formulary and Essentials formulary plans for the following drugs: Enbrel (etanercept), adalimumab products, infliximab products, Taltz (ixekizumab), ustekinumab products, Skyrizi (risankizumab-rzaa), Tremfya (guselkumab), Otezla (apremilast), Bimzelx (bimekizumab-bkzx), Cosentyx (secukinumab), Cimzia (certolizumab pegol), Rinvoq/Rinvoq LQ (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib extended-release), Simponi (golimumab), Simponi Aria (golimumab), Rinvoq LQ (upadacitinib), and Orencia (abatacept).
10/01/25	Interim Review, approved September 9, 2025. Removed Idacio (adalimumab-aacf) from the policy as it has been removed from the market. Added coverage criteria for Starjemza (ustekinumab-hmny). The following policy change is effective January 2, 2026, following 90-day provider notification. Updated Cyltezo (adalimumab-adbm) from a preferred product to a non-preferred product. Updated adalimumab-aaty (Yuflyma unbranded) and Yuflyma (adalimumab-aaty) from a non-preferred product to a preferred product. Updated Avsola (infliximab-axxq) from a non-preferred product to a preferred product. Updated infliximab (Janssen – unbranded) and Remicade (infliximab) to require that the individual has had an inadequate response or intolerance to the preferred products for new starts.
11/01/25	Interim Review, approved October 27, 2025. Updated Tremfya (guselkumab) coverage criteria age requirement from 18 years or older to 6 years or older.
01/01/26	Interim Review, approved December 22, 2025. Removed reference to the Preferred formulary (Formulary ID: 6064; Rx Plan G3) as it is no longer available. Clarified that Section 2 of this policy applies to plans with the High Cost Low Value (HCLV) drug list. Updated Otezla (apremilast) coverage criteria age requirement from 18 years or older to 6 years or older. Updated Xeljanz (tofacitinib) coverage criteria age requirement from 18 years or older to 2 years or older.
03/01/26	Annual Review, approved February 10, 2026. Updated Enbrel and Simponi Aria removing note: This medical necessity criteria does not apply to one Open formulary (Formulary ID: 6062; Rx Plan F1). The criteria for members with this custom Open formulary plan can be found in policy 5.01.647 Medical Necessity Criteria for Custom Open Formulary. Please check the member Plan booklet or member ID card to determine whether this policy criteria applies. Updated coverage criteria for Otezla (apremilast) specifying individual weigh at least 20 kg. Added coverage criteria for

Date	Comments
	Otezla XR (apremilast extended release) for the treatment of psoriatic arthritis. Added Otezla XR to list of preferred alternatives for Cimzia, Simponi, Bimzelx, Cosentyx, and Orencia. Updated Simponi Aria (golimumab) coverage criteria age requirement from 18 years or older to 2 years or older. Updated Tremfya (guselkumab) coverage criteria to include individuals weigh at least 40 kg.
06/01/26	Interim Review, approved May 12, 2026. Added coverage criteria for Sotyktu (deucravacitinib) for the treatment of active psoriatic arthritis. Added ustekinumab-aauz as a non-preferred product. Removed coverage criteria for Yuflyma (adalimumab-aaty) as product has been discontinued. Updated Simlandi (adalimumab-ryvk), adalimumab-ryvk, adalimumab-adbm [NDCs starting with 82009] from preferred products to non-preferred products. Updated criteria for second line adalimumab products updating preferred alternatives to adalimumab-aaty, adalimumab-adaz, and adalimumab-adbm [NDCs starting with 00597]. Updated criteria for Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Cosentyx (secukinumab), Orencia (abatacept), and Simponi (golimumab) SC updating list of preferred alternatives to adalimumab-aaty, adalimumab-adaz, adalimumab-adbm [NDCs starting with 00597]; and Sotyktu (deucravacitinib). Updated formatting removing the reference to Section 1: Open, Preferred, and Select Formulary Plans (Rx Plan A1, A2, B3, B4, C4, and F1) and Plans with No Pharmacy Benefit Coverage ONLY. Removed the following: Section 2: Essentials Formulary Plans (Rx Plan E1, E3, E4) and Plans with the High Cost Low Value Drug List and Section 3 Individual/Small Group/Student ISHIP Metallic Formulary Plans (Rx Plan M1, M2, and M4). Removed reference to non-formulary exception reviews.
07/01/26	Coding update. Added new HCPCS Q5164 effective, July 1, 2026.
08/01/26	Interim Review, approved July 27, 2026. Updated criteria for Skyrizi (risankizumab-rzaa) for treatment of psoriatic arthritis age requirement from aged 18 years to 6 years or older. Added tofacitinib to the policy with the same criteria as Xeljanz (tofacitinib). Added tofacitinib extended-release to the policy with the same criteria as Xeljanz XR (tofacitinib extended-release). Updated Cimzia, Cosentyx, Orencia, Simponi SC to include tofacitinib and tofacitinib extended-release as preferred alternatives where Xeljanz (tofacitinib) and Xeljanz XR (tofacitinib extended-release) are listed as preferred alternatives. Added adalimumab-bwwd to the policy with the same criteria as Hadlima (adalimumab-bwwd) and second-line adalimumab products.
10/01/26	Interim Review, approved September 8, 2026. Added Immgolis (golimumab-sldi) to the policy with the same criteria as Simponi (golimumab) SC. Added Immgolis Intri (golimumab-sldi) IV to the policy with the same criteria as Simponi (golimumab) IV. Updated Renflexis (infliximab-abda) from a non-preferred product to a preferred product. Updated non-preferred infliximab products, infliximab (Janssen – unbranded) and Remicade (infliximab), adding Renflexis (infliximab-abda) to list of preferred alternatives. The following policy changes are effective January 1, 2027, following 90-day provider notification. Updated Stelara (ustekinumab) from a preferred product to

Date	Comments
	non-preferred product, and removed Stelara as a preferred alternative for all non-preferred agents.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2026 Premera All Rights Reserved.

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