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MEMORIAL HERMANN HEALTH PLAN HOLDINGS, LLC
POLICY

POLICY TITLE: MHHP MEDM-MA IMM-002 Immunologic Drugs (non-oncology) Step Therapy Criteria

PUBLICATION DATE: 06/10/2025
LAST REVIEW DATE: 06/10/2025
VERSION: 2

Version	*Change Summary*	*Revised By*
1	Legacy document; Approved by P&T Committee 5/7/2025	D. Pierce/S. Soman
2	Rheumatologic indications chart error correction	D.Pierce

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POLICY PURPOSE:

The Memorial Hermann Health Immunologic Drugs (non-oncology) policy aims to advise providers of preferred drug products and outline the exceptions to preferred drug products during the prior authorization process. Step therapy criteria is applied in conjunction with any relevant National Coverage Determinations (NCD), Local Coverage Determination (LCD), InterQual and other MHHP internal medical necessity and or Part B drug criteria.

DEFINITIONS: None

SCOPE:

This policy applies to Memorial Hermann Medicare plans.

POLICY STATEMENT

The step therapy program applies to immunologic drugs as described in this policy. Requests for Part B drug coverage of non-preferred drugs must comply with step criteria in this policy. If approved, authorizations will be in place for 6 months. If a provider administers a non-preferred drug without obtaining prior authorization, the request for coverage may be denied. Preferred drugs may still require prior authorization. This policy applies to all Medicare members who are new to treatment with a non-preferred product. A member will not be required to change the current drug treatment. For the purposes of this policy, "current drug treatment" is defined as either a paid claim for the drug or clinical documentation confirming that the member has been using the non-preferred drug within the past 365 days. In addition, there must be evidence of regular follow-up visits with the prescribing physician within the last 6 months. The member must also demonstrate clinical improvement as a result of the ongoing treatment. If a new plan member is currently using a particular drug, MHHP will not require the member to switch to the preferred drug upon enrollment. An existing member currently using a particular drug will not be required to change drug/products if this policy is updated.

Coverage for non-preferred drugs is based on documentation of clinical scenarios that support medical necessity and exclusion of the use of a preferred drug. Not all indications for the non-preferred drug are listed in this policy. Indications and medications listed in this policy may change upon varying factors and should be evaluated by guidelines, the FDA and manufacturer package insert to verify appropriate use at the time of review.

Indications

- Ankylosing spondylitis
- Crohn's Disease
- Juvenile Idiopathic Arthritis
- Psoriasis
- Psoriatic Arthritis
- Rheumatoid Arthritis
- Ulcerative Colitis
- Sarcoidosis

Rheumatology Indications

Initial (New Starts) Authorization Criteria*		
DIAGNOSIS	**1ST PREFERRED**	**2ND PREFERRED**
Rheumatoid arthritis	Enbrel Adalimumab (Humira) Biosimilars**	Adalimumab (Humira) Tocilizumab subcutaneous products (Actemra, Tyenne) Rinvoq Xeljanz Cimzia Kevzara Kineret Olumiant Orencia SC Simponi SC
Juvenile Idiopathic Arthritis	Enbrel Adalimumab (Humira) Biosimilars**	Adalimumab (Humira) Tocilizumab Subcutaneous products (Actemra, Tyenne) Rinvoq Xeljanz Cimzia Kevzara Orencia SC
Ankylosing Spondylitis	Enbrel Adalimumab (Humira) Biosimilars** Taltz	Adalimumab (Humira) Rinvoq Xeljanz Bimzelx

		Cimzia Cosentyx Simponi SC
Psoriatic Arthritis	Enbrel Adalimumab (Humira) Biosimilars**	Adalimumab (Humira) Rinvoq Xeljanz Bimzelx Cimzia Cosentyx SC Orencia SC Simponi SC

**Any drugs not listed as preferred will be considered non-preferred until the next policy update*
*** Only FDA approved Adalilumab and Ustekinumab biosimilars are considered preferred drugs*

Dermatology and Gastroenterology Indications

Initial (New Starts) Authorization Criteria*		
Disease State	1st Preferred	2nd Preferred
Hidradenitis Suppurativa	Adalimumab (Humira) Biosimilars** Cosentyx SC	Adalimumab (Humira) Bimzelx
Psoriasis	Adalimumab (Humira) Biosimilars** Enbrel Otezla Skyrizi SC Sotyktu Ustekinumab (Stelara) Biosimilars** Taltz Tremfya SC	Adalimumab (Humira) Bimzelx Cimzia Cosentyx SC Ilumya Siliq
Chron's Disease	Adalimumab (Humira) Biosimilars** Omvoh SC Skyrizi SC Ustekinumab (Stelara) Biosimilars** Zymfentra	Adalimumab (Humira) Entyvio SC
Ulcerative Colitis	Adalimumab (Humira) Biosimilars** Omvoh SC	Adalimumab (Humira) Rinvoq Simponi SC

	Skyrizi SC Ustekinumab (Stelara) Biosimilars** Tremfya Velsipity Zymfentra	Xeljanz Entyvio SC Zeposia

**Any drugs not listed as preferred will be considered non-preferred until the next policy update*
*** Only FDA approved Adalilumab and Ustekinumab biosimilars are considered preferred drugs*

Criteria: Coverage for the non-preferred product (s) is provided when there is clinical documentation to support one or more of the following criteria:

1. The member has received the requested non-preferred drugs in the past 365 days and there is objective evidence of clinical benefit via imaging, lab results, or clinical assessment

OR

1. There has been an inadequate response to treatment with one or more of the preferred drugs

OR

2. There has been an adverse event related to the preferred drug (s)

OR

3. There is a contraindication to the preferred drug (s)

OR

4. The requested non-preferred drug is for a medically necessary indication not listed above and meets criteria under **MHHP Biosimilar First Policy.**

AND

5. Dosing must be in accordance with FDA approved labeling or otherwise supported by approved compendia and disease specific treatment guidelines.

Related documents

MHHP MEDM-MA 303 Medical Necessity Determinations

MHHP MEDM-MA BIO-007 Biosimilar First Policy

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