Texas Prior Authorization Program
Clinical Criteria

Drug/Drug Class

Cytokine and CAM Antagonists

This criteria was recommended for review by the Texas Medicaid Vendor Drug Program to ensure appropriate and safe utilization.

Clinical Criteria Information included in this Document

Actemra (Tocilizumab)

- Drugs requiring prior authorization: the list of drugs requiring prior authorization for this clinical criteria
- Prior authorization criteria logic: a description of how the prior authorization request will be evaluated against the clinical criteria rules
- Logic diagram: a visual depiction of the clinical criteria logic
- Supporting tables: a collection of information associated with the steps within the criteria (diagnosis codes, procedure codes, and therapy codes); provided when applicable
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Arcalyst (Rilonacept)

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Bimzelx (Bimekizumab-bkzx)

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Cibinqo (Abrocitinib)

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Cimzia (Certolizumab pegol)

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Cosentyx (Secukinumab)

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Enbrel (Etanercept)

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Enspryng (satralizumab-mwge)

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Entyvio SC (vedolizumab)

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Humira (Adalimumab) and Biosimilar Agents

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Ilaris (Canakinumab)

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Ilumya (Tildrakizumab-asmn)

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Kevzara (Sarilumab)

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Kineret (Anakinra)

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Litfulo (Ritlecitinib)

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Olumiant (Baricitinib)

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Omvoh (Minkizumab-mrkz)

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Orencia (Abatacept)

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Otezla (Apremilast)

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Rinvoq (Upadacitinib)

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Siliq (Brodalumab)

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Simponi (Golimumab)

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Skyrizi (Risankizumab-rzaa)

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Sotyktu (Deucravacitinib)

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Spevigo (Spesolimab-sbzo)

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Stelara (Ustekinumab) and Biosimilar Agents

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Taltz (Ixekizumab)

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Tremfya (Guselkumab)

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Tyenne (Tocilizumab-aazg)

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Xeljanz (Tofacitinib)

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Note: Click the hyperlink to navigate directly to that section.

Revision Notes

Added new indication of HS for Bimzelx as approved by the DUR Board

Added new indication for polyarticular juvenile idiopathic arthritis for ages 2-17 years for Kevzara as approved by the DUR Board

Added new indication of Crohn's disease and updated maximum dosage of 900 mg IV on weeks 0, 4, and 8 for Omvoh as approved by the DUR Board

Added new indication for ulcerative colitis in adults for Skyrizi as approved by the DUR Board

PAXPRESS™

Actemra (Tocilizumab)

Drugs Requiring Prior Authorization

The listed GCNs may not be an indication of Texas Medicaid Formulary coverage. To learn the current formulary coverage, visit txvendordrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	**GCN**
ACTEMRA 162MG/0.9ML SYRINGE	35486
ACTEMRA ACTPEN 162 MG/0.9 ML	45082

PAXPRESS™

Actemra (Tocilizumab)

Clinical Criteria Logic

1. Is the client greater than or equal to (≥) 18 years of age?

   [ ] Yes – Go to #2

   [ ] No – Go to #5

2. Does the client have a diagnosis of rheumatoid arthritis (RA) in the last 730 days?

   [ ] Yes – Go to #4

   [ ] No – Go to #3

3. Does the client have a diagnosis of giant cell arteritis (GCA) or systemic sclerosis-associated interstitial lung disease (SSc-ILD) in the last 730 days?

   [ ] Yes – Go to #7

   [ ] No – Go to #5

4. Does the client have 1 claim for a DMARD in the last 180 days?

   [ ] Yes – Go to #7

   [ ] No, and the request is for continuing therapy – Go to #7

   [ ] No, and the request is for initial therapy – Deny

5. Does the client have a diagnosis of polyarticular juvenile idiopathic arthritis (PJIA) or systemic juvenile idiopathic arthritis (SJIA) in the last 730 days?

   [ ] Yes – Go to #6

   [ ] No – Deny

6. Is the client greater than or equal to (≥) 2 years of age?

   [ ] Yes – Go to #7

   [ ] No – Deny

7. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

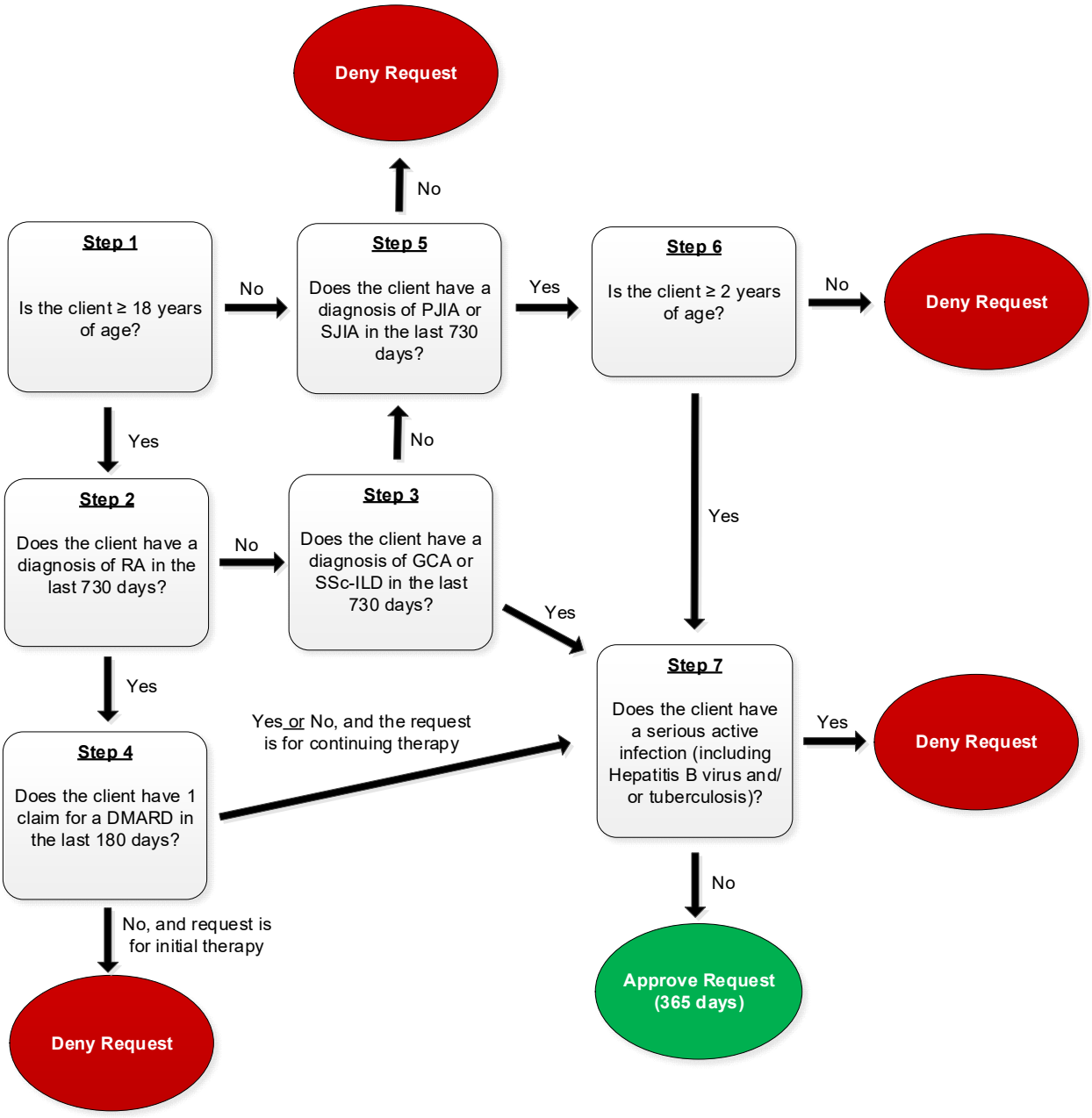
   [ ] Yes – Deny

   [ ] No – Approve (365 days)

PAXPRESS™

Actemra (Tocilizumab)

Clinical Criteria Logic Diagram



Arcalyst (Rilonacept)

Drugs Requiring Prior Authorization

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Drugs Requiring Prior Authorization	
Label Name	**GCN**
ARCALYST 220MG INJECTION	99473

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Arcalyst (Rilonacept)

Clinical Criteria Logic

1. Does the client have a diagnosis of deficiency of interleukin-1 receptor antagonist (DIRA) in the last 730 days?

   [ ] Yes – Go to #4

   [ ] No – Go to #2

2. Is the client greater than or equal to (≥) 12 years of age?

   [ ] Yes – Go to #3

   [ ] No – Deny

3. Does the client have a diagnosis of cryopyrin associated periodic syndrome (CAPS), familial cold auto-inflammatory syndrome (FCAS), Muckle-Wells syndrome (MWS), or recurrent pericarditis (RP) in the last 730 days?

   [ ] Yes – Go to #4

   [ ] No – Deny

4. Does the client have a claim for a biologic DMARD in the last 30 days?

   [ ] Yes – Deny

   [ ] No – Go to #5

5. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

   [ ] Yes – Deny

   [ ] No – Approve (365 days)

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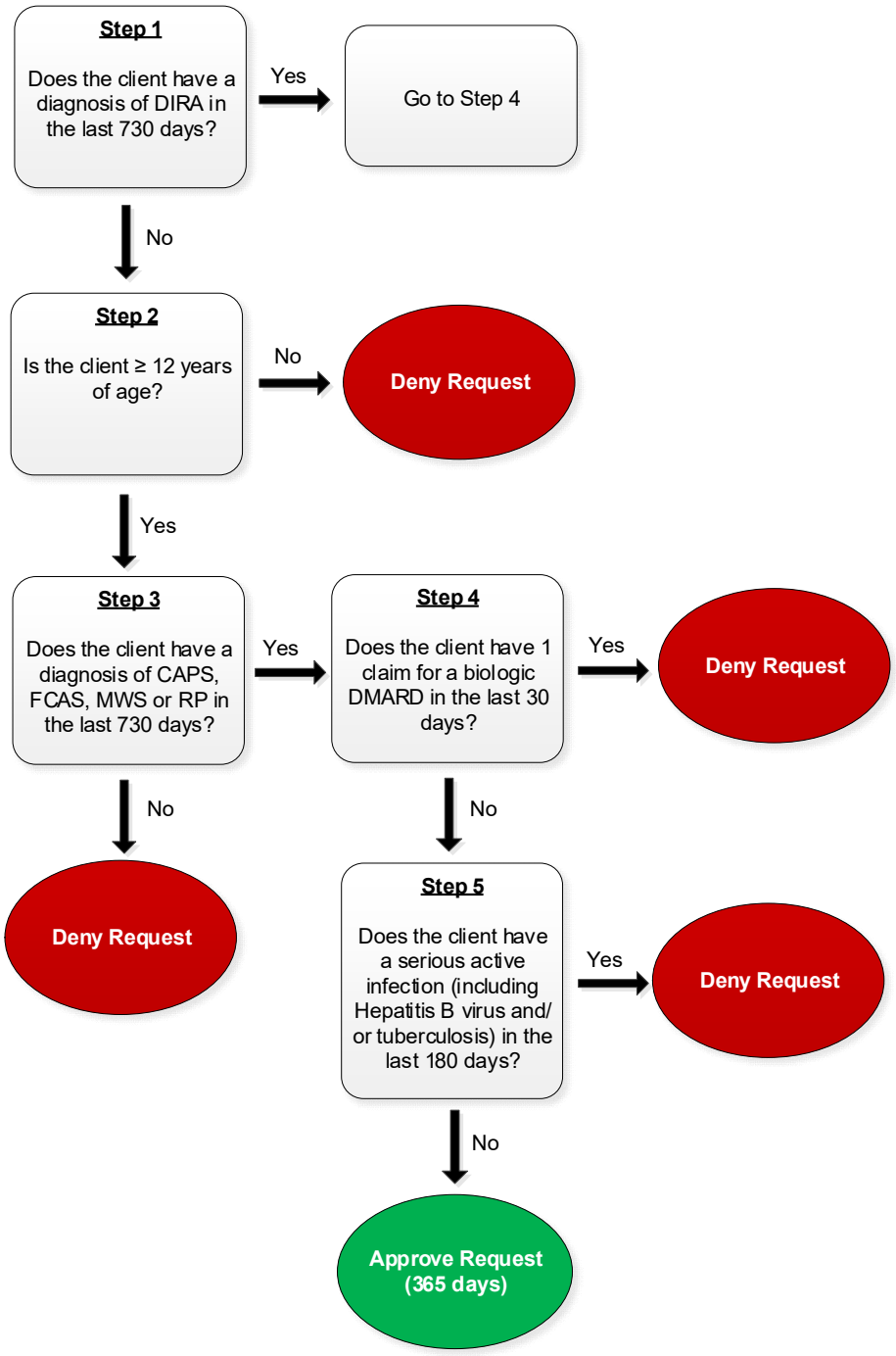
Arcalyst (Rilonacept)

Clinical Criteria Logic Diagram



PAXPRESS™

Bimzelx (Bimekizumab-bkzx)

Drugs Requiring Prior Authorization

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Drugs Requiring Prior Authorization	
Label Name	**GCN**
BIMZELX 160 MG/ML AUTOINJECTOR	54888
BIMZELX 160 MG/ML SYRINGE	51344

PAXPRESS™

Bimzelx (Bimekizumab-bkzx)

Clinical Criteria Logic

1. Is the client greater than or equal to (≥) 18 years of age?

   [ ] Yes – Go to #2

   [ ] No – Deny

2. Is this a renewal request?

   [ ] Yes – Go to #6

   [ ] No – Go to #3

3. Does the client have a diagnosis of ankylosing spondylitis (AS), hidradenitis suppurativa (HS), non-radiographic axial spondyloarthritis (nr-axSpA), plaque psoriasis (PS), or psoriatic arthritis (PsA) in the last 730 days?

   [ ] Yes – Go to #4

   [ ] No – Deny

4. Does the client have a claim for a TNF blocker in the last 730 days?

   [ ] Yes – Go to #6

   [ ] No – Go to #5

5. Does the client have an intolerance or a contraindication to a TNF blocker? [Manual]

   [ ] Yes – Go to #6

   [ ] No – Deny

6. Does the client have a diagnosis of cirrhosis in the last 365 days?

   [ ] Yes – Deny

   [ ] No – Go to #7

7. Does the client have a diagnosis of suicidal ideation in the last 365 days?

   [ ] Yes – Deny

   [ ] No – Go to #8

8. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

   [ ] Yes – Deny

   [ ] No – Go to #9

9. Will the client have concurrent therapy with a JAK inhibitor or biologic DMARD?

   [ ] Yes – Deny

[ ] No – Go to #10

10. Is the requested dose for less than or equal to (≤) 320 mg per 28 days?

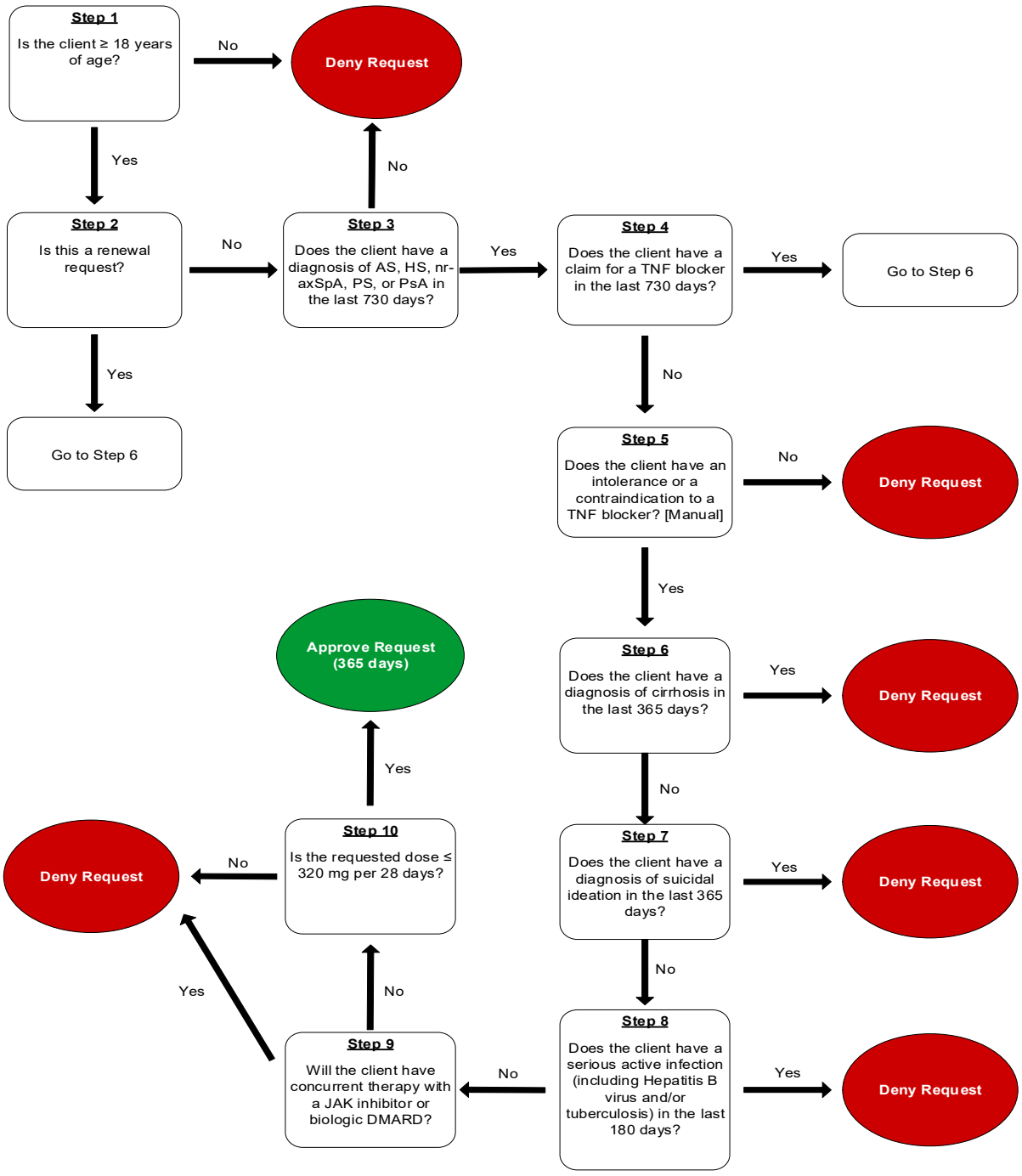
[ ] Yes – Approve (365 days)

[ ] No – Deny

PAXPRESS™

Bimzelx (Bimekizumab-bkzx)

Clinical Criteria Logic Diagram



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Cibinqo (Abrocitinib)

Drugs Requiring Prior Authorization

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Drugs Requiring Prior Authorization	
Label Name	**GCN**
CIBINQO 50 MG TABLET	51825
CIBINQO 100 MG TABLET	51827
CIBINQO 200 MG TABLET	51828

PAXPRESS™

Cibinqo (Abrocitinib)

Clinical Criteria Logic

1. Does the client have a diagnosis of refractory, moderate to severe atopic dermatitis (AD) in the last 730 days?

   [ ] Yes – Go to #2

   [ ] No – Deny

2. Is the client greater than or equal to (≥) 12 years of age?

   [ ] Yes – Go to #3

   [ ] No – Deny

3. Has the client had 30 continuous days of therapy with at least one systemic agent for the treatment of atopic dermatitis in the last 90 days?

   [ ] Yes – Go to #5

   [ ] No, and this is a renewal request – Go to #5

   [ ] No, and this is an initial request – Go to #4

4. Has the client had inadequate response or intolerance to systemic agents for the treatment of atopic dermatitis? [Manual]

   [ ] Yes – Go to #5

   [ ] No – Deny

5. Will the client have concurrent therapy with a JAK inhibitor (JAKi), biologic DMARD, or potent immunosuppressant?

   [ ] Yes – Deny

   [ ] No – Go to #6

6. Has the client had therapy with a moderate to strong inhibitor of both CYP2C19 and CYP2C9, strong CYP2C19 inducer, or strong CYP2C9 inducer in the last 90 days?

   [ ] Yes – Deny

   [ ] No – Go to #7

7. Does the client have a diagnosis of severe hepatic impairment or severe renal impairment (eGFR < 30 mL/min) in the last 365 days?

   [ ] Yes – Deny

   [ ] No – Go to #8

8. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

[ ] Yes – Deny

[ ] No – Go to #9

9. Does the client have a diagnosis of mild to moderate renal impairment in the last 365 days?

   [ ] Yes – Go to #12

   [ ] No – Go to #10

10. Is the client a poor CYP2C19 metabolizer? [Manual]

    [ ] Yes – Go to #12

    [ ] No – Go to #11

11. Is the requested dose less than or equal to (≤) 1 tablet daily?

    [ ] Yes – Approve (365 days)

    [ ] No – Deny

12. Is the requested dose less than or equal to (≤) the recommended adjusted dose?

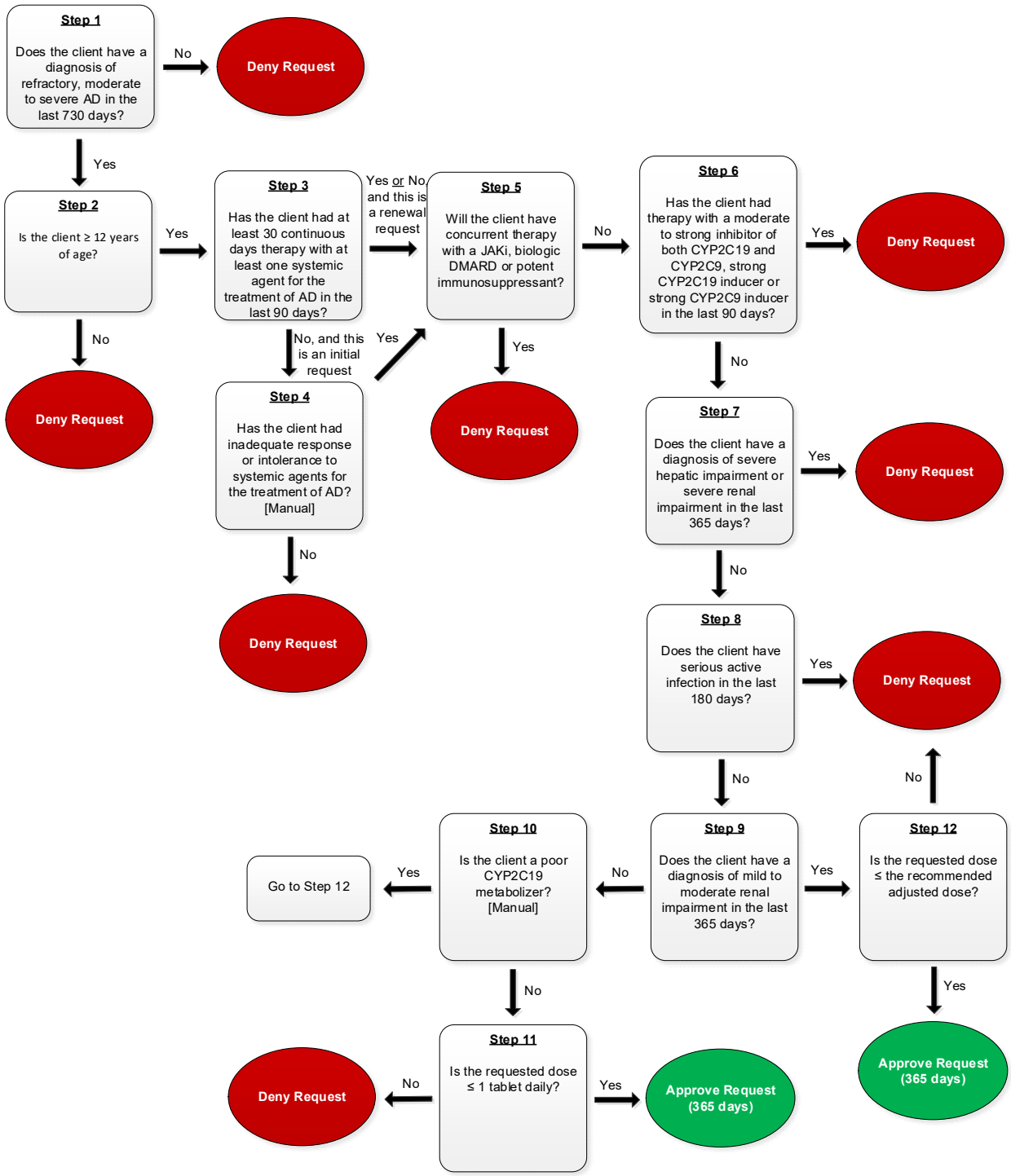
    [ ] Yes – Approve (365 days)

    [ ] No – Deny

PAXPRESS™

Cibinqo (Abrocitinib)

Clinical Criteria Logic Diagram



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Cimzia (Certolizumab pegol)

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Drugs Requiring Prior Authorization	
Label Name	**GCN**
CIMZIA 200MG/ML SYRINGE KIT	23471
CIMZIA 200MG/ML STARTER KIT	23471

PAXPRESS™

Cimzia (Certolizumab pegol)

Clinical Criteria Logic

1. Is the client greater than or equal to (≥) 18 years of age?

   [ ] Yes – Go to #2

   [ ] No – Go to #5

2. Does the client have a diagnosis of Crohn's disease (CD) in the last 730 days?

   [ ] Yes – Go to #3

   [ ] No – Go to #4

3. Has the client had a 30-day treatment trial of conventional therapy for Crohn's disease in the last 180 days?

   [ ] Yes – Go to #7

   [ ] No, and the request is for continuing therapy – Go to #7

   [ ] No, and the request is for initial therapy – Go to #4

4. Does the client have a diagnosis of ankylosing spondylitis (AS), non-radiographic axial spondyloarthritis (nr-axSpA), psoriatic arthritis (PsA), plaque psoriasis (PS), and/or rheumatoid arthritis (RA) in the last 730 days?

   [ ] Yes – Go to #7

   [ ] No – Go to #5

5. Is the client greater than or equal to (≥) 2 years of age?

   [ ] Yes – Go to #6

   [ ] No – Deny

6. Does the client have a diagnosis of polyarticular juvenile idiopathic arthritis (pJIA) in the last 730 days?

   [ ] Yes – Go to #7

   [ ] No – Deny

7. Does the client have a history of a demyelinating disease (multiple sclerosis, optic neuritis, Guillain-Barre syndrome) in the last 365 days?

   [ ] Yes – Deny

   [ ] No – Go to #8

8. Does the client have a history of heart failure in the last 365 days?

   [ ] Yes – Deny

[ ] No – Go to #9

9. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

   [ ] Yes – Deny

   [ ] No – Go to #10

10. Does the client have a history of hematologic abnormalities in the last 60 days?

    [ ] Yes – Deny

    [ ] No – Go to #11

11. Does the client have 1 claim for a contraindicated drug in the last 30 days?

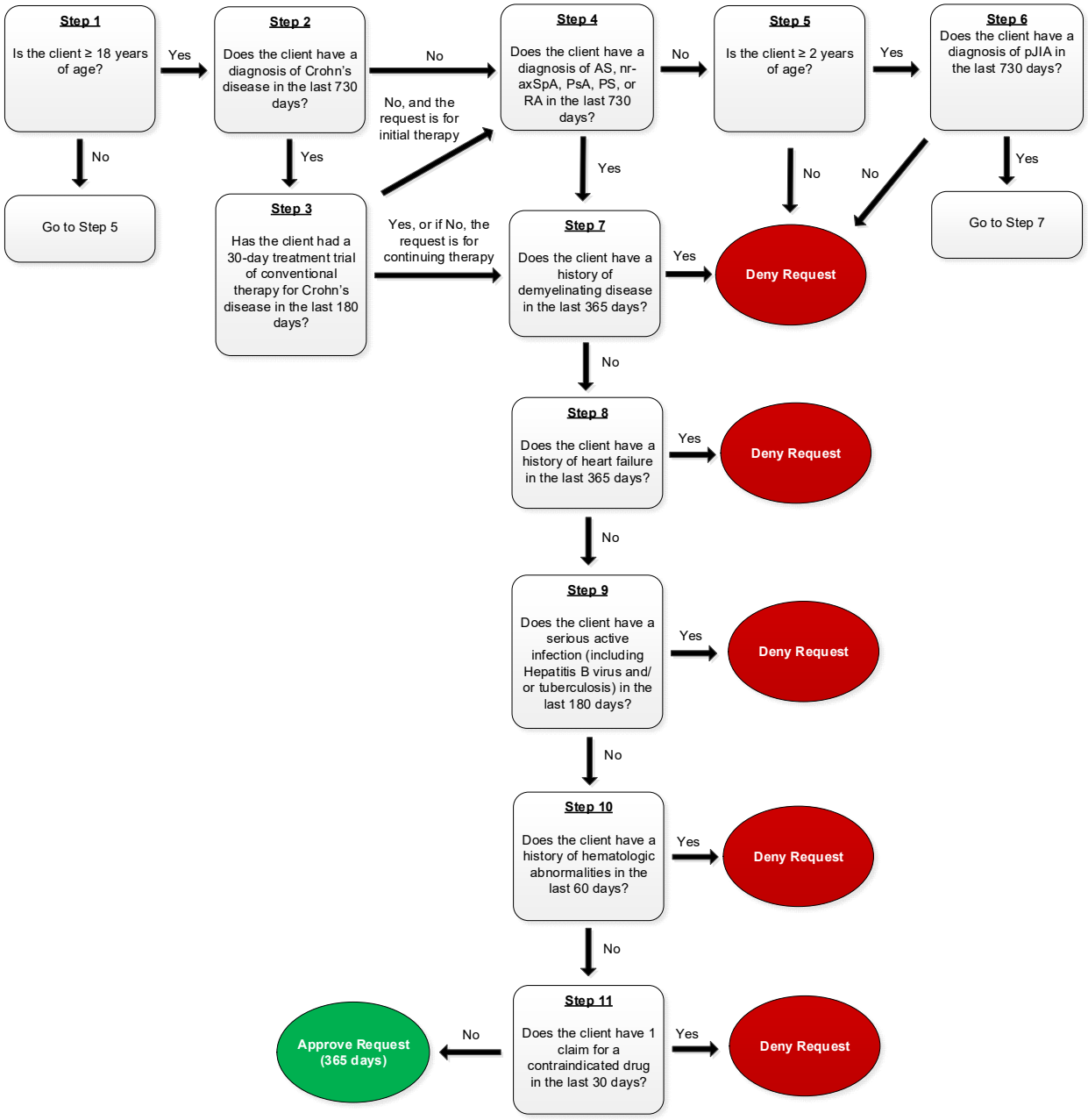
    [ ] Yes – Deny

    [ ] No – Approve (365 days)

PAXPRESS™

Cimzia (Certolizumab pegol)

Clinical Criteria Logic Diagram



PAXPRESS™

Cosentyx (Secukinumab)

Drugs Requiring Prior Authorization

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Drugs Requiring Prior Authorization	
Label Name	**GCN**
COSENTYX 300 MG DOSE-2 PENS	37789
COSENTYX 150 MG/ML PEN INJECT	37789
COSENTYX 150 MG/ML SYRINGE	37788
COSENTYX 300 MG DOSE-2 SYRINGES	37788
COSENTYX 75 MG/0.5ML SYRINGE	49732

PAXPRESS™

Cosentyx (Secukinumab)

Clinical Criteria Logic

1. Does the client have a diagnosis of psoriatic arthritis (PsA) in the last 730 days?

   [ ] Yes – Go to #2

   [ ] No – Go to #3

2. Is the client greater than or equal to (≥) 2 years of age?

   [ ] Yes – Go to #9

   [ ] No – Deny

3. Does the client have a diagnosis of enthesitis-related arthritis (ERA) in the last 730 days?

   [ ] Yes – Go to #4

   [ ] No – Go to #5

4. Is the client greater than or equal to (≥) 4 years of age?

   [ ] Yes – Go to #9

   [ ] No – Deny

5. Does the client have a diagnosis of moderate to severe plaque psoriasis (PS) in the last 730 days?

   [ ] Yes – Go to #6

   [ ] No – Go to #7

6. Is the client greater than or equal to (≥) 6 years of age?

   [ ] Yes – Go to #9

   [ ] No – Deny

7. Does the client have a diagnosis of ankylosing spondylitis (AS), hidradenitis suppurativa (HS), or non-radiographic axial spondyloarthritis (nr-axSpA) in the last 730 days?

   [ ] Yes – Go to #8

   [ ] No – Deny

8. Is the client greater than or equal to (≥) 18 years of age?

   [ ] Yes – Go to #9

   [ ] No – Deny

9. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

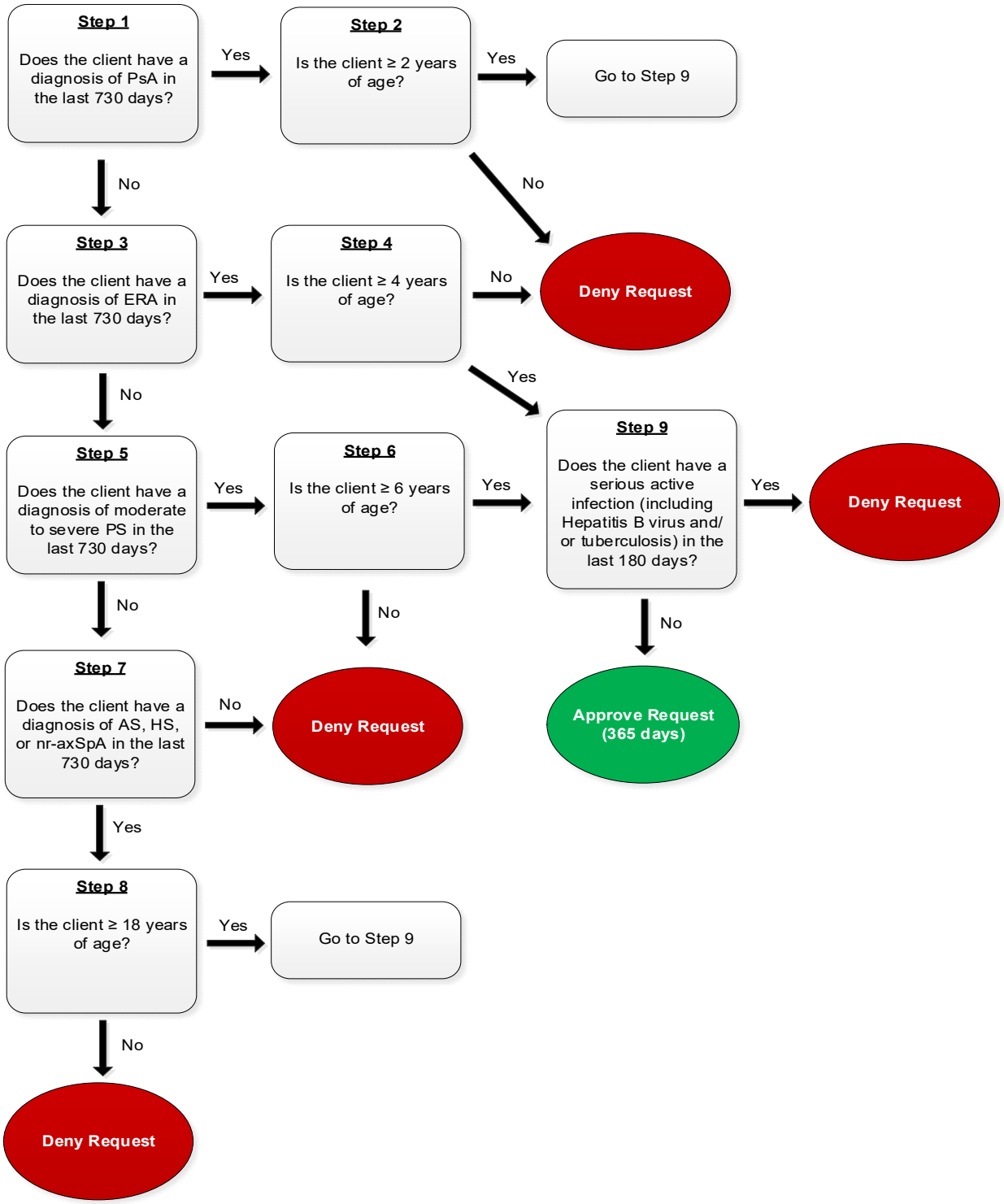
[ ] Yes – Deny

[ ] No – Approve (365 days)

PAXPRESS™

Cosentyx (Secukinumab)

Clinical Criteria Logic Diagram



PAXPRESS™

Enbrel (Etanercept)

Drugs Requiring Prior Authorization

The listed GCNs may not be an indication of Texas Medicaid Formulary coverage. To learn the current formulary coverage, visit txvendordrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	**GCN**
ENBREL 25 MG KIT	52651
ENBREL 50 MG/ML SYRINGE	23574
ENBREL 50 MG/ML SURECLICK SYR	97724
ENBREL 25 MG/0.5 ML SYRINGE	98398
ENBREL 50 MG/ML MINI CARTRIDGE	43924
ENBREL 25 MG/0.5 ML VIAL	48417

PAXPRESS™

Enbrel (Etanercept)

Clinical Criteria Logic

1. Does the client have a diagnosis of polyarticular juvenile idiopathic arthritis (PJIA) or psoriatic arthritis (PsA) in the last 730 days?

   [ ] Yes – Go to #4

   [ ] No – Go to #2

2. Does the client have a diagnosis of plaque psoriasis (PS) in the last 730 days?

   [ ] Yes – Go to #5

   [ ] No – Go to #3

3. Does the client have a diagnosis of ankylosing spondylitis (AS) or rheumatoid arthritis (RA) the last 730 days?

   [ ] Yes – Go to #6

   [ ] No – Deny

4. Is the client greater than or equal to (≥) 2 years of age?

   [ ] Yes – Go to #7

   [ ] No – Deny

5. Is the client greater than or equal to (≥) 4 years of age?

   [ ] Yes – Go to #7

   [ ] No – Deny

6. Is the client greater than or equal to (≥) 18 years of age?

   [ ] Yes – Go to #7

   [ ] No – Deny

7. Does the client have a history of heart failure in the last 365 days?

   [ ] Yes – Deny

   [ ] No – Go to #8

8. Does the client have a history of demyelinating disease (multiple sclerosis, optic neuritis, and/or Guillain-Barre syndrome) in the last 365 days?

   [ ] Yes – Deny

   [ ] No – Go to #9

9. Does the client have a history of hematologic abnormalities in the last 180 days?

   [ ] Yes – Deny

[ ] No – Go to #10

10. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

    [ ] Yes – Deny

    [ ] No – Go to #11

11. Does the client have 1 claim for a contraindicated drug in the last 30 days?

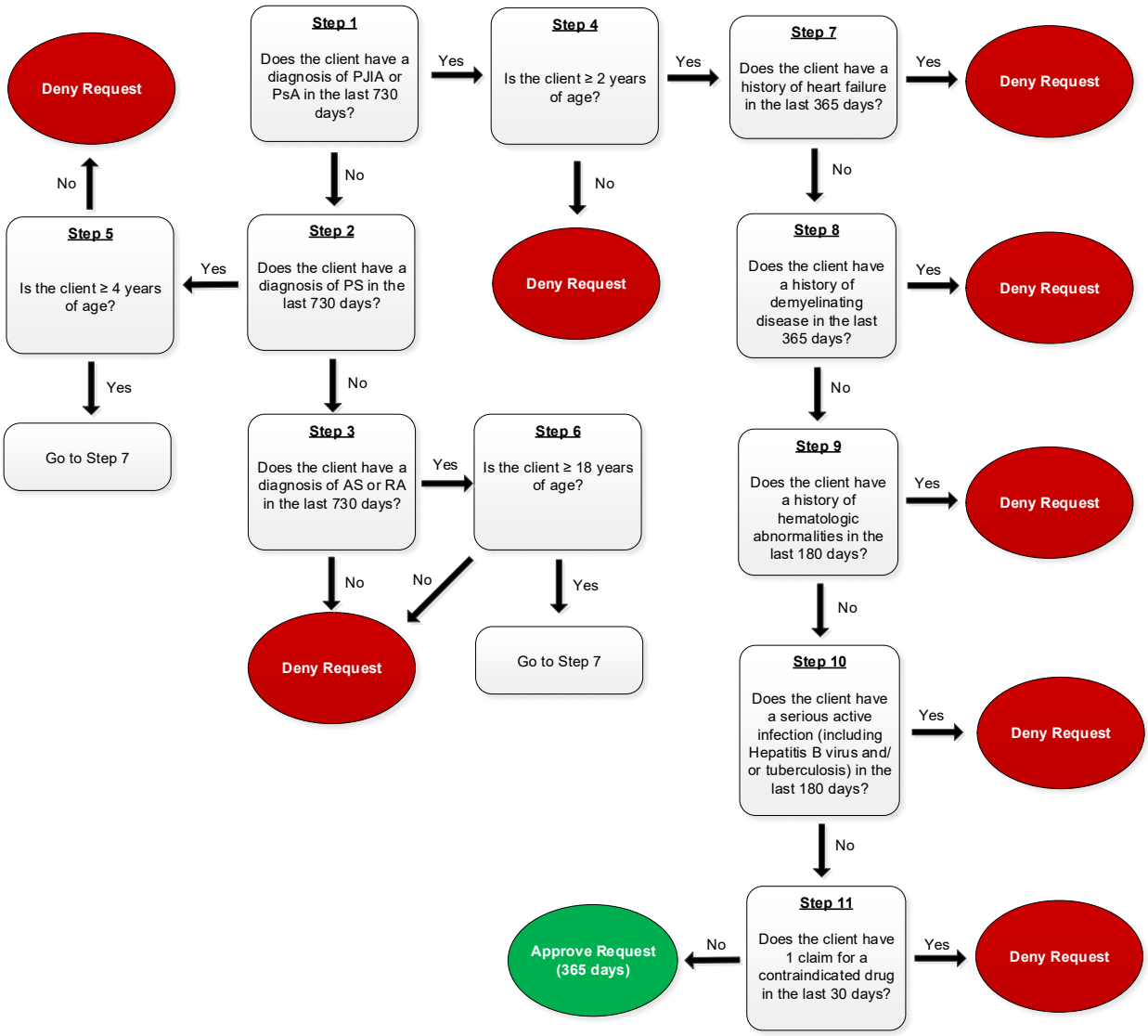
    [ ] Yes – Deny

    [ ] No – Approve (365 days)

PAXPRESS™

Enbrel (Etanercept)

Clinical Criteria Logic Diagram



PAXPRESS™

Enspryng (satralizumab-mwge)

Drugs Requiring Prior Authorization

The listed GCNs may not be an indication of Texas Medicaid Formulary coverage. To learn the current formulary coverage, visit txvendordrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	**GCN**
ENSPRYNG 120 MG/ML SYRINGE	48477

PAXPRESS™

Enspryng (satralizumab-mwge)

Clinical Criteria Logic

1. Is the client greater than or equal to (≥) 18 years of age?

   [ ] Yes – Go to #2

   [ ] No – Deny

2. Does the client have a diagnosis of neuromyelitis optica spectrum disorder (NMOSD) in the last 730 days?

   [ ] Yes – Go to #3

   [ ] No – Deny

3. Will the client have concurrent therapy with a drug listed in Table 3?

   [ ] Yes – Deny

   [ ] No – Go to #4

4. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

   [ ] Yes – Deny

   [ ] No – Go to #5

5. Is the requested dose less than or equal to (≤) 120 mg every 2 weeks for 3 doses, then 120 mg every 4 weeks? [Manual]

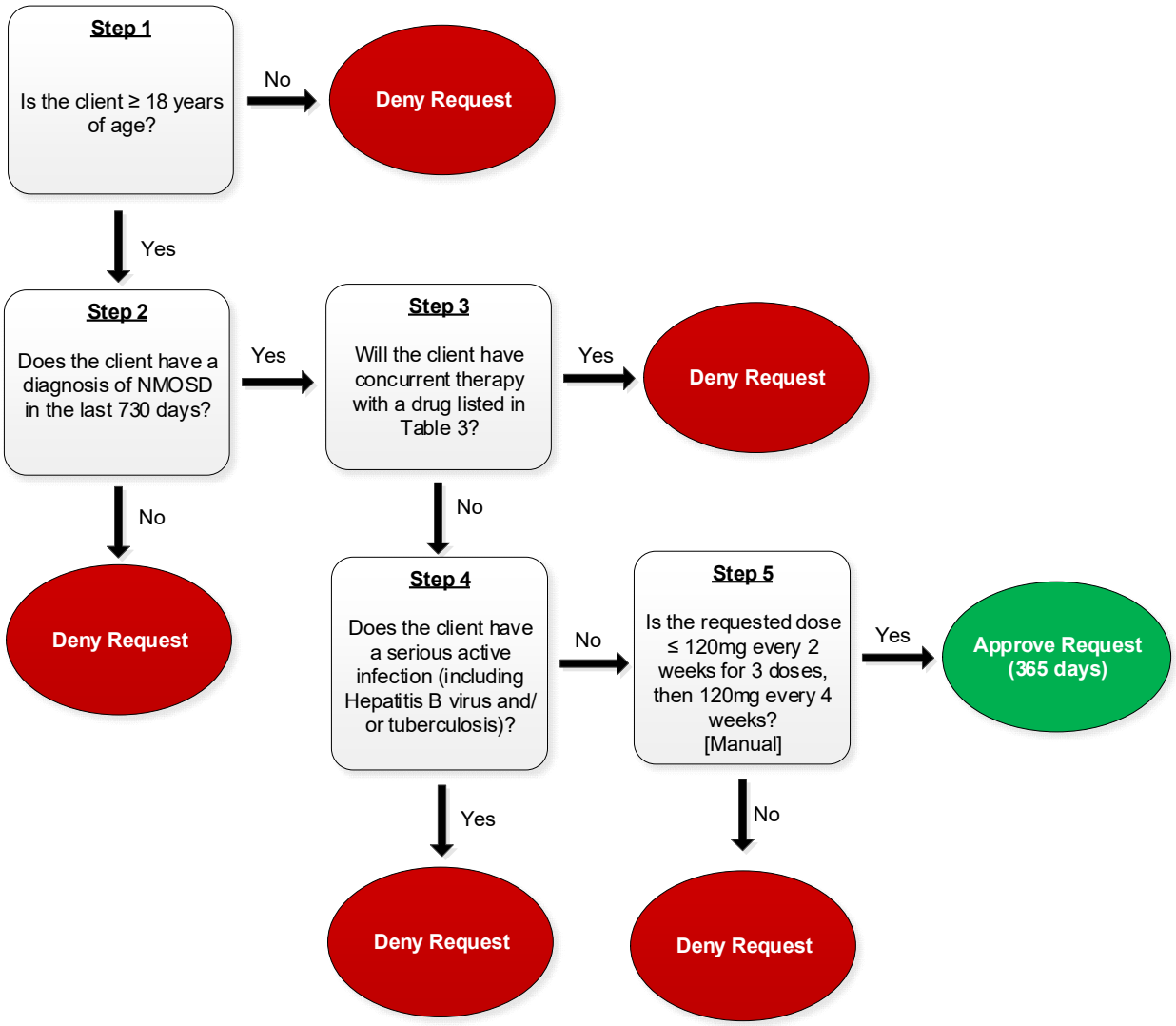
   [ ] Yes – Approve (365 days)

   [ ] No – Deny

PAXPRESS™

Enspryng (satralizumab-mwge)

Clinical Criteria Logic Diagram



Entyvio SC (vedolizumab)

Drugs Requiring Prior Authorization

The listed GCNs may not be an indication of Texas Medicaid Formulary coverage. To learn the current formulary coverage, visit txvendordrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	**GCN**
ENTYVIO 108 MG/0.68 ML PEN	48647

PAXPRESS™

Entyvio SC (vedolizumab)

Clinical Criteria Logic

1. Is the client greater than or equal to (≥) 18 years of age?

   [ ] Yes – Go to #2

   [ ] No – Deny

2. Does the client have a diagnosis of ulcerative colitis (UC) or Crohn's disease (CD) in the last 730 days?

   [ ] Yes – Go to #3

   [ ] No – Deny

3. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

   [ ] Yes – Deny

   [ ] No – Go to #4

4. Does the client have a diagnosis of progressive multifocal leukoencephalopathy (PML) or hepatic impairment in the last 180 days?

   [ ] Yes – Deny

   [ ] No – Go to #5

5. Is the requested dose less than or equal to (≤) 2-108 mg injections per 28 days?

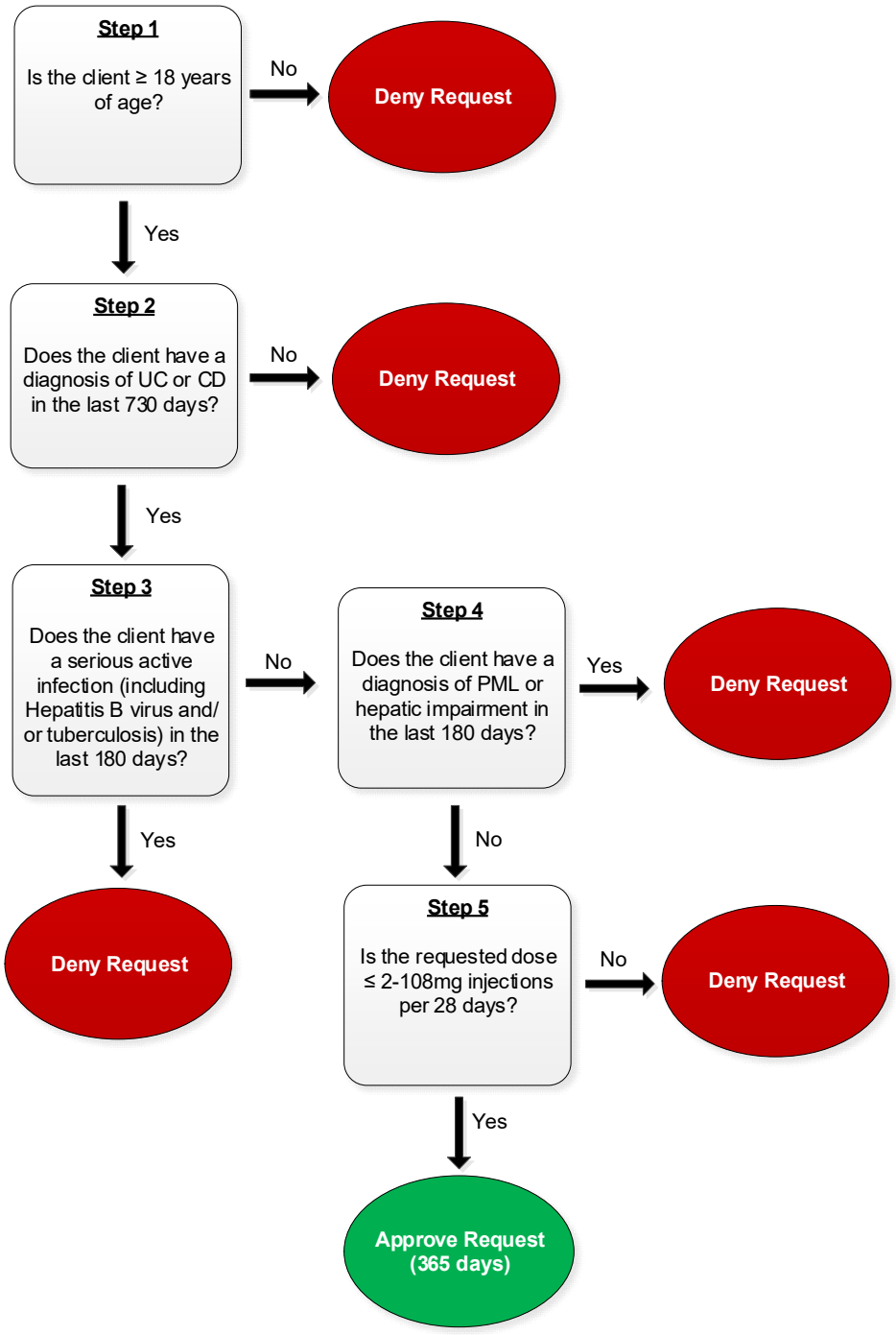
   [ ] Yes – Approve (365 days)

   [ ] No – Deny

PAXPRESS™

Entyvio SC (vedolizumab)

Clinical Criteria Logic Diagram



PAXPRESS™

Humira (Adalimumab)

Drugs Requiring Prior Authorization

The listed GCNs may not be an indication of Texas Medicaid Formulary coverage. To learn the current formulary coverage, visit txvendordrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	**GCN**
HUMIRA (CF) 10 MG/0.1 ML SYRINGE	44659
HUMIRA (CF) 20 MG/0.2 ML SYRINGE	44664
HUMIRA (CF) 40 MG/0.4 ML SYRINGE	43505
HUMIRA (CF) PEN 80 MG/0.8 ML	44014
HUMIRA (CF) PEDI CROHN 80 MG/0.8	43904
HUMIRA (CF) PEN PEDI UC 80 MG	44014
HUMIRA (CF) PEDI CROHN 80-40MG	44677
HUMIRA (CF) PEN 40 MG/0.4 ML	43506
HUMIRA (CF) PEN CRHN-UC-HS 80 MG	44014
HUMIRA (CF) PEN PS-UV-AHS 80-40 MG	44954
HUMIRA 40 MG/0.8 ML SYRINGE	18924
HUMIRA PEN 40 MG/0.8 ML	97005
HUMIRA PEN CROHN-UC-HS 40 MG	97005
HUMIRA PEN PS-UV-ADOL HS 40 MG	97005

PAXPRESS™

Humira (Adalimumab)

Clinical Criteria Logic

1. Does the client have a diagnosis of ankylosing spondylitis (AS), plaque psoriasis (PS), psoriatic arthritis (PsA), and/or rheumatoid arthritis (RA) in the last 730 days?

   [ ] Yes – Go to #6

   [ ] No – Go to #2

2. Does the client have a diagnosis of Crohn's disease (CD) in the last 730 days?

   [ ] Yes – Go to #8

   [ ] No – Go to #3

3. Does the client have a diagnosis of ulcerative colitis (UC) in the last 730 days?

   [ ] Yes – Go to #9

   [ ] No – Go to #4

4. Does the client have a diagnosis of juvenile idiopathic arthritis (JIA) or uveitis (UV) in the last 730 days?

   [ ] Yes – Go to #10

   [ ] No – Go to #5

5. Does the client have a diagnosis of hidradenitis suppurativa (HS) in the last 730 days?

   [ ] Yes – Go to #7

   [ ] No – Deny

6. Is the client greater than or equal to (≥) 18 years of age?

   [ ] Yes – Go to #12

   [ ] No – Deny

7. Is the client greater than or equal to (≥) 12 years of age?

   [ ] Yes – Go to #12

   [ ] No – Deny

8. Is the client greater than or equal to (≥) 6 years of age?

   [ ] Yes – Go to #11

   [ ] No – Deny

9. Is the client greater than or equal to (≥) 5 years of age?

   [ ] Yes – Go to #11

[ ] No – Deny

10. Is the client greater than or equal to (≥) 2 years of age?

    [ ] Yes – Go to #12

    [ ] No – Deny

11. Has the client had at least a 30-day trial with conventional therapy for Crohn's disease (for clients with a diagnosis of CD) or conventional therapy for ulcerative colitis (for clients with a diagnosis of UC) in the last 180 days?

    [ ] Yes – Go to #12

    [ ] No, and the request is for continuing therapy – Go to #12

    [ ] No, and the request is for initial therapy – Deny

12. Does the client have a history of heart failure in the last 365 days?

    [ ] Yes – Deny

    [ ] No – Go to #13

13. Does the client have a history of demyelinating disease (multiple sclerosis, optic neuritis, and/or Guillain-Barre syndrome) in the last 365 days?

    [ ] Yes – Deny

    [ ] No – Go to #14

14. Does the client have a history of hematologic abnormalities in the last 180 days?

    [ ] Yes – Deny

    [ ] No – Go to #15

15. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

    [ ] Yes – Deny

    [ ] No – Go to #16

16. Does the client have 1 claim for another TNF Blocker (other than adalimumab products) in the last 30 days?

    [ ] Yes – Deny

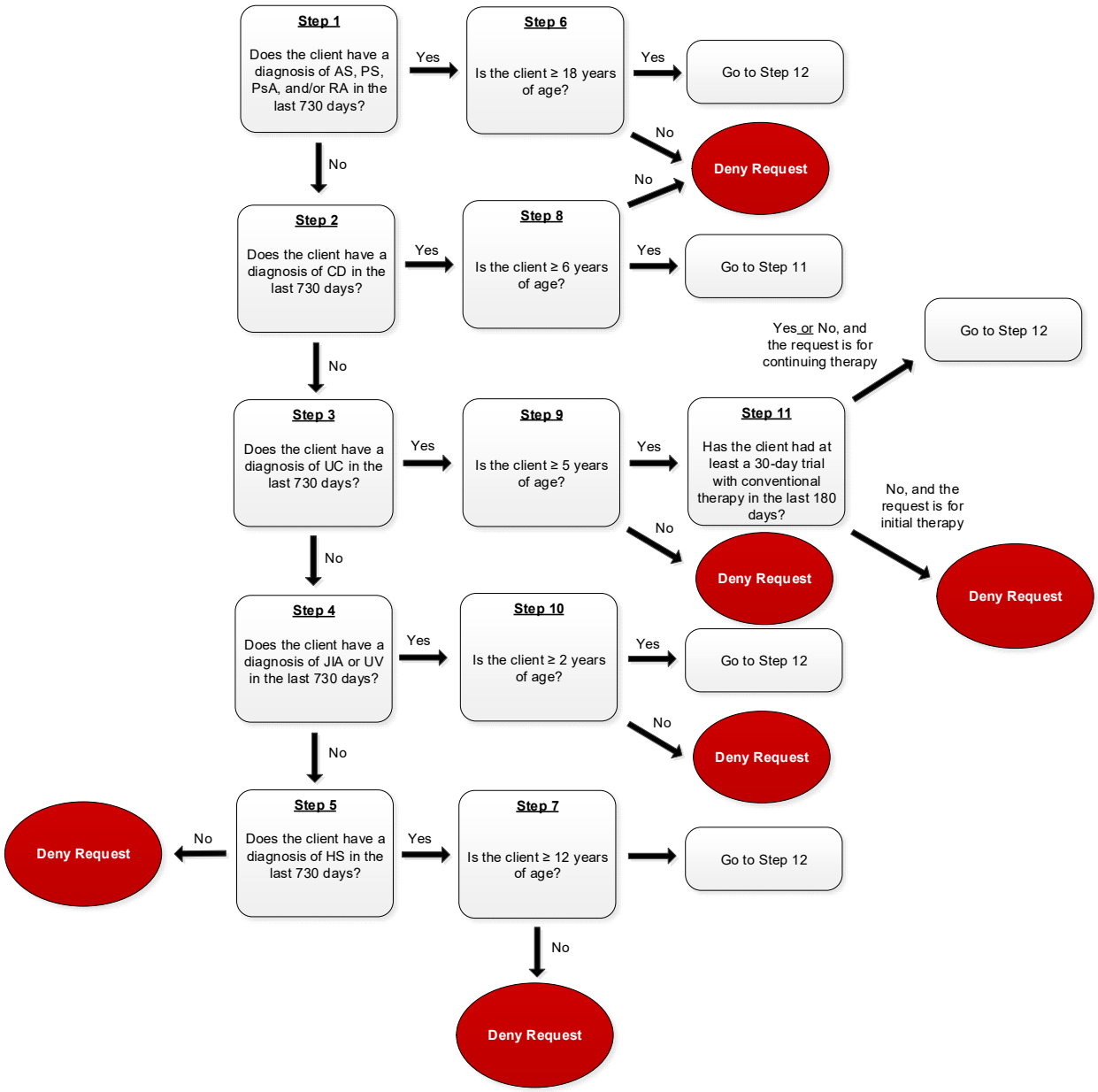
    [ ] No – Approve (365 days)

PAXPRESS™

Humira (Adalimumab)

Clinical Criteria Logic Diagram

Page 1:

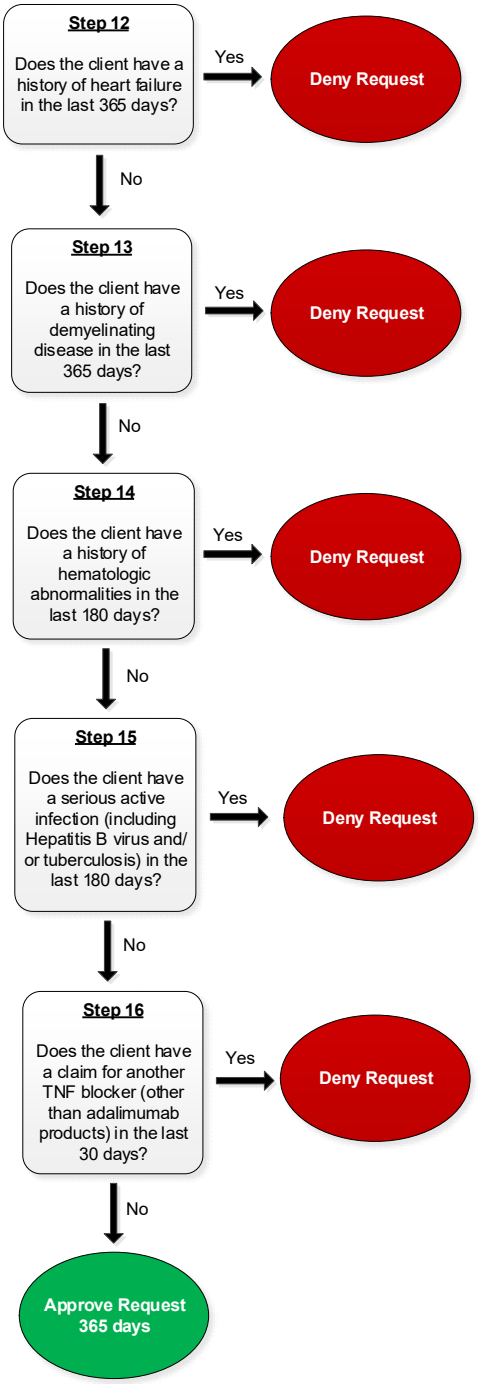


PAXPRESS™

Humira (Adalimumab)

Clinical Criteria Logic Diagram

Page 2:



PAXPRESS™

Adalimumab Biosimilars

Drugs Requiring Prior Authorization

The listed GCNs may not be an indication of Texas Medicaid Formulary coverage. To learn the current formulary coverage, visit txvendordrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	**GCN**
ADALIMUMAB-AACF (CF) SYR 40 MG	56164
ADALIMUMAB-ADAZ (CF) PEN 40 MG	53875
ADALIMUMAB-ADAZ (CF) 40 MG SYRNG	53884
ADALIMUMAB-ADBM (CF) 40 MG SYRNG	55665
ADALIMUMAB-ADBM (CF) CRHN 40 MG	55668
ADALIMUMAB-ADBM (CF) PEN 40 MG	55668
ADALIMUMAB-ADBM (CF) PEN PSORIA-UV 40 MG	55668
ADALIMUMAB-FKJP (CF) 20 MG SYRG	48318
ADALIMUMAB-FKJP (CF) 40 MG SYRG	48336
ADALIMUMAB-FKJP (CF) PEN 40 MG	48317
ADALIMUMAB-RYVK (CF) AI 40 MG	55332
ADALIMUMAB-RYVK (CF) 40 MG SYRG	56016
AMJEVITA 10 MG/0.2 ML SYRINGE	54007
AMJEVITA 20 MG/0.4 ML SYRINGE	42592
AMJEVITA 40 MG/0.8 ML AUTOINJ	42639
AMJEVITA 40 MG/0.8 ML SYRINGE	42637
CYLTEZO (CF) 10 MG/0.2 ML SYRNG	53841
CYLTEZO (CF) 20 MG/0.4 ML SYRNG	53842
CYLTEZO (CF) 40 MG/0.4 ML SYRNG	55665
CYLTEZO (CF) 40 MG/0.8 ML SYRNG	43789

Drugs Requiring Prior Authorization	
Label Name	**GCN**
CYLTEZO (CF) PEN 40 MG/0.4 ML	55668
CYLTEZO (CF) PEN 40 MG/0.8 ML	54205
CYLTEZO (CF) PEN CRH-UC-HS 40 MG	54205
CYLTEZO (CF) PEN CRH-UC-HS 40 MG	55668
CYLTEZO (CF) PEN PSORIA-UV 40 MG	54205
CYLTEZO (CF) PEN PSORIA-UV 40 MG	55668
HADLIMA (CF) 40 MG/0.4 ML SYRNG	53846
HADLIMA (CF) PUSHTOUCH 40MG/0.4	53848
HADLIMA 40 MG/0.8 ML SYRINGE	46718
HADLIMA PUSHTOUCH 40 MG/0.8 ML	46717
HULIO (CF) 20 MG/0.4 ML SYRINGE	48318
HULIO (CF) 20 MG/0.4 ML SYRINGE	55235
HULIO (CF) 40 MG/0.8 ML	48317
HULIO (CF) 40 MG/0.8 ML	48336
HULIO (CF) 40MG/0.8 ML SYRINGE	55694
HULIO (CF) PEN 40 MG/0.8 ML	55693
HYRIMOZ (CF) 10 MG/0.1 ML SYRNG	53885
HYRIMOZ (CF) 20 MG/0.2 ML SYRNG	53883
HYRIMOZ (CF) 40 MG/0.4 ML SYRNG	53884
HYRIMOZ (CF) PEDI CROHN 80 MG	53899
HYRIMOZ (CF) PEDI CROHN 80-40 MG	53891
HYRIMOZ (CF) PEN 40 MG/0.4 ML	53875
HYRIMOZ (CF) PEN 80 MG/0.8 ML	53887
HYRIMOZ (CF) PEN CROHN-UC 80 MG	53887

Drugs Requiring Prior Authorization	
Label Name	**GCN**
HYRIMOZ (CF) PEN PSORIA 80-40 MG	53878
IDACIO (CF) PEN 40 MG/0.8 ML	53387
IDACIO (CF) PEN PSORIASIS 40 MG	53387
IDACIO (CF) PEN CROHNS-UC 40 MG	53387
IDACIO (CF) 40 MG/0.8 ML SYRINGE	53386
IDACIO (CF) PEN 40 MG/0.8 ML	56152
SIMLANDI (CF) AI 40 MG/0.4 ML	55332
SIMLANDI (CF) AI 80 MG/0.8 ML	57361
SIMLANDI (CF) 20 MG/0.2 ML SYRG	56047
SIMLANDI (CF) 80 MG/0.8 ML SYRG	56048

PAXPRESS™

Adalimumab Biosimilars

Clinical Criteria Logic

1. Does the client have a diagnosis of ankylosing spondylitis (AS), hidradenitis suppurativa (HS), plaque psoriasis (PS), psoriatic arthritis (PsA), rheumatoid arthritis (RA), ulcerative colitis (UC), and/or uveitis (UV) in the last 730 days?

   [ ] Yes – Go to #4

   [ ] No – Go to #2

2. Does the client have a diagnosis of Crohn's disease (CD) in the last 730 days?

   [ ] Yes – Go to #5

   [ ] No – Go to #3

3. Does the client have a diagnosis of juvenile idiopathic arthritis (JIA) in the last 730 days?

   [ ] Yes – Go to #6

   [ ] No – Deny

4. Is the client greater than or equal to (≥) 18 years of age?

   [ ] Yes, and the request is for a diagnosis other than UC – Go to #8

   [ ] Yes, and the request is for diagnosis of UC – Go to #7

   [ ] No – Deny

5. Is the client greater than or equal to (≥) 6 years of age?

   [ ] Yes – Go to #7

   [ ] No – Deny

6. Is the client greater than or equal to (≥) 2 years of age?

   [ ] Yes – Go to #8

   [ ] No – Deny

7. Has the client had at least a 30-day trial with conventional therapy for Crohn's disease (for clients with a diagnosis of CD) or conventional therapy for ulcerative colitis (for clients with a diagnosis of UC) in the last 180 days?

   [ ] Yes – Go to #8

   [ ] No, and the request is for continuing therapy – Go to #8

   [ ] No, and the request is for initial therapy – Deny

8. Does the client have a history of heart failure in the last 365 days?

   [ ] Yes – Deny

[ ] No – Go to #9

9. Does the client have a history of demyelinating disease (multiple sclerosis, optic neuritis, and/or Guillain-Barre syndrome) in the last 365 days?

   [ ] Yes – Deny

   [ ] No – Go to #10

10. Does the client have a history of hematologic abnormalities in the last 180 days?

    [ ] Yes – Deny

    [ ] No – Go to #11

11. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

    [ ] Yes – Deny

    [ ] No – Go to #12

12. Does the client have 1 claim for another TNF Blocker (other than adalimumab products) in the last 30 days?

    [ ] Yes – Deny

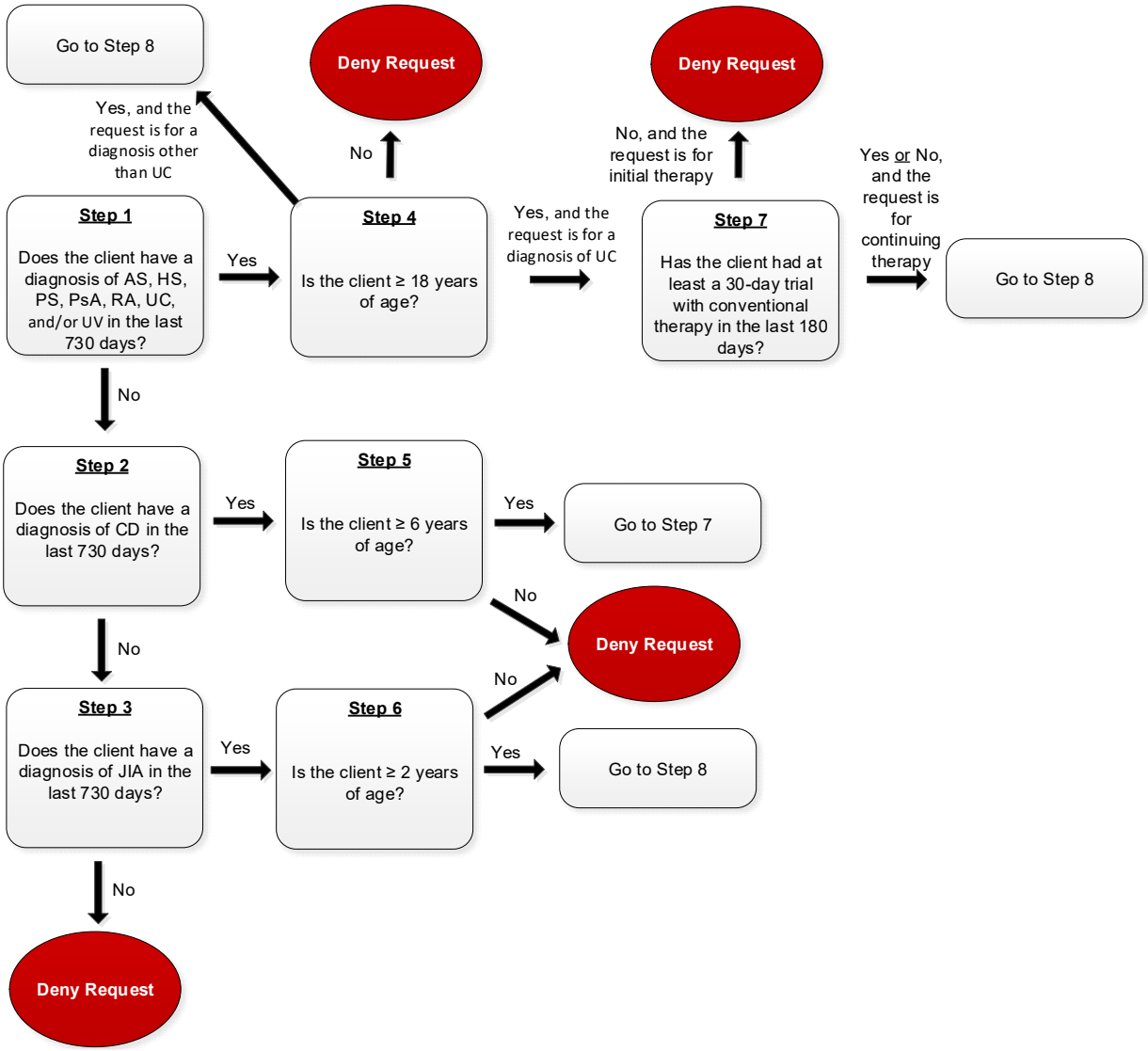
    [ ] No – Approve (365 days)

PAXPRESS™

Adalimumab Biosimilars

Clinical Criteria Logic Diagram

Page 1:

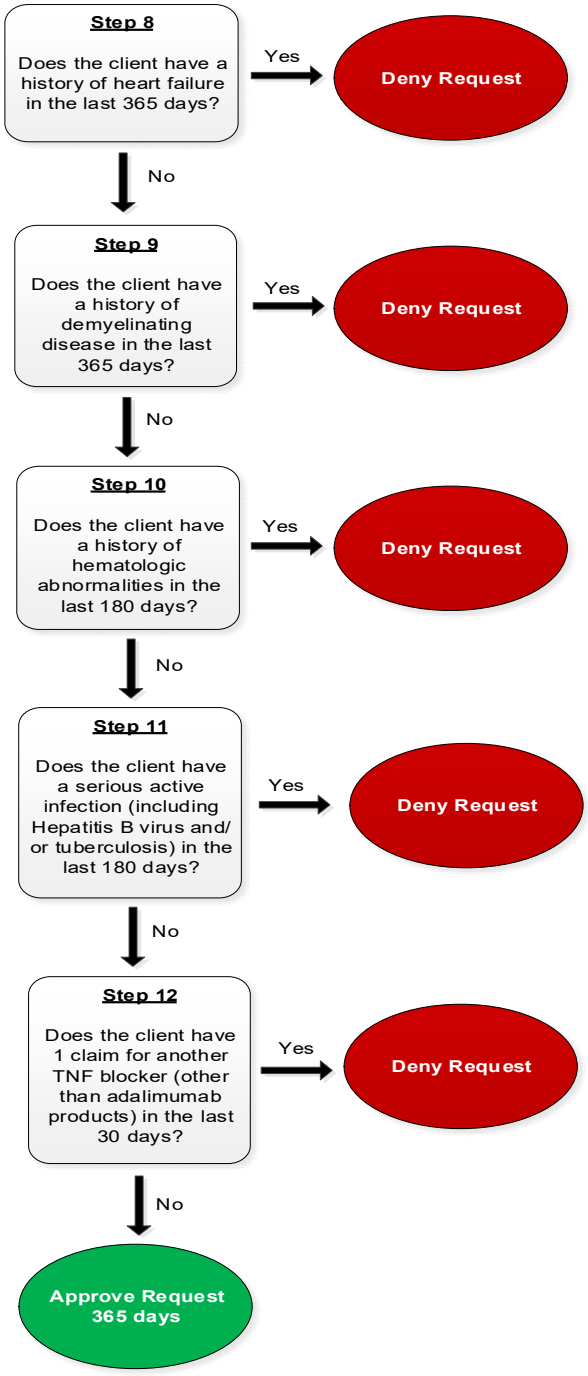


PAXPRESS™

Adalimumab Biosimilars

Clinical Criteria Logic Diagram

Page 2:



PAXPRESS™

Ilaris (Canakinumab)

Drugs Requiring Prior Authorization

The listed GCNs may not be an indication of Texas Medicaid Formulary coverage. To learn the current formulary coverage, visit txvendordrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	**GCN**
ILARIS 150MG/ML VIAL	43148

PAXPRESS™

Ilaris (Canakinumab)

Clinical Criteria Logic

1. Does the client have a diagnosis of cryopyrin-associated periodic syndrome (CAPS) in the last 730 days?

   [ ] Yes – Go to #3

   [ ] No – Go to #2

2. Does the client have a diagnosis of familial Mediterranean fever (FMF), hyperimmunoglobulin D syndrome (HIDS)/mevalonate kinase deficiency (MKD), tumor necrosis factor receptor associated periodic syndrome (TRAPS), or active Still's disease/systemic juvenile idiopathic arthritis (SJIA) in the last 730 days?

   [ ] Yes – Go to #4

   [ ] No – Deny

3. Is the client greater than or equal to (≥) 4 years of age?

   [ ] Yes – Go to #5

   [ ] No – Deny

4. Is the client greater than or equal to (≥) 2 years of age?

   [ ] Yes – Go to #5

   [ ] No – Deny

5. Does the client have 1 claim for an interleukin-1 (IL-1) inhibitor or tumor necrosis factor (TNF) blocker in the last 30 days?

   [ ] Yes – Deny

   [ ] No – Go to #6

6. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

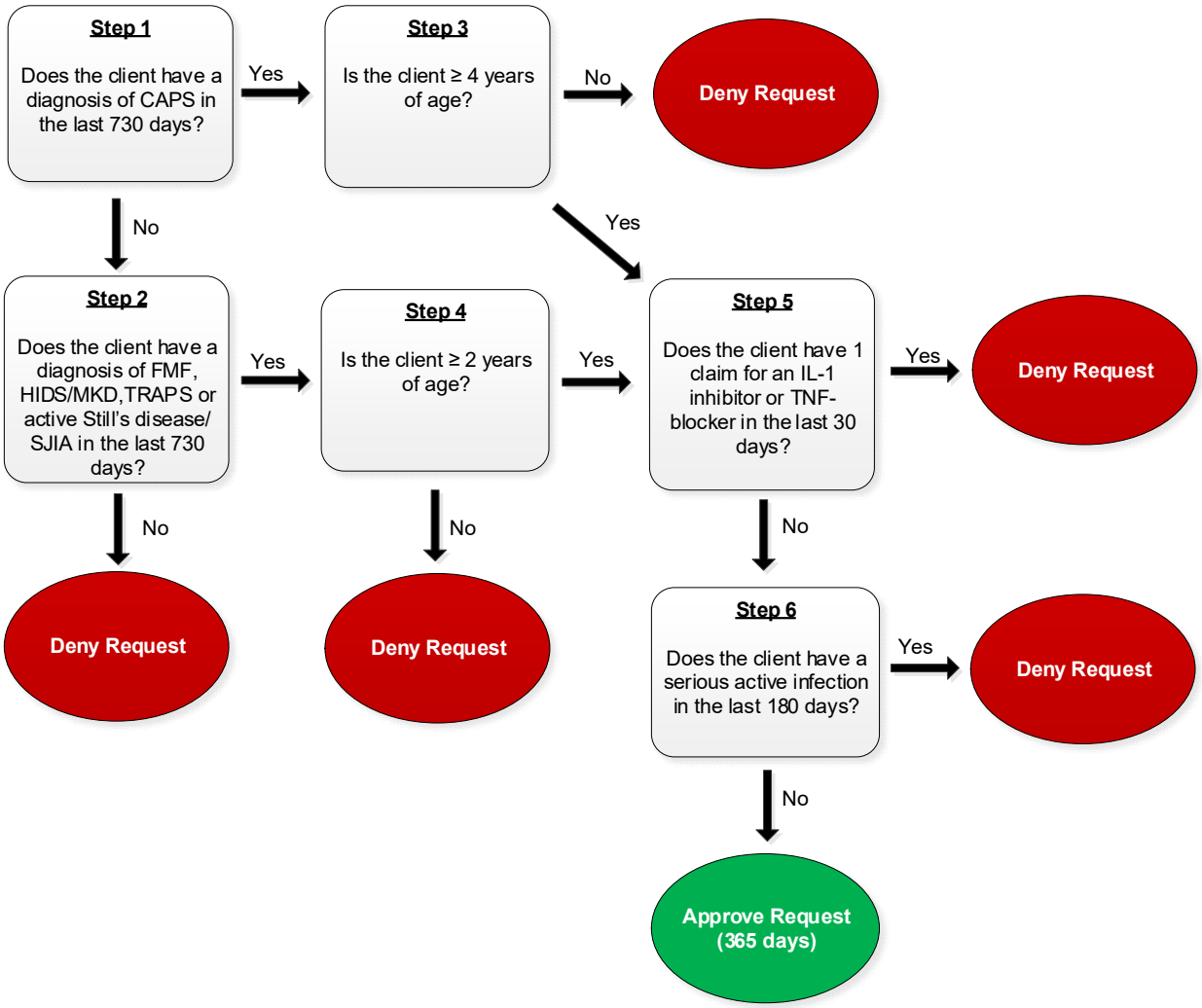
   [ ] Yes – Deny

   [ ] No – Approve (365 days)

PAXPRESS™

Ilaris (Canakinumab)

Clinical Criteria Logic Diagram



PAXPRESS™

Ilumya (Tildrakizumab-asmn)

Drugs Requiring Prior Authorization

The listed GCNs may not be an indication of Texas Medicaid Formulary coverage. To learn the current formulary coverage, visit txvendordrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	**GCN**
ILUMYA 100 MG/ML SYRINGE	44553

PAXPRESS™

Ilumya (Tildrakizumab-asmn)

Clinical Criteria Logic

1. Is the client greater than or equal to (≥) 18 years of age?

   [ ] Yes – Go to #2

   [ ] No – Deny

2. Does the client have a diagnosis of moderate to severe plaque psoriasis (PS) in the last 730 days?

   [ ] Yes – Go to #3

   [ ] No – Deny

3. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

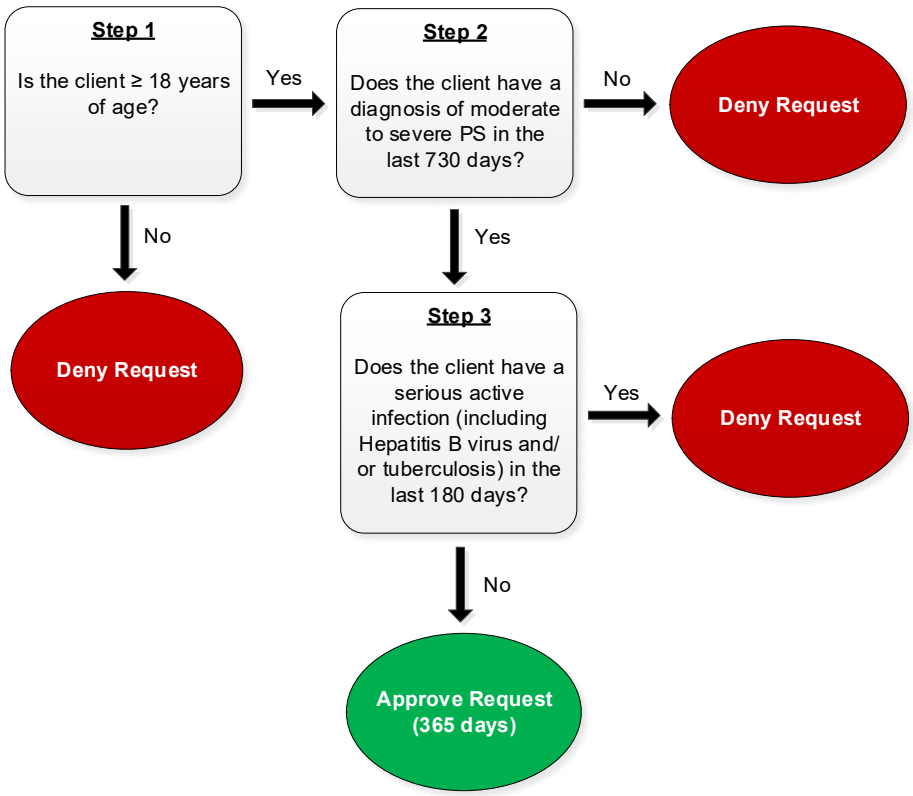
   [ ] Yes – Deny

   [ ] No – Approve (365 days)

PAXPRESS™

Ilumya (Tildrakizumab-asmn)

Clinical Criteria Logic Diagram



PAXPRESS™

Kevzara (Sarilumab)

Drugs Requiring Prior Authorization

The listed GCNs may not be an indication of Texas Medicaid Formulary coverage. To learn the current formulary coverage, visit txvendordrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	**GCN**
KEVZARA 150 MG/1.14 ML SYRINGE	43223
KEVZARA 200 MG/1.14 ML SYRINGE	43224
KEVZARA 150 MG/1.14 ML PEN INJ	44269
KEVZARA 200 MG/1.14 ML PEN INJ	44277

PAXPRESS™

Kevzara (Sarilumab)

Clinical Criteria Logic

1. Is the client greater than or equal to (≥) 18 years of age?

   [ ] Yes – Go to #3

   [ ] No – Go to #2

2. Is the client greater than or equal to (≥) 2 years of age and less than (<) 18 years of age?

   [ ] Yes – Go to #6

   [ ] No – Deny

3. Does the client have a diagnosis of rheumatoid arthritis (RA) in the last 730 days?

   [ ] Yes – Go to #4

   [ ] No – Go to #5

4. Does the client have a claim for a disease-modifying antirheumatic drug (DMARD) in the last 180 days?

   [ ] Yes – Go to #7

   [ ] No – Deny

5. Does the client have a diagnosis of polymyalgia rheumatica (PMR) in the last 730 days?

   [ ] Yes – Go to #7

   [ ] No – Deny

6. Does the client have a diagnosis of polyarticular juvenile idiopathic arthritis (PJIA) in the past 730 days?

   [ ] Yes – Go to #7

   [ ] No – Deny

7. Does the client have a history of hematologic abnormalities in the last 60 days?

   [ ] Yes – Deny

   [ ] No – Go to #8

8. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

   [ ] Yes – Deny

   [ ] No – Go to #9

9. Does the client have a diagnosis of active hepatic disease or hepatic impairment in the last 365 days?

    [ ] Yes – Deny

    [ ] No, and the diagnosis is PJIA – Go to #10

    [ ] No, and the diagnosis is RA or PMR – Approve (365 days)

10. Does the client weigh greater than or equal to (≥) 63 kg? [Manual]

    [ ] Yes – Go to #11

    [ ] No – Deny

11. Is the requested dose for less than or equal to (≤) 200 mg every 14 days?

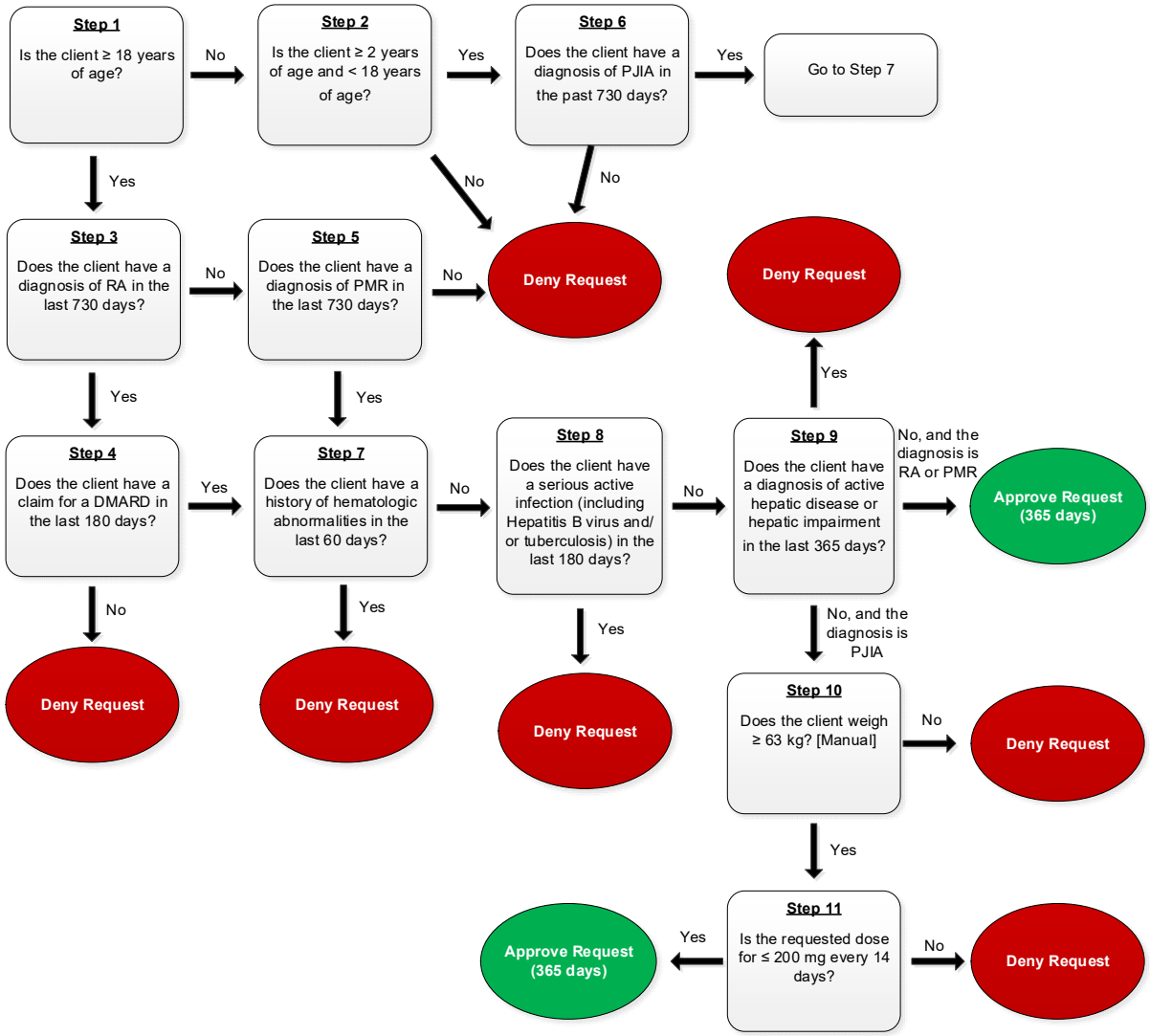
    [ ] Yes – Approve (365 days)

    [ ] No – Deny

PAXPRESS™

Kevzara (Sarilumab)

Clinical Criteria Logic Diagram



PAXPRESS™

Kineret (Anakinra)

Drugs Requiring Prior Authorization

The listed GCNs may not be an indication of Texas Medicaid Formulary coverage. To learn the current formulary coverage, visit txvendordrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	**GCN**
KINERET 100MG/0.67ML SYRINGE	14867

PAXPRESS™

Kineret (Anakinra)

Clinical Criteria Logic

1. Does the client have a diagnosis of rheumatoid arthritis (RA) in the last 730 days?

   [ ] Yes – Go to #2

   [ ] No – Go to #5

2. Is the client greater than or equal to (≥) 18 years of age?

   [ ] Yes – Go to #3

   [ ] No – Deny

3. Does the client have 1 claim for a DMARD in the last 180 days?

   [ ] Yes – Go to #6

   [ ] No – Go to #4

4. Does the client have a contraindication to or is the client non-responsive to DMARDs? [Manual]

   [ ] Yes – Go to #6

   [ ] No – Deny

5. Does the client have a diagnosis of cryopyrin-associated periodic syndrome (CAPS) or deficiency of interleukin-1 receptor antagonist (DIRA) in the last 730 days?

   [ ] Yes – Go to #6

   [ ] No – Deny

6. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

   [ ] Yes – Deny

   [ ] No – Go to #7

7. Does the client have 1 claim for a TNF blocker in the last 30 days?

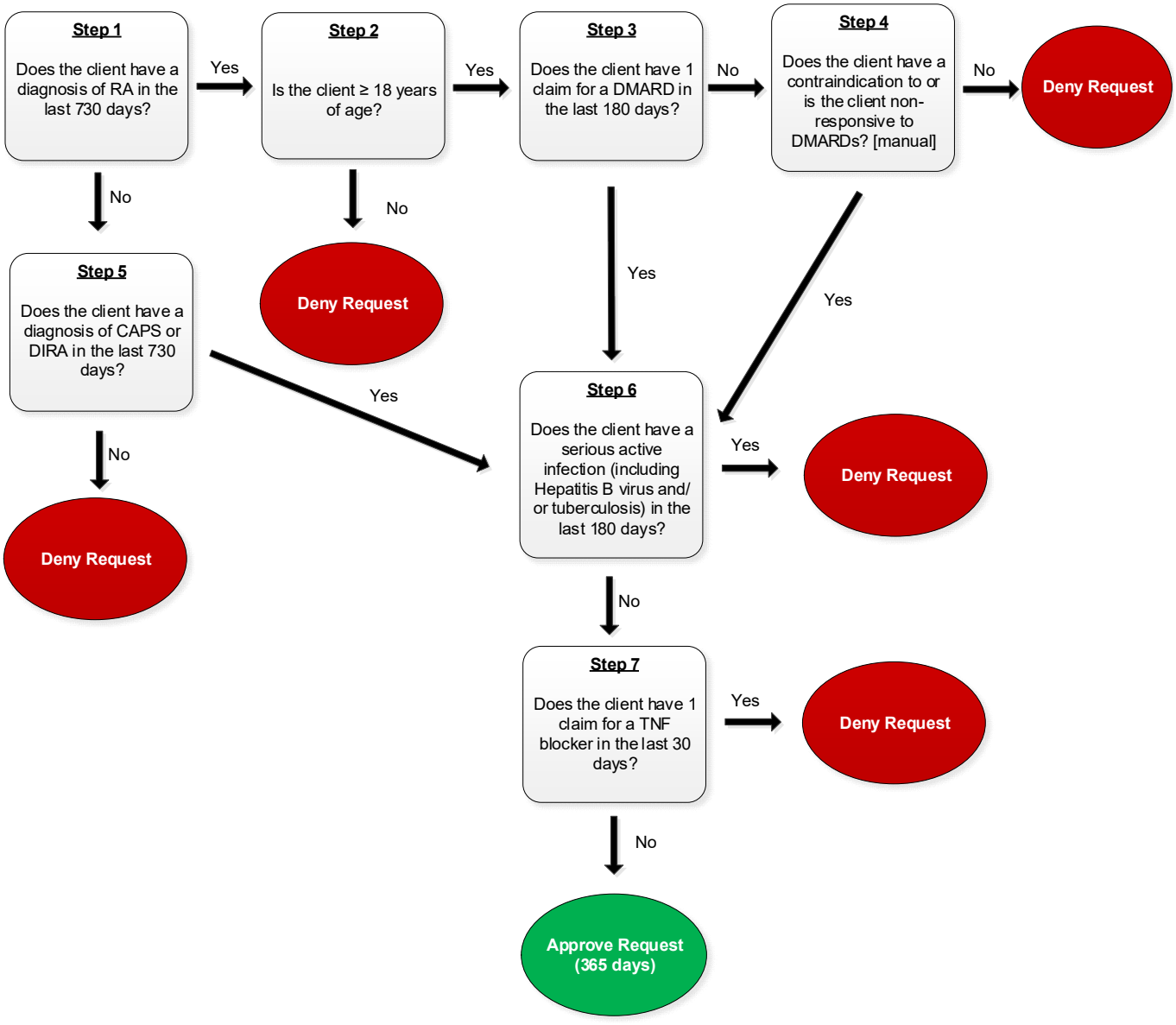
   [ ] Yes – Deny

   [ ] No – Approve (365 days)

PAXPRESS™

Kineret (Anakinra)

Clinical Criteria Logic Diagram



PAXPRESS™

Litfulo (Ritlecitinib)

Drugs Requiring Prior Authorization

The listed GCNs may not be an indication of Texas Medicaid Formulary coverage. To learn the current formulary coverage, visit txvendordrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	**GCN**
LITFULO 50 MG CAPSULE	54429

PAXPRESS™

Litfulo (Ritlecitinib)

Clinical Criteria Logic

1. Is the client greater than or equal to (≥) 12 years of age?

   [ ] Yes – Go to #2

   [ ] No – Deny

2. Does the client have a diagnosis of alopecia areata in the last 730 days?

   [ ] Yes – Go to #3

   [ ] No – Deny

3. Will the client have concurrent therapy with a JAK inhibitor, biologic DMARD, or potent immunosuppressant?

   [ ] Yes – Deny

   [ ] No – Go to #4

4. Will the client have concurrent therapy with a strong CYP3A4 inducer?

   [ ] Yes – Deny

   [ ] No – Go to #5

5. Does the client have a diagnosis of severe hepatic impairment in the last 365 days?

   [ ] Yes – Deny

   [ ] No – Go to #6

6. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

   [ ] Yes – Deny

   [ ] No – Go to #7

7. Does the client have a diagnosis that indicates increased risk of thrombosis or malignancy in the last 180 days?

   [ ] Yes – Deny

   [ ] No – Go to #8

8. Will the client have concurrent therapy with another Cytokine and CAM antagonist?

   [ ] Yes – Deny

   [ ] No – Go to #9

9. Is the requested dose less than or equal to (≤) 1 capsule daily?

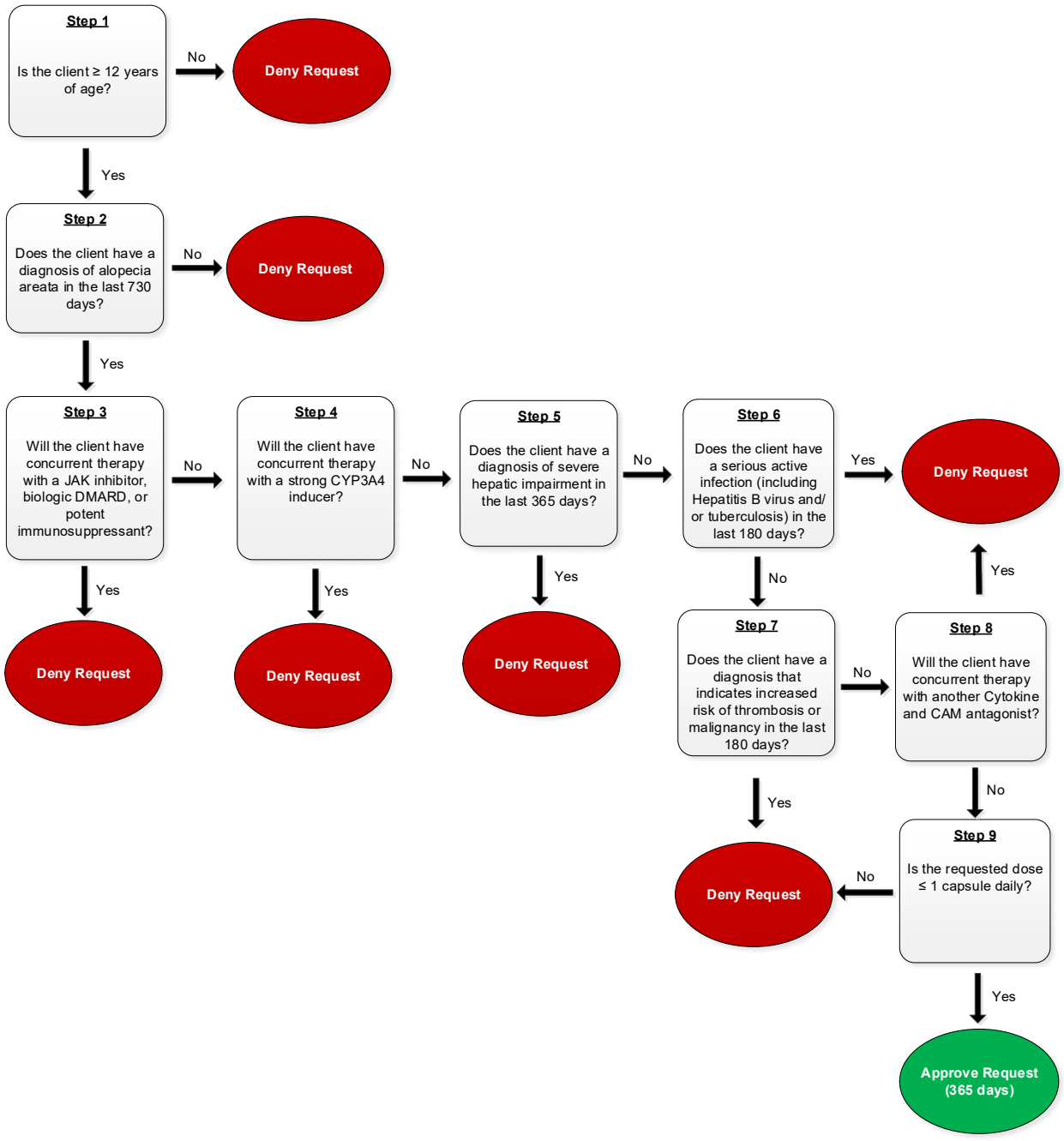
   [ ] Yes – Approve (365 days)

[ ] No – Deny

PAXPRESS™

Litfulo (Ritlecitinib)

Clinical Criteria Logic Diagram



PAXPRESS™

Olumiant (Baricitinib)

Drugs Requiring Prior Authorization

The listed GCNs may not be an indication of Texas Medicaid Formulary coverage. To learn the current formulary coverage, visit txvendordrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	**GCN**
OLUMIANT 1 MG TABLET	47205
OLUMIANT 2 MG TABLET	43468

PAXPRESS™

Olumiant (Baricitinib)

Clinical Criteria Logic

1. Is the client greater than or equal to (≥) 18 years of age?

   [ ] Yes – Go to #2

   [ ] No – Deny

2. Does the client have a diagnosis of rheumatoid arthritis (RA) in the last 730 days?

   [ ] Yes – Go to #3

   [ ] No – Go to #4

3. Does the client have 1 claim for a TNF antagonist in the last 180 days?

   [ ] Yes – Go to #5

   [ ] No – Deny

4. Does the client have a diagnosis of alopecia areata in the last 730 days?

   [ ] Yes – Go to #5

   [ ] No – Deny

5. Will the client have concurrent therapy with a JAK inhibitor, biologic DMARD, or potent immunosuppressant?

   [ ] Yes – Deny

   [ ] No – Go to #6

6. Does the client have a diagnosis that indicates increased risk of GI perforation, thrombosis, or malignancy in the last 180 days?

   [ ] Yes – Deny

   [ ] No – Go to #7

7. Does the client have a diagnosis of severe renal (eGFR < 30mL/min/1.73m^2) or severe hepatic impairment in the last 365 days?

   [ ] Yes – Deny

   [ ] No – Go to #8

8. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

   [ ] Yes – Deny

   [ ] No – Go to #9

9. Is the requested dose less than or equal to (≤) 1 tablet daily?

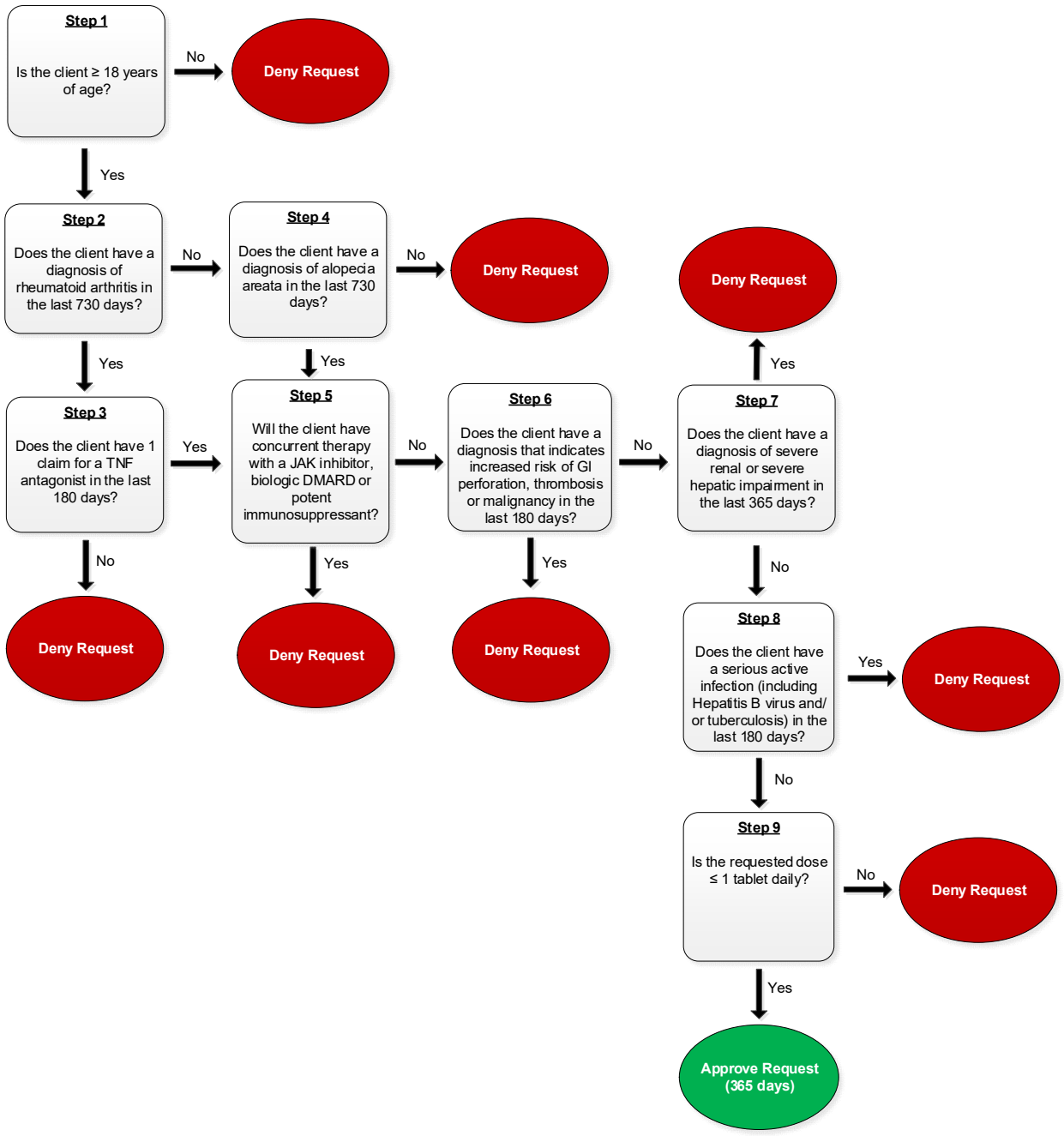
[ ] Yes – Approve (365 days)

[ ] No – Deny

PAXPRESS™

Olumiant (Baricitinib)

Clinical Criteria Logic Diagram



PAXPRESS™

Omvoh (Minkizumab-mrkz)

Drugs Requiring Prior Authorization

The listed GCNs may not be an indication of Texas Medicaid Formulary coverage. To learn the current formulary coverage, visit txvendordrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	**GCN**
OMVOH 100 MG/ML PEN	54920
OMVOH 100 MG/ML SYRINGE	55033
OMVOH 200 MG/2 ML PEN	57115
OMVOH 200 MG/2 ML SYRINGE	57116
OMVOH 300 MG DOSE – 2 PENS (200 MG + 100 MG)	57114
OMVOH 300 MG DOSE – 2 SYRINGES (200 MG + 100 MG)	57113

PAXPRESS™

Omvoh (Minkizumab-mrkz)

Clinical Criteria Logic

1. Is the client greater than or equal to (≥) 18 years of age?

   [ ] Yes – Go to #2

   [ ] No – Deny

2. Is this a renewal request?

   [ ] Yes – Go to #6

   [ ] No – Go to #3

3. Does the client have a diagnosis of ulcerative colitis (UC) or moderately to severely active Crohn's disease in the last 730 days?

   [ ] Yes – Go to #4

   [ ] No – Deny

4. Does the client have a claim for a TNF blocker in the last 730 days?

   [ ] Yes – Go to #6

   [ ] No – Go to #5

5. Does the client have an intolerance or a contraindication to TNF blockers? [Manual]

   [ ] Yes – Go to #6

   [ ] No – Deny

6. Does the client have a diagnosis of cirrhosis in the last 365 days?

   [ ] Yes – Deny

   [ ] No – Go to #7

7. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

   [ ] Yes – Deny

   [ ] No – Go to #8

8. Will the client have concurrent therapy with a JAK inhibitor or biologic DMARD agent?

   [ ] Yes – Deny

   [ ] No, and the diagnosis is UC – Go to #9

   [ ] No, and the diagnosis is Crohn's disease – Go to #10

9. Is the requested dose for less than or equal to (≤) 200 mg per 28 days?

[ ] Yes – Approve (365 days)

[ ] No – Deny

10. Is the requested dose for less than or equal to (≤) 300 mg every 28 days after induction dosing?

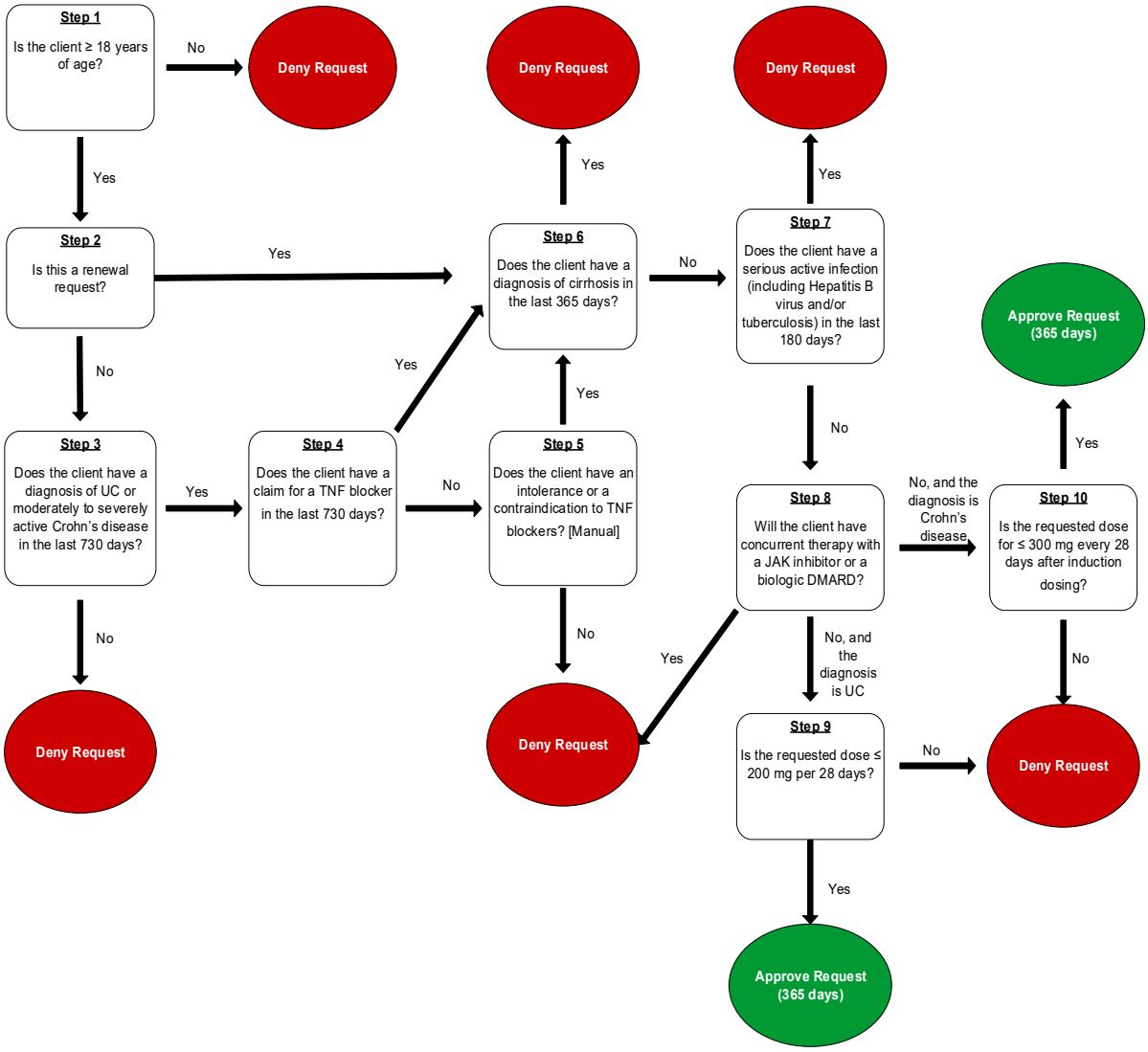
    [ ] Yes – Approve (365 days)

    [ ] No – Deny

PAXPRESS™

Omvoh (Minkizumab-mrkz)

Clinical Criteria Logic Diagram



PAXPRESS™

Orencia (Abatacept)

Drugs Requiring Prior Authorization

The listed GCNs may not be an indication of Texas Medicaid Formulary coverage. To learn the current formulary coverage, visit txvendordrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	**GCN**
ORENCIA 125 MG/ML SYRINGE	30289
ORENCIA CLICKJECT 125MG/ML	41656
ORENCIA 50 MG/0.4 ML SYRINGE	43389
ORENCIA 87.5 MG/0.7 ML SYRINGE	43397

PAXPRESS™

Orencia (Abatacept)

Clinical Criteria Logic

1. Does the client have a diagnosis of rheumatoid arthritis (RA) in the last 730 days?

   [ ] Yes – Go to #2

   [ ] No – Go to #3

2. Is the client greater than or equal to (≥) 18 years of age?

   [ ] Yes – Go to #6

   [ ] No – Deny

3. Does the client have a diagnosis of prophylaxis of acute graft versus host disease (aGVHD), polyarticular juvenile idiopathic arthritis (PJIA), psoriatic arthritis (PsA), or systemic juvenile idiopathic arthritis (SJIA) in the last 730 days?

   [ ] Yes – Go to #4

   [ ] No – Deny

4. Is the client ≥ 2 years of age?

   [ ] Yes, and the diagnosis is PJIA, PsA, or SJIA – Go to #6

   [ ] Yes, and the diagnosis is aGVHD – Go to #5

   [ ] No – Deny

5. Will the client have concurrent therapy with a calcineurin inhibitor and methotrexate?

   [ ] Yes – Go to #6

   [ ] No – Deny

6. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

   [ ] Yes – Deny

   [ ] No – Go to #7

7. Does the client have 1 claim for a TNF blocker in the last 30 days?

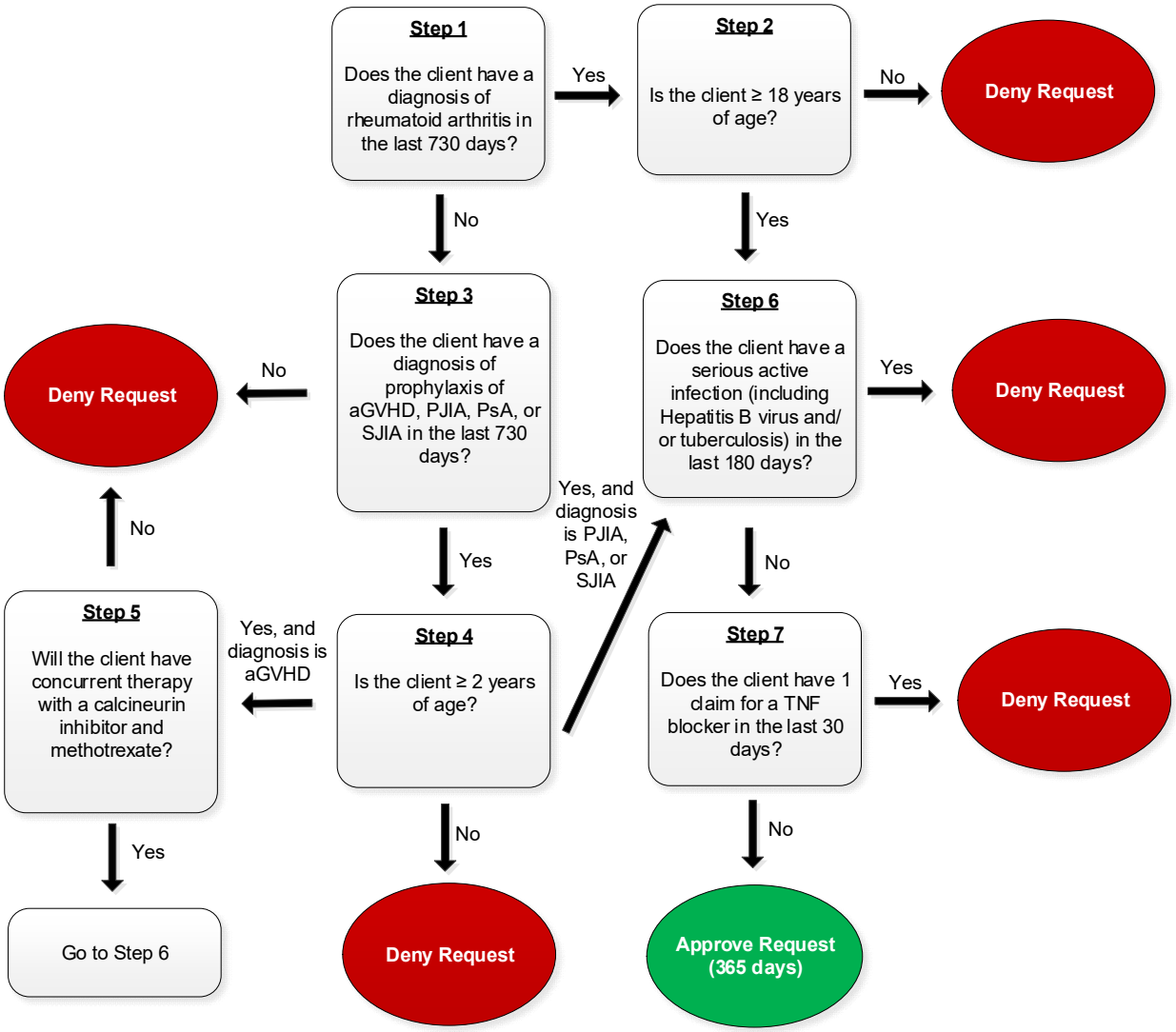
   [ ] Yes – Deny

   [ ] No – Approve (365 days)

PAXPRESS™

Orencia (Abatacept)

Clinical Criteria Logic Diagram



PAXPRESS™

Otezla (Apremilast)

Drugs Requiring Prior Authorization

The listed GCNs may not be an indication of Texas Medicaid Formulary coverage. To learn the current formulary coverage, visit txvendordrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	**GCN**
OTEZLA 10-20 MG STARTER 28 DAY	56084
OTEZLA 20 MG TABLET	56083
OTEZLA 30 MG TABLET	36172
OTEZLA 28 DAY STARTER PACK	37765

PAXPRESS™

Otezla (Apremilast)

Clinical Criteria Logic

1. Is the client greater than or equal to (≥) 18 years of age?

   [ ] Yes – Go to #2

   [ ] No – Go to #3

2. Does the client have a diagnosis of oral ulcers associated with Behcet's Disease or psoriatic arthritis (PsA) in the last 730 days?

   [ ] Yes – Go to #5

   [ ] No – Go to #3

3. Does the client have a diagnosis of plaque psoriasis in the last 730 days?

   [ ] Yes – Go to #4

   [ ] No – Deny

4. Is the client greater than or equal to (≥) 6 years of age?

   [ ] Yes – Go to #5

   [ ] No – Deny

5. Does the client have 1 claim for a strong CYP3A4 inducer in the last 90 days?

   [ ] Yes – Deny

   [ ] No – Go to #6

6. Does the client have 1 claim for a TNF-blocker or IL-17 inhibitor in the last 30 days?

   [ ] Yes – Deny

   [ ] No – Go to #7

7. Does the client have a diagnosis of chronic kidney disease (stage 4 or 5) in the last 365 days?

   [ ] Yes – Go to #8

   [ ] No – Approve (365 days)

8. Is the requested dose less than or equal to (≤) 30 mg per day?

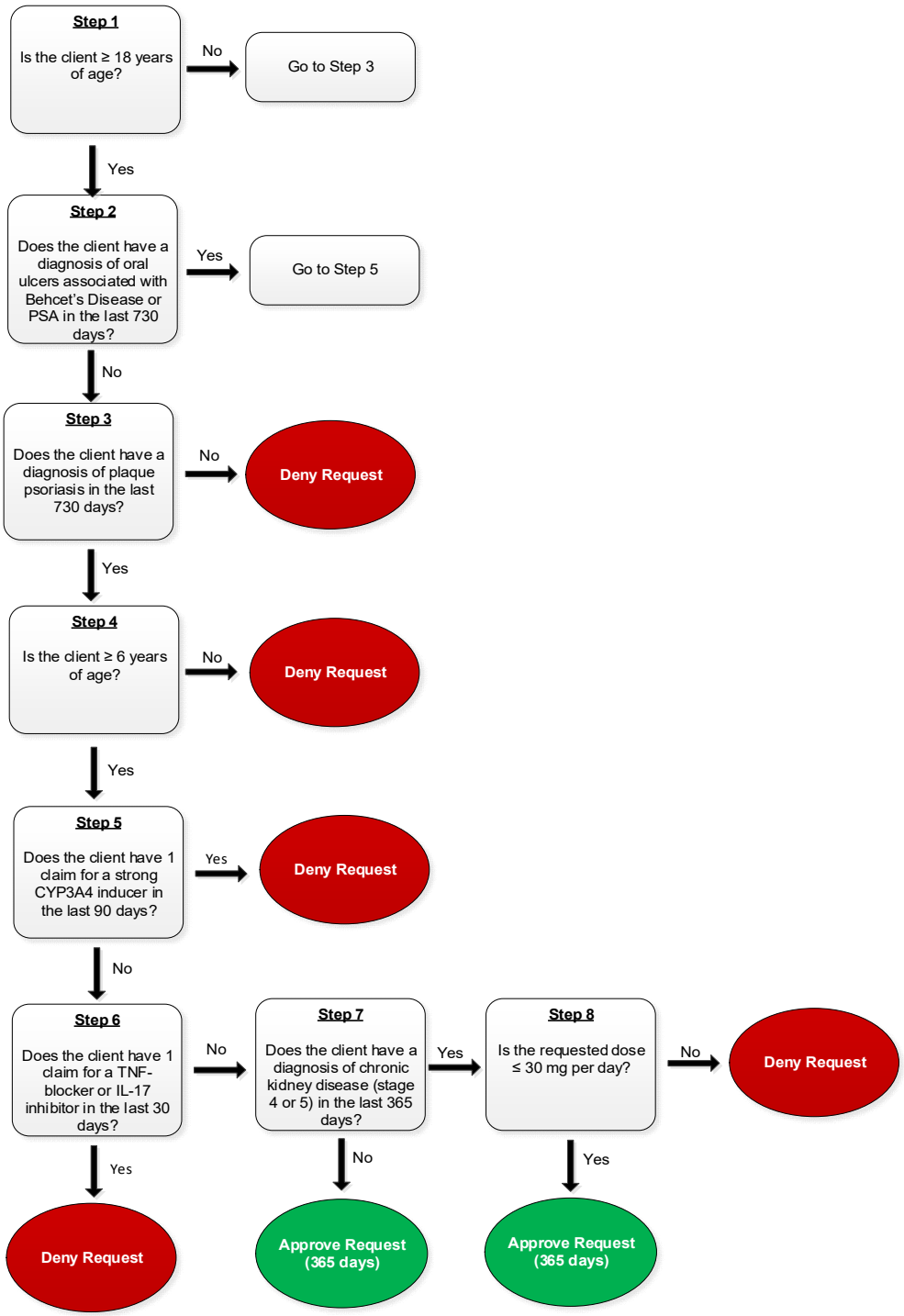
   [ ] Yes – Approve (365 days)

   [ ] No – Deny

PAXPRESS™

Otezla (Apremilast)

Clinical Criteria Logic Diagram



PAXPRESS™

Rinvoq (Upadacitinib)

Drugs Requiring Prior Authorization

The listed GCNs may not be an indication of Texas Medicaid Formulary coverage. To learn the current formulary coverage, visit txvendordrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	**GCN**
RINVOQ LQ 1 MG/ML SOLUTION	55651
RINVOQ ER 15 MG TABLET	46822
RINVOQ ER 30 MG TABLET	51719
RINVOQ ER 45 MG TABLET	52085

PAXPRESS™

Rinvoq (Upadacitinib)

Clinical Criteria Logic

1. Does the client have a diagnosis of active psoriatic arthritis (PsA) or active polyarticular juvenile idiopathic arthritis (PJIA) in the last 730 days?

   [ ] Yes – Go to #2

   [ ] No – Go to #3

2. Is the client greater than or equal to (≥) 2 years of age?

   [ ] Yes – Go to #11

   [ ] No – Deny

3. Does the client have a diagnosis of refractory, moderate to severe atopic dermatitis (AD) in the last 730 days?

   [ ] Yes – Go to #4

   [ ] No – Go to #5

4. Is the client greater than or equal to (≥) 12 years of age?

   [ ] Yes – Go to #7

   [ ] No – Deny

5. Does the client have a diagnosis of active ankylosing spondylitis (AS) , moderately to severely active Crohn's disease (CD), active non-radiographic axial spondyloarthritis (nr-axSpA), moderately to severely active rheumatoid arthritis (RA), or ulcerative colitis (UC) in the last 730 days?

   [ ] Yes – Go to #6

   [ ] No – Deny

6. Is the client greater than or equal to (≥) 18 years of age?

   [ ] Yes – Go to #9

   [ ] No – Deny

7. Has the client had 30 continuous days of therapy with at least one systemic agent for the treatment of atopic dermatitis in the last 90 days?

   [ ] Yes – Go to #11

   [ ] No, and this is a renewal request – Go to #11

   [ ] No, and this is an initial request – Go to #8

8. Has the client had inadequate response or intolerance to systemic agents for the treatment of atopic dermatitis? [Manual]

[ ] Yes – Go to #11

[ ] No – Deny

9. Has the client had therapy with at least one TNF blocker in the last 90 days?

   [ ] Yes – Go to #11

   [ ] No – Go to #10

10. Has the client had inadequate response or intolerance to TNF blockers? [Manual]

    [ ] Yes – Go to #11

    [ ] No – Deny

11. Will the client have concurrent therapy with a JAK inhibitor, biologic DMARD agent, or potent immunosuppressant?

    [ ] Yes – Deny

    [ ] No – Go to #12

12. Does the client have 1 claim for a strong CYP3A4 inducer in the last 90 days?

    [ ] Yes – Deny

    [ ] No – Go to #13

13. Does the client have a diagnosis that indicates increased risk of GI perforation, thrombosis, or malignancy in the last 180 days?

    [ ] Yes – Deny

    [ ] No – Go to #14

14. Does the client have a diagnosis of severe hepatic impairment in the last 365 days?

    [ ] Yes – Deny

    [ ] No – Go to #15

15. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

    [ ] Yes – Deny

    [ ] No – Go to #16

16. Is the requested dose less than or equal to (≤) 45 mg daily?

    [ ] Yes – Approve (365 days)

    [ ] No – Deny

PAXPRESS™

Rinvoq (Upadacitinib)

Clinical Criteria Logic Diagram

PAXPRESS™

Siliq (Brodalumab)

Drugs Requiring Prior Authorization

The listed GCNs may not be an indication of Texas Medicaid Formulary coverage. To learn the current formulary coverage, visit txvendordrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	**GCN**
SILIQ 210 MG/1.5 ML SYRINGE	43055

PAXPRESS™

Siliq (Brodalumab)

Clinical Criteria Logic

1. Is the client greater than or equal to (≥) 18 years of age?

   [ ] Yes – Go to #2

   [ ] No – Deny

2. Does the client have a diagnosis of moderate to severe plaque psoriasis (PS) in the last 730 days?

   [ ] Yes – Go to #3

   [ ] No – Deny

3. Does the client have a history of 30 days conventional therapy for plaque psoriasis (PS) in the last 180 days?

   [ ] Yes – Go to #4

   [ ] No, and the request is for continuing therapy – Go to #4

   [ ] No, and the request is for initial therapy – Deny

4. Does the client have a claim for another biologic drug in the last 30 days?

   [ ] Yes – Deny

   [ ] No – Go to #5

5. Does the client have a diagnosis of Crohn's disease (CD) in the last 365 days?

   [ ] Yes – Deny

   [ ] No – Go to #6

6. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

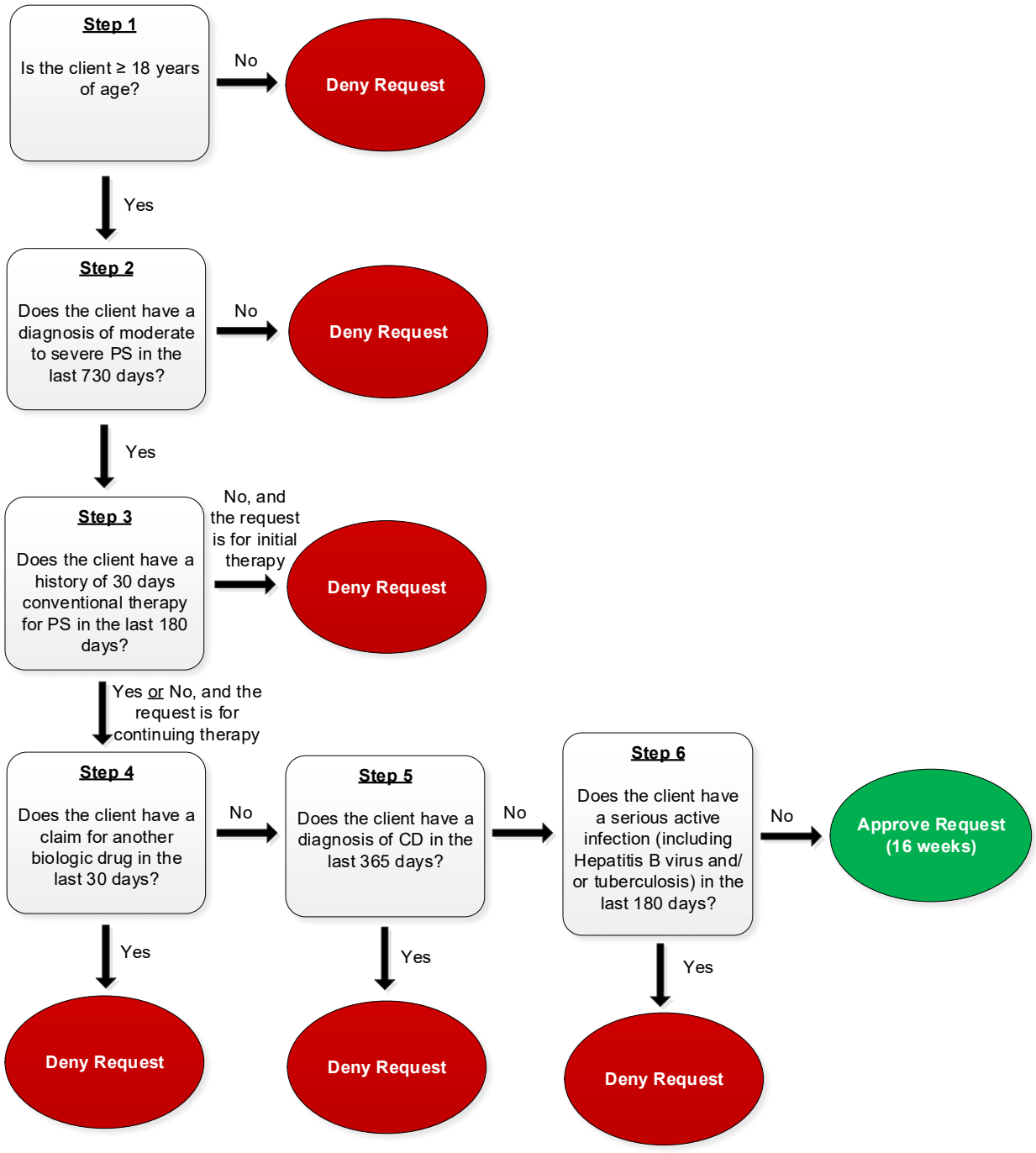
   [ ] Yes – Deny

   [ ] No – Approve (16 weeks)

PAXPRESS™

Siliq (Brodalumab)

Clinical Criteria Logic Diagram



PAXPRESS™

Simponi (Golimumab)

Drugs Requiring Prior Authorization

The listed GCNs may not be an indication of Texas Medicaid Formulary coverage. To learn the current formulary coverage, visit txvendordrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	**GCN**
SIMPONI 100 MG/ML PEN INJECTOR	35001
SIMPONI 100 MG/ML SYRINGE	34697
SIMPONI 50 MG/0.5 ML PEN INJECTOR	22533
SIMPONI 50MG/0.5 ML SYRINGE	22536
SIMPONI ARIA 50 MG/4 ML VIAL	34983

PAXPRESS™

Simponi (Golimumab)

Clinical Criteria Logic

1. Is the client greater than or equal to (≥) 18 years of age?

   [ ] Yes – Go to #2

   [ ] No, and the request is for Simponi Aria – Go to #5

   [ ] No, and the request is for Simponi – Deny

2. Does the client have a diagnosis of rheumatoid arthritis (RA) in the last 730 days?

   [ ] Yes – Go to #4

   [ ] No – Go to #3

3. Does the client have a diagnosis of ankylosing spondylitis (AS), psoriatic arthritis (PsA), and/or ulcerative colitis (UC) in the last 730 days?

   [ ] Yes – Go to #7

   [ ] No – Deny

4. Does the client have 1 claim for methotrexate in the last 60 days?

   [ ] Yes – Go to #7

   [ ] No – Deny

5. Is the client greater than or equal to (≥) 2 years of age?

   [ ] Yes – Go to #6

   [ ] No – Deny

6. Does the client have a diagnosis of polyarticular juvenile idiopathic arthritis (PJIA) or psoriatic arthritis (PsA) in the last 730 days?

   [ ] Yes – Go to #7

   [ ] No – Deny

7. Does the client have a history of heart failure in the last 365 days?

   [ ] Yes – Deny

   [ ] No – Go to #8

8. Does the client have a history of demyelinating disease (multiple sclerosis, optic neuritis, and/or Guillain-Barre syndrome) in the last 365 days?

   [ ] Yes – Deny

   [ ] No – Go to #9

9. Does the client have a history of hematologic abnormalities in the last 180 days?

[ ] Yes – Deny

[ ] No – Go to #10

10. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

    [ ] Yes – Deny

    [ ] No – Go to #11

11. Does the client have 1 claim for a contraindicated drug in the last 30 days?

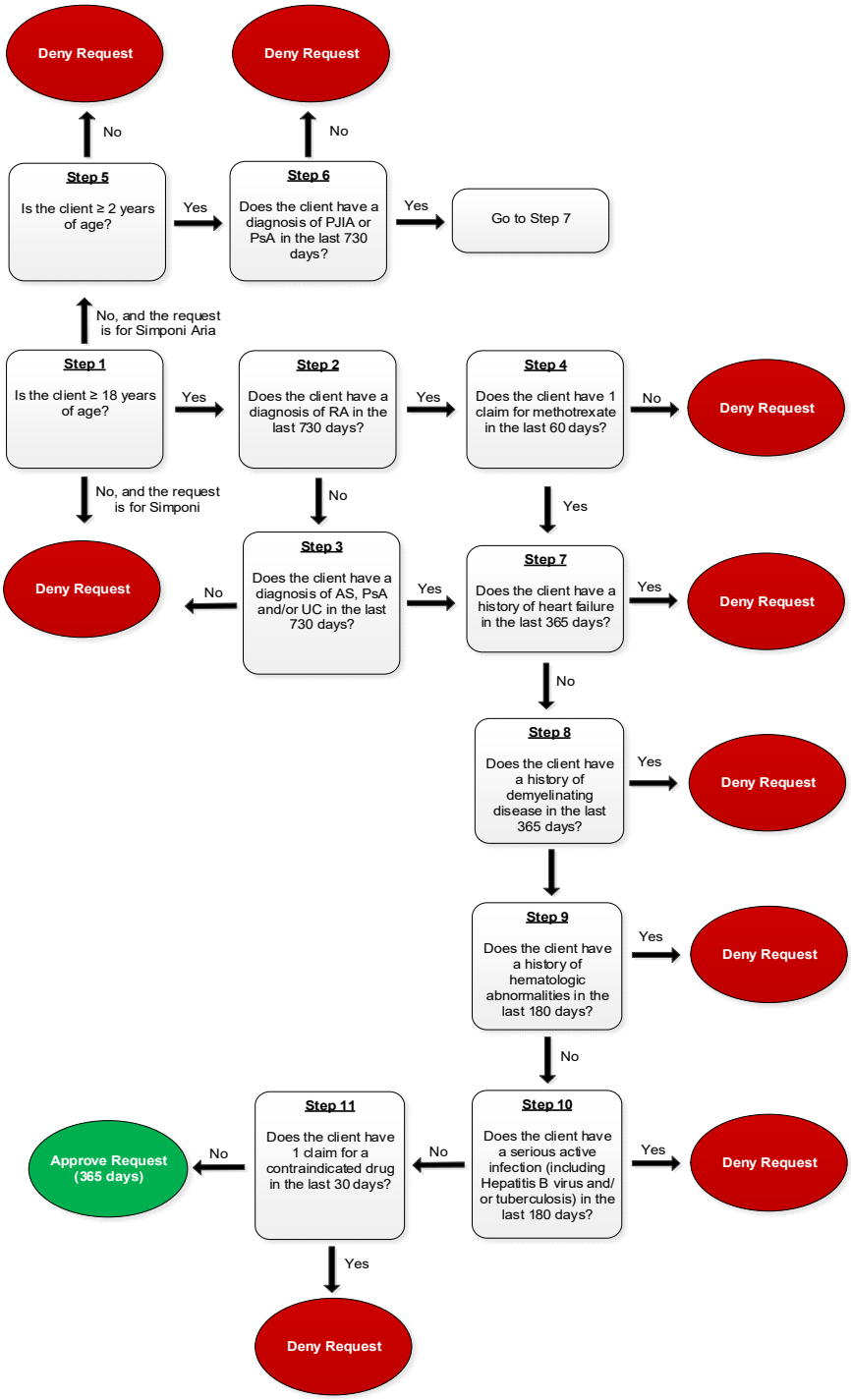
    [ ] Yes – Deny

    [ ] No – Approve (365 days)

PAXPRESS™

Simponi (Golimumab)

Clinical Criteria Logic Diagram



PAXPRESS™

Skyrizi (Risankizumab-rzaa)

Drugs Requiring Prior Authorization

The listed GCNs may not be an indication of Texas Medicaid Formulary coverage. To learn the current formulary coverage, visit txvendordrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	**GCN**
SKYRIZI 150 MG/ML SYRINGE	49617
SKYRIZI 150 MG/ML PEN	49591
SKYRIZI 180 MG/1.2 ML ON-BODY	53397
SKYRIZI 360 MG/2.4 ML ON-BODY	52475

PAXPRESS™

Skyrizi (Risankizumab-rzaa)

Clinical Criteria Logic

1. Is the client greater than or equal to (≥) 18 years of age?

   [ ] Yes – Go to #2

   [ ] No – Deny

2. Does the client have a diagnosis of moderately to severely active ulcerative colitis (UC), moderately to severely active Crohn's disease (CD), moderate to severe plaque psoriasis (PS), or active psoriatic arthritis (PsA) in the last 730 days?

   [ ] Yes – Go to #3

   [ ] No – Deny

3. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

   [ ] Yes – Deny

   [ ] No – Go to #4

4. Is the request for less than or equal to (≤) one 150 mg syringe/pen or one 180 mg or 360 mg cartridge?

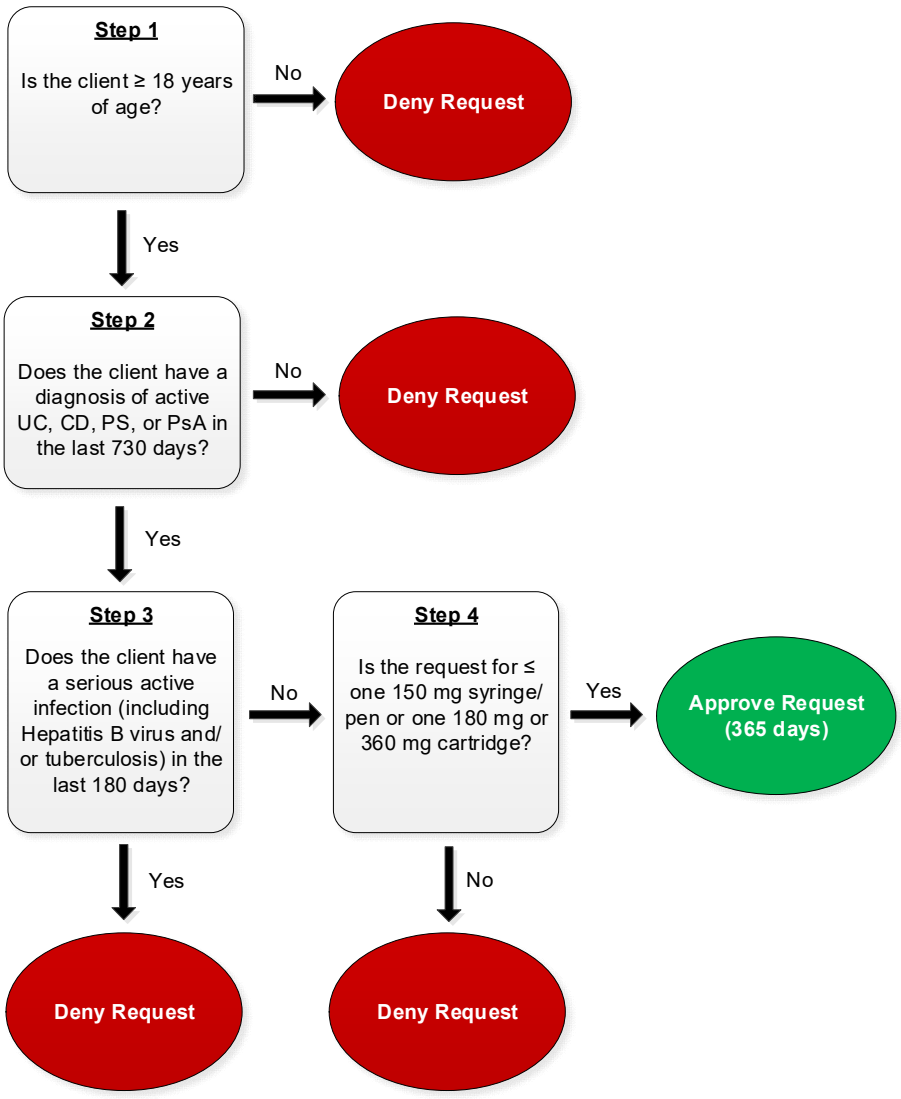
   [ ] Yes – Approve (365 days)

   [ ] No – Deny

PAXPRESS™

Skyrizi (Risankizumab-rzaa)

Clinical Criteria Logic Diagram



PAXPRESS™

Sotyktu (Deucravacitinib)

Drugs Requiring Prior Authorization

The listed GCNs may not be an indication of Texas Medicaid Formulary coverage. To learn the current formulary coverage, visit txvendordrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	**GCN**
SOTYKTU 6 MG TABLET	52879

PAXPRESS™

Sotyktu (Deucravacitinib)

Clinical Criteria Logic

1. Does the client have a diagnosis of moderate to severe plaque psoriasis (PS) in the last 730 days?

   [ ] Yes – Go to #2

   [ ] No – Deny

2. Is the client greater than or equal to (≥) 18 years of age?

   [ ] Yes – Go to #3

   [ ] No – Deny

3. Will the client have concurrent therapy with a JAK inhibitor (JAKi), biologic DMARD, or potent immunosuppressant?

   [ ] Yes – Deny

   [ ] No – Go to #4

4. Does the client have a diagnosis of severe hepatic impairment in the last 365 days?

   [ ] Yes – Deny

   [ ] No – Go to #5

5. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

   [ ] Yes – Deny

   [ ] No – Go to #6

6. Is the requested dose less than or equal to (≤) 1 tablet daily?

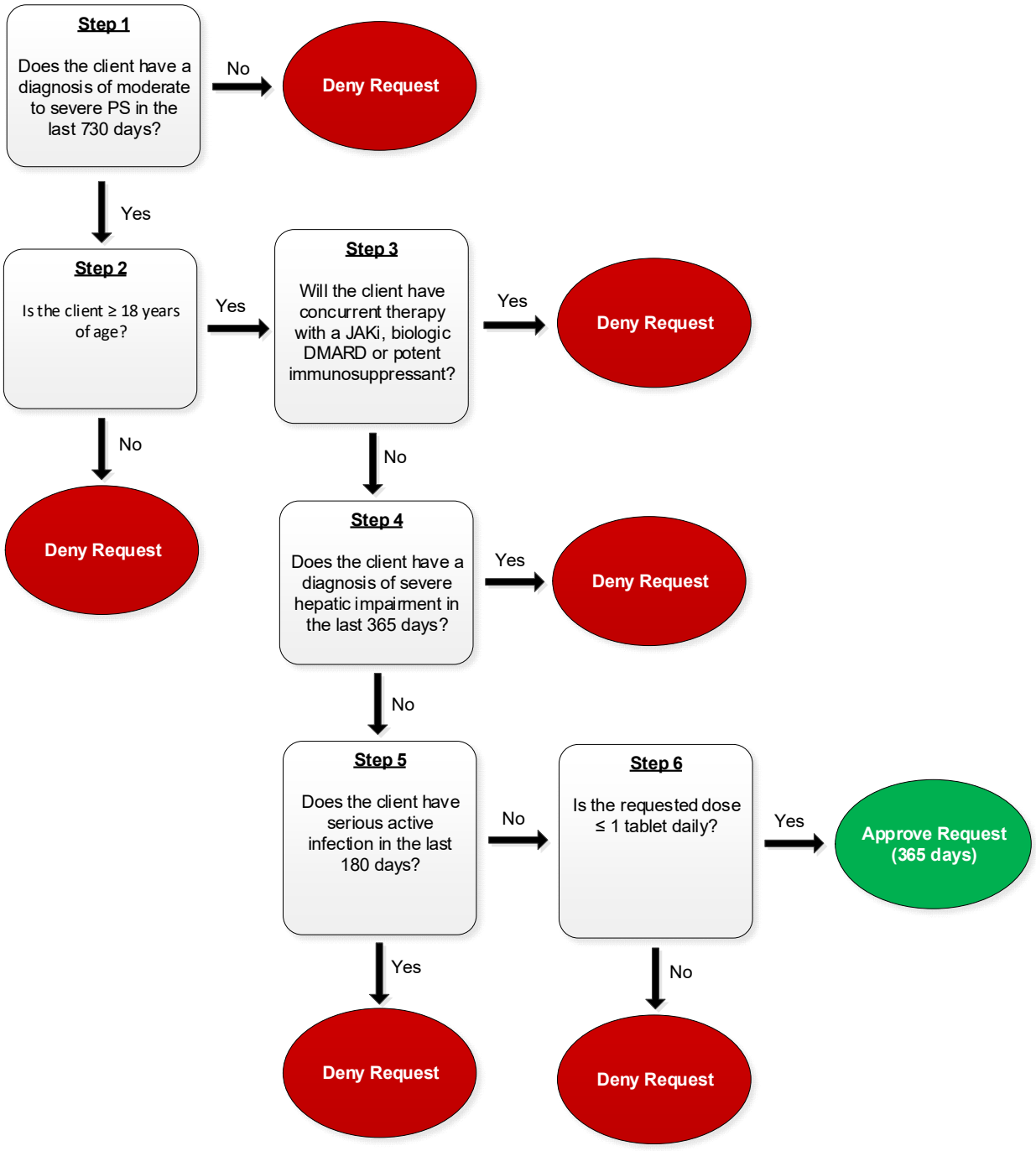
   [ ] Yes – Approve (365 days)

   [ ] No – Deny

PAXPRESS™

Sotyktu (Deucravacitinib)

Clinical Criteria Logic Diagram



PAXPRESS™

Spevigo (Spesolimab-sbzo)

Drugs Requiring Prior Authorization

The listed GCNs may not be an indication of Texas Medicaid Formulary coverage. To learn the current formulary coverage, visit txvendordrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	**GCN**
SPEVIGO 150 MG/ML SYRINGE	55498

PAXPRESS™

Spevigo (Spesolimab-sbzo)

Clinical Criteria Logic

1. Is the client greater than or equal to (≥) 12 years of age?

   [ ] Yes – Go to #2

   [ ] No – Deny

2. Does the client have a diagnosis of generalized pustular psoriasis (GPP) in the last 730 days?

   [ ] Yes – Go to #3

   [ ] No – Deny

3. Does the client have a diagnosis of active tuberculosis (TB) in the last 180 days?

   [ ] Yes – Deny

   [ ] No – Go to #4

4. Is this a renewal request, or has the client had initial treatment with intravenous Spevigo?

   [ ] Yes – Go to #6

   [ ] No – Go to #5

5. Is the request for less than or equal to (≤) 4-150 mg syringes?

   [ ] Yes – Approve (30 days)

   [ ] No – Deny

6. Is the request for less than or equal to (≤) 2-150 mg syringes per 28 days?

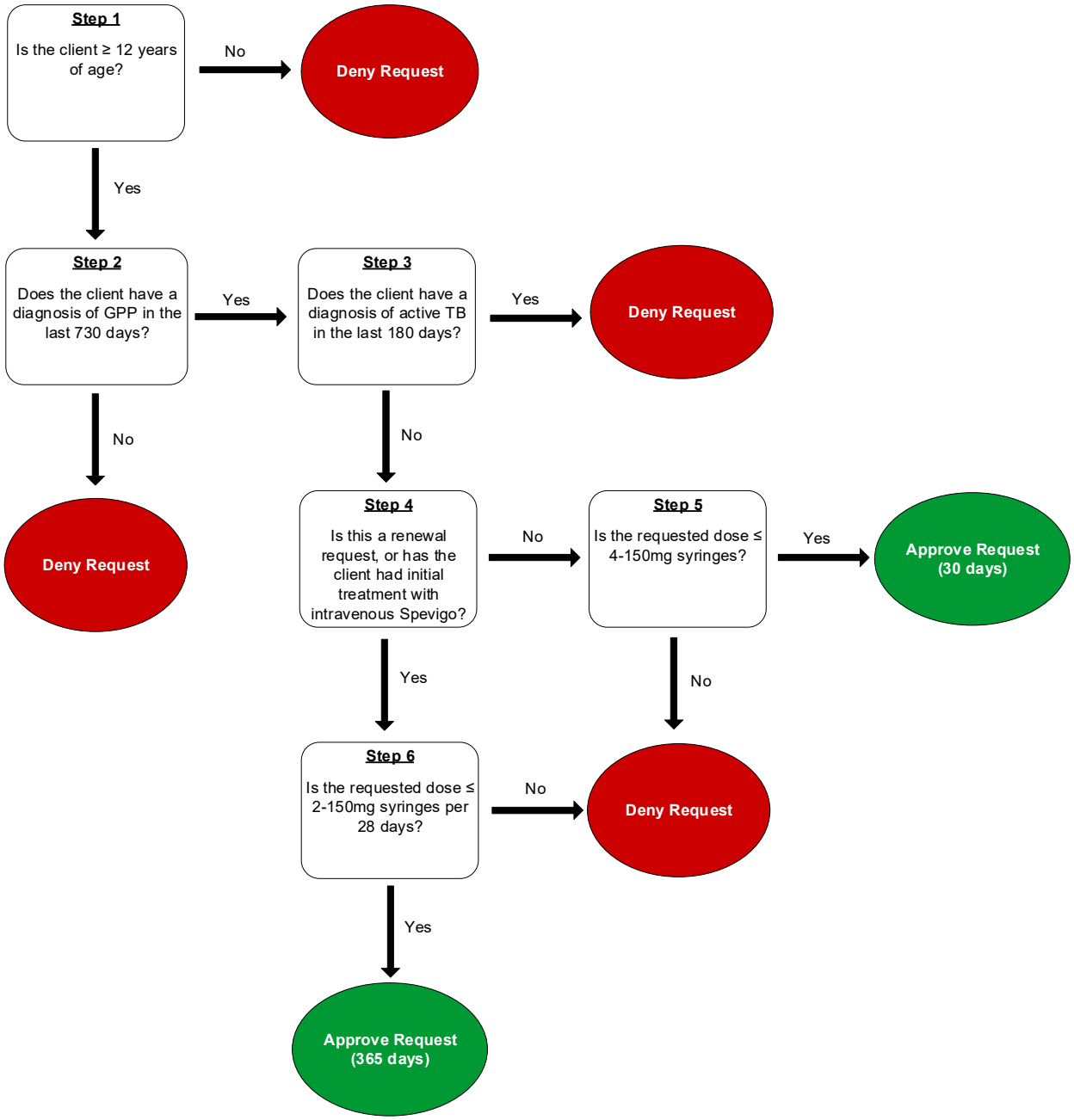
   [ ] Yes – Approve (365 days)

   [ ] No – Deny

PAXPRESS™

Spevigo (Spesolimab-sbzo)

Clinical Criteria Logic Diagram



Stelara (Ustekinumab) and Biosimilar Agents

Drugs Requiring Prior Authorization

The listed GCNs may not be an indication of Texas Medicaid Formulary coverage. To learn the current formulary coverage, visit txvendordrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	**GCN**
OTULFI 45 MG/0.5 ML SYRINGE	56286
OTULFI 90 MG/ML SYRINGE	56287
SELARSDI 45 MG/0.5 ML SYRINGE	55583
SELARSDI 90 MG/ML SYRINGE	55584
STELARA 45 MG/0.5 ML SYRINGE	28158
STELARA 45 MG/0.5 ML VIAL	19903
STELARA 90 MG/ML SYRINGE	28159
STEQEYMA 45 MG/0.5 ML SYRINGE	56753
STEQEYMA 90 MG/ML SYRINGE	56754
USTEKINUMAB-TTWE 45 MG/0.5ML SYRINGE	55956
USTEKINUMAB-TTWE 90 MG/ML SYRINGE	55957
YESINTEK 45 MG/0.5 ML SYRINGE	56599
YESINTEK 45 MG/0.5 ML VIAL	56607
YESINTEK 90 MG/ML SYRINGE	56603

PAXPRESS™

Stelara (Ustekinumab) and Biosimilar Agents

Clinical Criteria Logic

1. Is the client greater than or equal to (≥) 6 years of age?

   [ ] Yes – Go to #2

   [ ] No – Deny

2. Does the client have a diagnosis of plaque psoriasis (PS) or psoriatic arthritis (PsA) in the last 730 days?

   [ ] Yes – Go to #6

   [ ] No – Go to #3

3. Is the client greater than or equal to (≥) 18 years of age?

   [ ] Yes – Go to #4

   [ ] No – Deny

4. Does the client have a diagnosis of Crohn's disease (CD) or ulcerative colitis (UC) in the last 730 days?

   [ ] Yes – Go to #5

   [ ] No – Deny

5. Has the client had at least 30 days therapy for an immunomodulator, corticosteroid, or TNF blocker in the last 180 days?

   [ ] Yes – Go to #6

   [ ] No – Deny

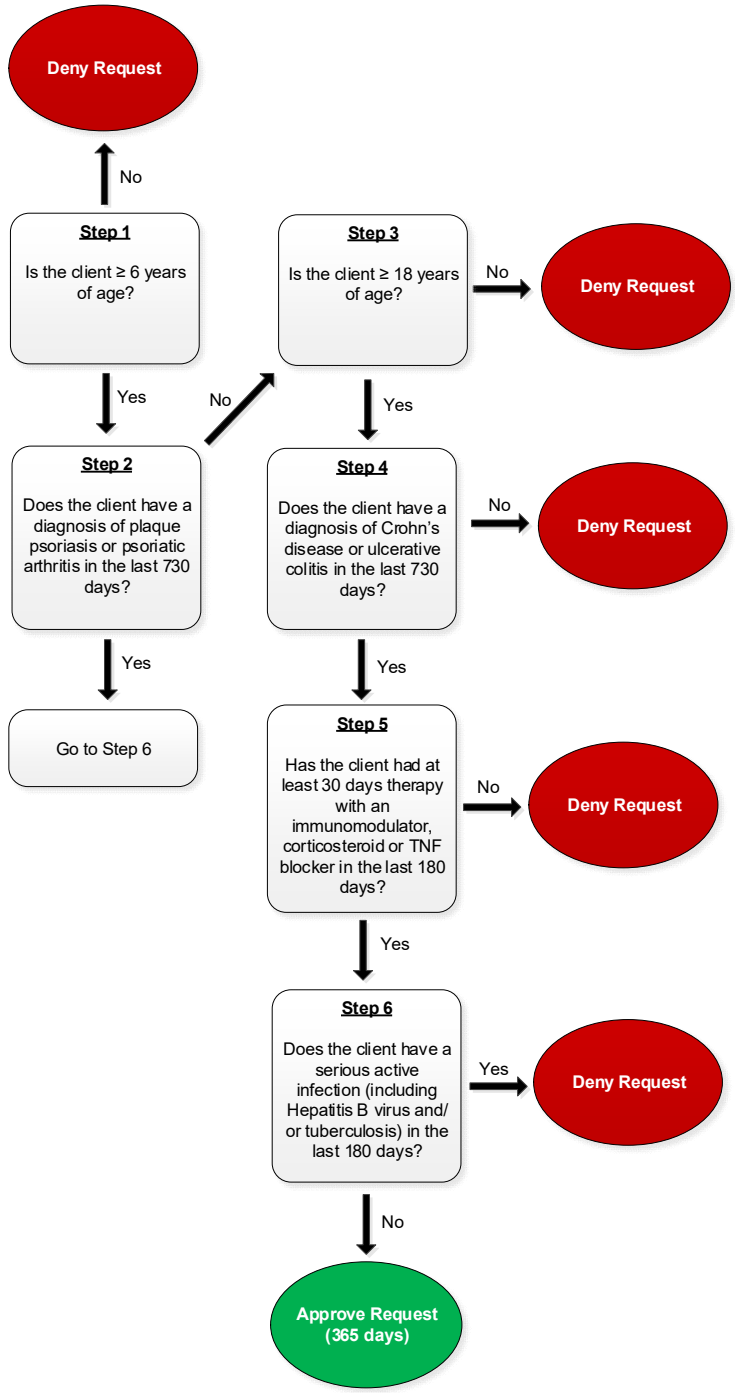
6. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

   [ ] Yes – Deny

   [ ] No – Approve (365 days)

Stelara (Ustekinumab) and Biosimilar Agents

Clinical Criteria Logic Diagram



PAXPRESS™

Taltz (Ixekizumab)

Drugs Requiring Prior Authorization

The listed GCNs may not be an indication of Texas Medicaid Formulary coverage. To learn the current formulary coverage, visit txvendordrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	**GCN**
TALTZ 20 MG/0.25 ML SYRINGE	55341
TALTZ 40 MG/ 0.5 ML SYRINGE	55342
TALTZ 80 MG/ML AUTOINJECTOR (3-PK)	40848
TALTZ 80 MG/ML AUTOINJECTOR	40848
TALTZ 80 MG/ML AUTOIN (2-PK)	40848
TALTZ 80 MG/ML SYRINGE	40849

PAXPRESS™

Taltz (Ixekizumab)

Clinical Criteria Logic

1. Is the client greater than or equal to (≥) 6 years of age?

   [ ] Yes – Go to #2

   [ ] No – Deny

2. Does the client have a diagnosis of moderate to severe plaque psoriasis (PS) in the last 730 days?

   [ ] Yes – Go to #5

   [ ] No – Go to #3

3. Is the client greater than or equal to (≥) 18 years of age?

   [ ] Yes – Go to #4

   [ ] No – Deny

4. Does the client have a diagnosis of ankylosing spondylitis (AS), non-radiographic axial spondyloarthritis (nr-axSpA), or psoriatic arthritis (PsA) in the last 730 days?

   [ ] Yes – Go to #5

   [ ] No – Deny

5. Does the client have 1 claim for another biologic drug in the last 30 days?

   [ ] Yes – Deny

   [ ] No – Go to #6

6. Does the client have a diagnosis of Crohn's disease (CD) or ulcerative colitis (UC) in the last 365 days?

   [ ] Yes – Deny

   [ ] No – Go to #7

7. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

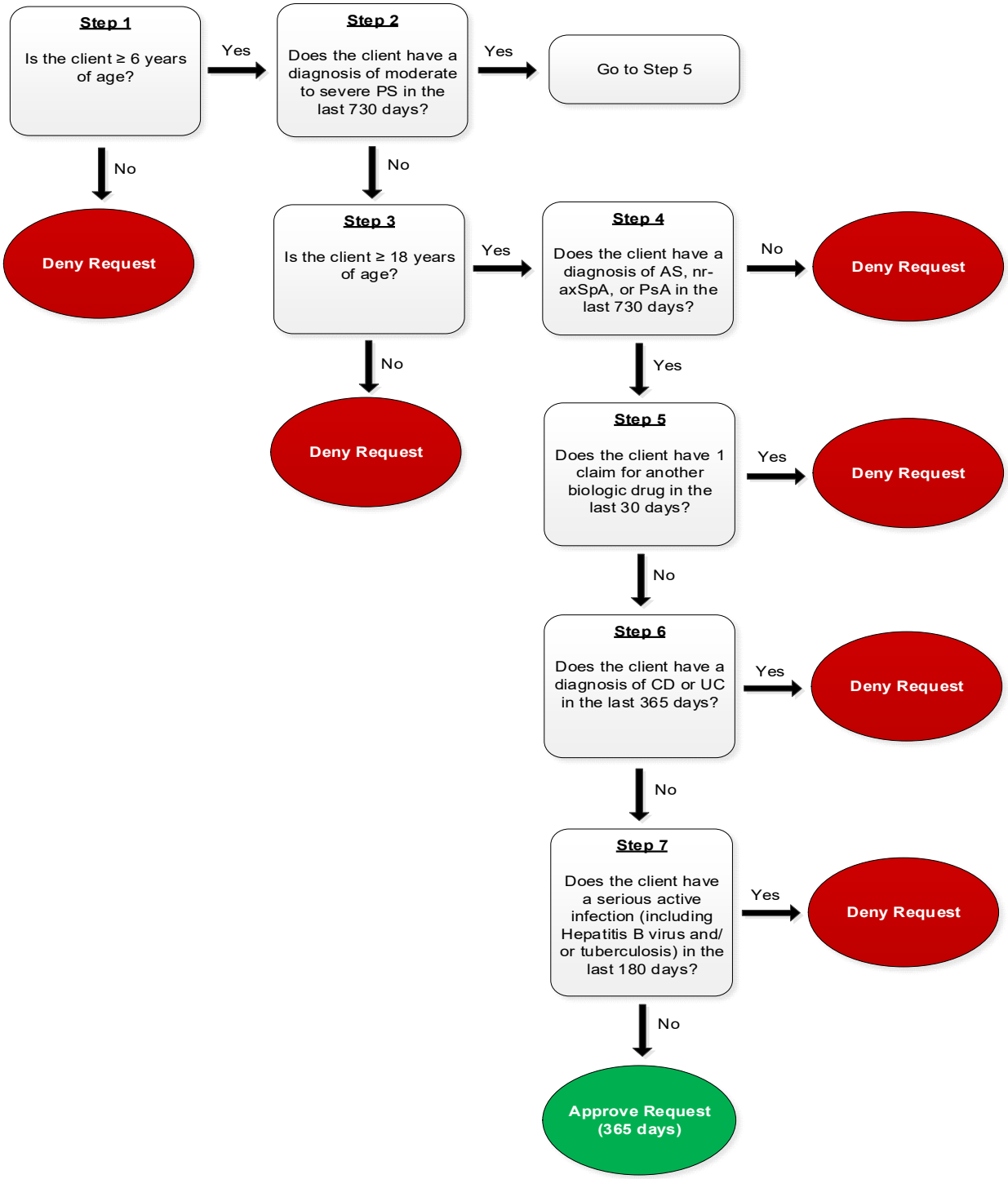
   [ ] Yes – Deny

   [ ] No – Approve (365 days)

PAXPRESS™

Taltz (Ixekizumab)

Clinical Criteria Logic Diagram



PAXPRESS™

Tremfya (Guselkumab)

Drugs Requiring Prior Authorization

The listed GCNs may not be an indication of Texas Medicaid Formulary coverage. To learn the current formulary coverage, visit txvendordrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	**GCN**
TREMFYA 100 MG/ML PEN	57417
TREMFYA 100 MG/ML SYRINGE	43612
TREMFYA 100 MG/ML INJECTOR	46024
TREMFYA 200 MG/2 ML PEN	56229
TREMFYA 200 MG/2 ML SYRINGE	56228

PAXPRESS™

Tremfya (Guselkumab)

Clinical Criteria Logic

1. Is the client greater than or equal to (≥) 18 years of age?

   [ ] Yes – Go to #2

   [ ] No – Deny

2. Does the client have a diagnosis of moderate to severe plaque psoriasis (PS), psoriatic arthritis (PsA), or ulcerative colitis (UC) in the last 730 days?

   [ ] Yes – Go to #3

   [ ] No – Deny

3. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

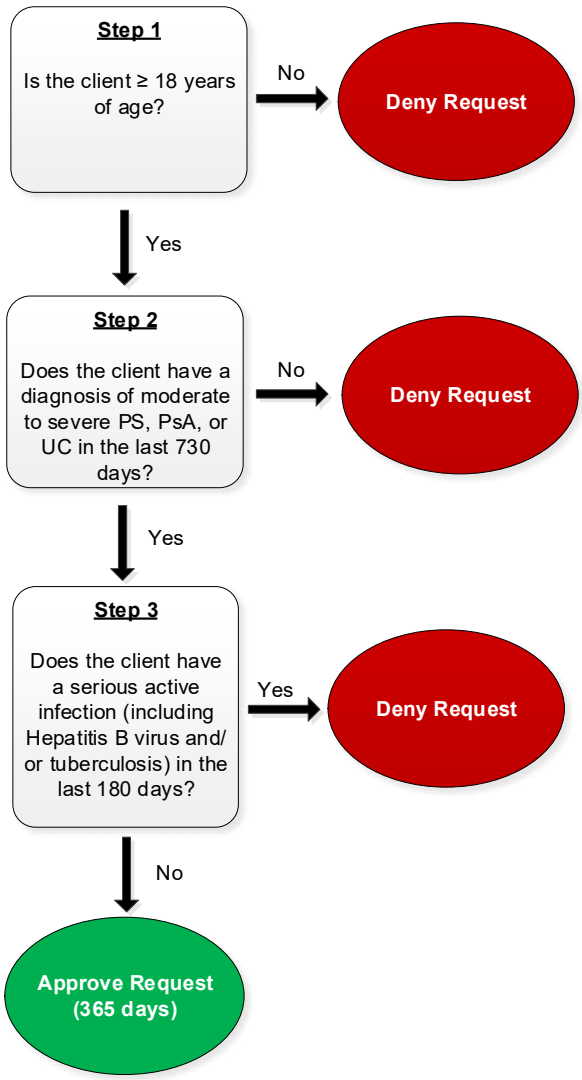
   [ ] Yes – Deny

   [ ] No – Approve (365 days)

PAXPRESS™

Tremfya (Guselkumab)

Clinical Criteria Logic Diagram



PAXPRESS™

Tyenne (Tocilizumab-aazg)

Drugs Requiring Prior Authorization

The listed GCNs may not be an indication of Texas Medicaid Formulary coverage. To learn the current formulary coverage, visit txvendordrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	**GCN**
TYENNE 162MG/0.9ML AUTOINJECT	55373
TYENNE 162MG/0.9ML SYRINGE	55374

PAXPRESS™

Tyenne (Tocilizumab-aazg)

Clinical Criteria Logic

1. Is this a refill request, or has the client had initial treatment with intravenous tocilizumab?

   [ ] Yes – Go to #8

   [ ] No – Go to #2

2. Is the client greater than or equal to (≥) 18 years of age?

   [ ] Yes – Go to #3

   [ ] No – Go to #6

3. Does the client have a diagnosis of rheumatoid arthritis (RA) in the last 730 days?

   [ ] Yes – Go to #5

   [ ] No – Go to #4

4. Does the client have a diagnosis of giant cell arteritis (GCA) in the last 730 days?

   [ ] Yes – Go to #8

   [ ] No – Go to #6

5. Does the client have 1 claim for a DMARD agent in the last 180 days?

   [ ] Yes – Go to #8

   [ ] No – Deny

6. Does the client have a diagnosis of polyarticular juvenile idiopathic arthritis (PJIA) or systemic juvenile idiopathic arthritis (SJIA) in the last 730 days?

   [ ] Yes – Go to #7

   [ ] No – Deny

7. Is the client greater than or equal to (≥) 2 years of age?

   [ ] Yes – Go to #8

   [ ] No – Deny

8. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

   [ ] Yes – Deny

   [ ] No – Approve (Go to #9)

9. Will the client have concurrent therapy with a biologic DMARD?

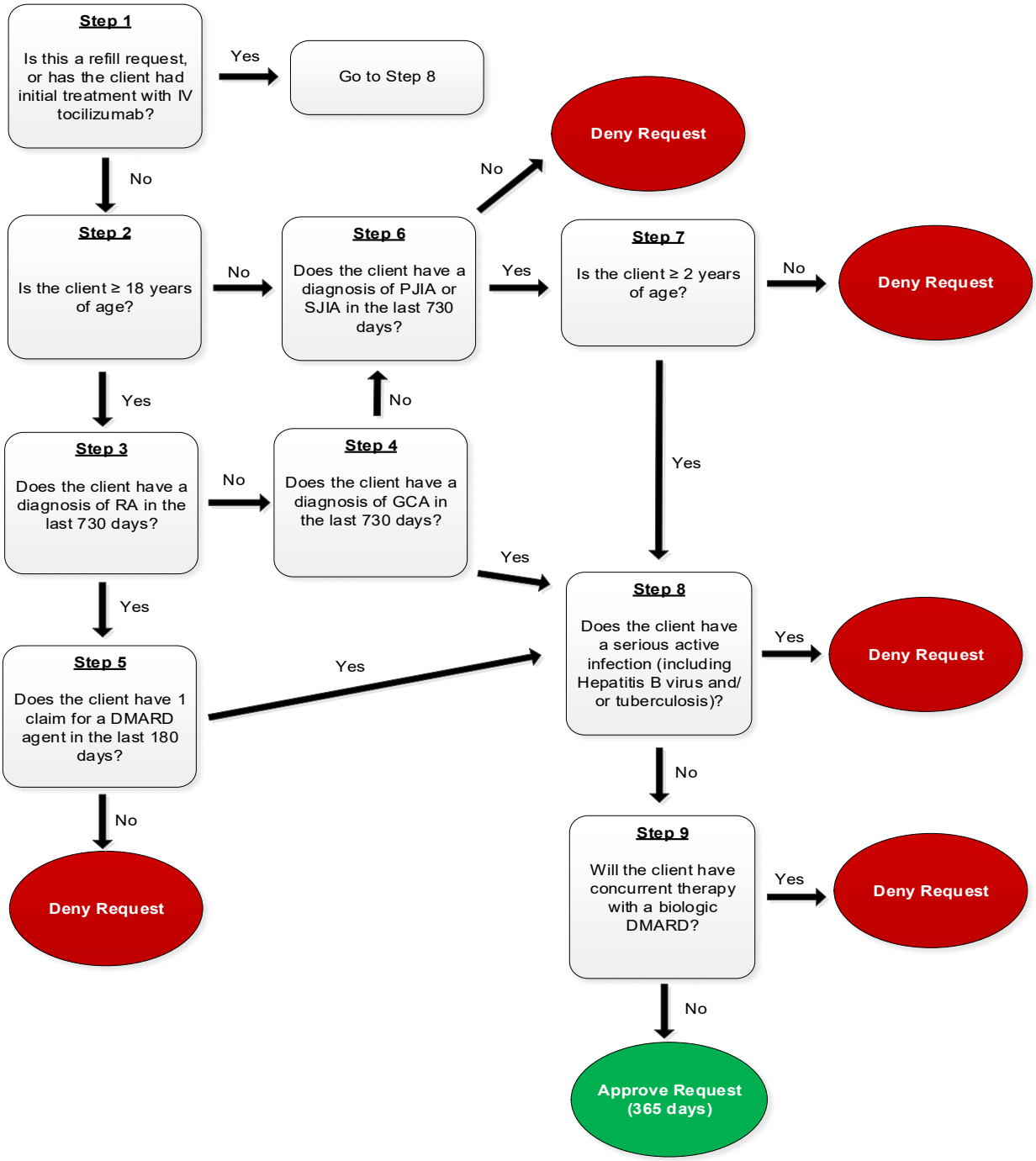
   [ ] Yes – Deny

[ ] No – Approve (365 days)

PAXPRESS™

Tyenne (Tocilizumab-aazg)

Clinical Criteria Logic Diagram



PAXPRESS™

Xeljanz (Tofacitinib)

Drugs Requiring Prior Authorization

The listed GCNs may not be an indication of Texas Medicaid Formulary coverage. To learn the current formulary coverage, visit txvendordrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	**GCN**
XELJANZ 1 MG/ML SOLUTION	48684
XELJANZ 5 MG TABLET	33617
XELJANZ 10 MG TABLET	44882
XELJANZ XR 11 MG TABLET	38086

PAXPRESS™

Xeljanz (Tofacitinib)

Clinical Criteria Logic

1. Is this a refill request?

   [ ] Yes – Go to #7

   [ ] No – go to #2

2. Is the client greater than or equal to (≥) 2 years of age?

   [ ] Yes – Go to #3

   [ ] No – Deny

3. Does the client have a diagnosis of juvenile idiopathic arthritis (JIA) in the last 730 days?

   [ ] Yes – Go to #6

   [ ] No, and the request is for Xeljanz/Xeljanz XR tablets – Go to #4

   [ ] No, and the request is for Xeljanz oral solution – Deny

4. Is the client greater than or equal to (≥) 18 years of age?

   [ ] Yes – Go to #5

   [ ] No – Deny

5. Does the client have a diagnosis of ankylosing spondylitis (AS), psoriatic arthritis (PsA), rheumatoid arthritis (RA), or ulcerative colitis (UC) in the last 730 days?

   [ ] Yes – Go to #6

   [ ] No – Deny

6. Has the client had therapy with one or more TNF blockers in the last 90 days?

   [ ] Yes – Go to #7

   [ ] No – Deny

7. Will the client have concurrent therapy with a biological DMARD or potent immunosuppressant in the last 180 days?

   [ ] Yes – Deny

   [ ] No – Go to #8

8. Does the client have 1 claim for a strong CYP3A4 inducer in the last 60 days?

   [ ] Yes – Deny

   [ ] No – Go to #9

9. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

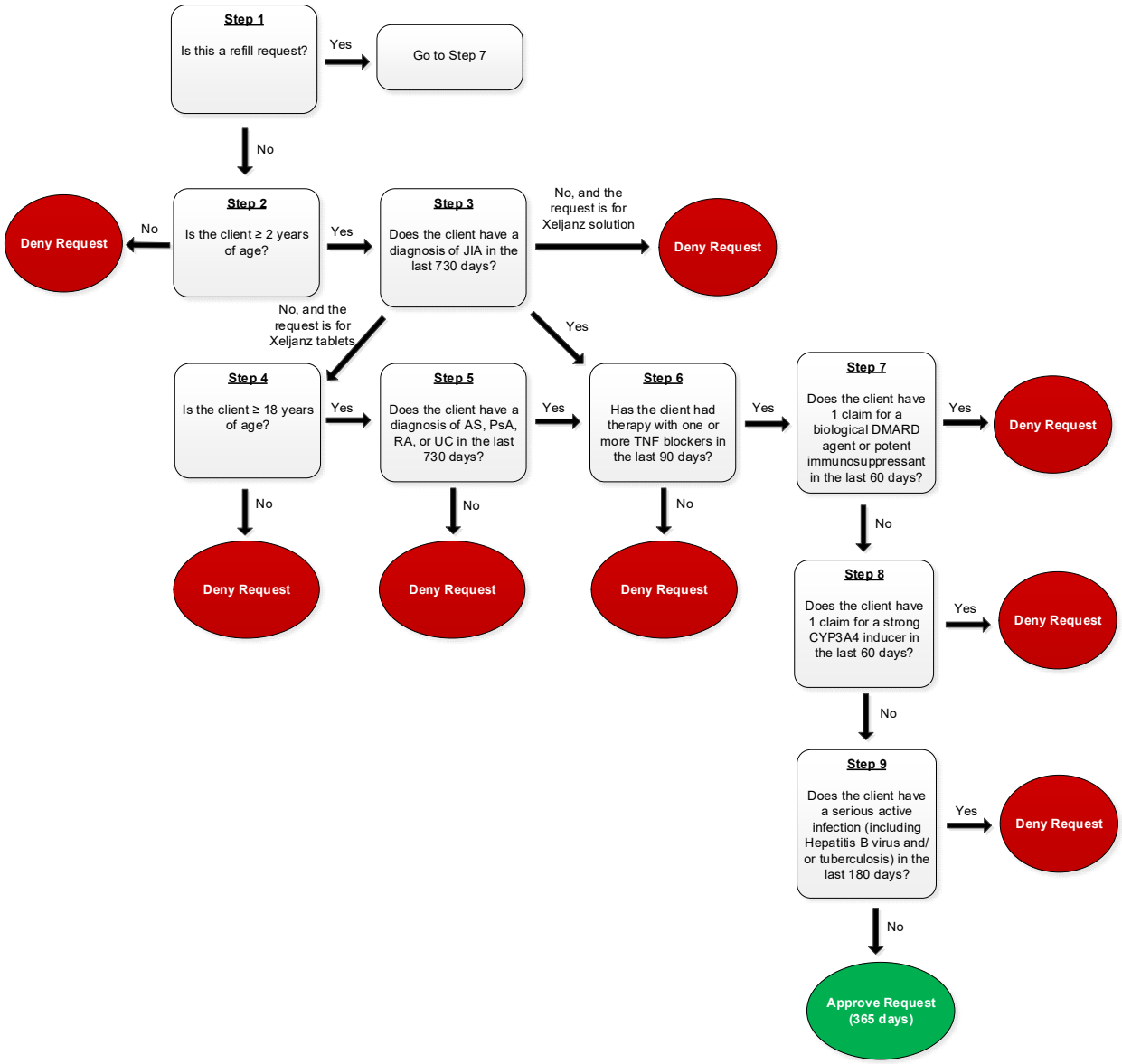
   [ ] Yes – Deny

   [ ] No – Approve (365 days)

PAXPRESS™

Xeljanz (Tofacitinib)

Clinical Criteria Logic Diagram



PAXPRESS™

Cytokine and CAM Antagonists

Clinical Criteria Supporting Tables

Active Tuberculosis	
ICD-10 Code	**Description**
A150	TUBERCULOSIS OF LUNG
A154	TUBERCULOSIS OF INTRATHORACIC LYMPH NODES
A155	TUBERCULOSIS OF LARYNX, TRACHEA AND BRONCHUS
A156	TUBERCULOUS PLEURISY
A157	PRIMARY RESPIRATORY TUBERCULOSIS
A158	OTHER RESPIRATORY TUBERCULOSIS
A159	RESPIRATORY TUBERCULOSIS UNSPECIFIED

Acute Graft Versus Host Disease (aGVHD)	
ICD-10 Code	**Description**
D89810	ACUTE GRAFT-VERSUS-HOST DISEASE

Alopecia Areata	
ICD-10 Code	**Description**
L630	ALOPECIA (CAPITIS) TOTALIS
L631	ALOPECIA UNIVERSALIS
L632	OPHIASIS
L638	OTHER ALOPECIA AREATA
L639	ALOPECIA AREATA, UNSPECIFIED

Ankylosing Spondylitis (AS)	
ICD-10 Code	**Description**
M450	ANKYLOSING SPONDYLITIS OF MULTIPLE SITES IN SPINE
M451	ANKYLOSING SPONDYLITIS OF OCCIPITO-ATLANTO-AXIAL REGION
M452	ANKYLOSING SPONDYLITIS OF CERVICAL REGION
M453	ANKYLOSING SPONDYLITIS OF CERVICOTHORACIC REGION
M454	ANKYLOSING SPONDYLITIS OF THORACIC REGION
M455	ANKYLOSING SPONDYLITIS OF THORACOLUMBAR REGION
M456	ANKYLOSING SPONDYLITIS LUMBAR REGION
M457	ANKYLOSING SPONDYLITIS OF LUMBOSACRAL REGION
M458	ANKYLOSING SPONDYLITIS SACRAL AND SACROCOCCYGEAL REGION
M459	ANKYLOSING SPONDYLITIS OF UNSPECIFIED SITES IN SPINE

Atopic Dermatitis	
ICD-10 Code	**Description**
L200	BESNIER'S PRURIGO
L2081	ATOPIC NEURODERMATITIS
L2082	FLEXURAL ECZEMA
L2084	INTRINSIC (ALLERGIC) ECZEMA
L2089	OTHER ATOPIC DERMATITIS
L209	ATOPIC DERMATITIS, UNSPECIFIED

Oral ulcers associated with Behcet’s Disease	
ICD-10 Code	**Description**
M352	BEHCET’S DISEASE

Cryopyrin-Associated Periodic Syndrome (CAPS)	
ICD-10 Code	**Description**
M042	CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES

Crohn's Disease (CD)	
ICD-10 Code	**Description**
K5000	CROHN'S DISEASE OF SMALL INTESTINE WITHOUT COMPLICATIONS
K50011	CROHN'S DISEASE OF SMALL INTESTINE WITH RECTAL BLEEDING
K50012	CROHN'S DISEASE OF SMALL INTESTINE WITH INTESTINAL OBSTRUCTION
K50013	CROHN'S DISEASE OF SMALL INTESTINE WITH FISTULA
K50014	CROHN'S DISEASE OF SMALL INTESTINE WITH ABSCESS
K50018	CROHN'S DISEASE OF SMALL INTESTINE WITH OTHER COMPLICATION
K50019	CROHN'S DISEASE OF SMALL INTESTINE WITH UNSPECIFIED COMPLICATIONS
K5010	CROHN'S DISEASE OF LARGE INTESTINE WITHOUT COMPLICATIONS
K50111	CROHN'S DISEASE OF LARGE INTESTINE WITH RECTAL BLEEDING
K50112	CROHN'S DISEASE OF LARGE INTESTINE WITH INTESTINAL OBSTRUCTION
K50113	CROHN'S DISEASE OF LARGE INTESTINE WITH FISTULA
K50114	CROHN'S DISEASE OF LARGE INTESTINE WITH ABSCESS
K50118	CROHN'S DISEASE OF LARGE INTESTINE WITH OTHER COMPLICATION
K50119	CROHN'S DISEASE OF LARGE INTESTINE WITH UNSPECIFIED COMPLICATIONS
K5080	CROHN'S DISEASE OF BOTH SMALL AND LARGE INTESTINE WITHOUT COMPLICATIONS
K50811	CROHN'S DISEASE OF BOTH SMALL AND LARGE INTESTINE WITH RECTAL BLEEDING
K50812	CROHN'S DISEASE OF BOTH SMALL AND LARGE INTESTINE WITH INTESTINAL OBSTRUCTION
K50813	CROHN'S DISEASE OF BOTH SMALL AND LARGE INTESTINE WITH FISTULA

Crohn's Disease (CD)	
ICD-10 Code	**Description**
K50814	CROHN'S DISEASE OF BOTH SMALL AND LARGE INTESTINE WITH ABSCESS
K50818	CROHN'S DISEASE OF BOTH SMALL AND LARGE INTESTINE WITH OTHER COMPLICATION
K50819	CROHN'S DISEASE OF BOTH SMALL AND LARGE INTESTINE WITH UNSPECIFIED COMPLICATIONS
K5090	CROHN'S DISEASE, UNSPECIFIED WITHOUT COMPLICATIONS
K50911	CROHN'S DISEASE, UNSPECIFIED, WITH RECTAL BLEEDING
K50912	CROHN'S DISEASE, UNSPECIFIED, WITH INTESTINAL OBSTRUCTION
K50913	CROHN'S DISEASE, UNSPECIFIED, WITH FISTULA
K50914	CROHN'S DISEASE, UNSPECIFIED, WITH ABSCESS
K50918	CROHN'S DISEASE, UNSPECIFIED, WITH OTHER COMPLICATION
K50919	CROHN'S DISEASE, UNSPECIFIED, WITH UNSPECIFIED COMPLICATIONS

Deficiency of Interleukin-1 Receptor Antagonist (DIRA)	
ICD-10 Code	**Description**
M048	OTHR AUTOINFLAMMATORY SYNDROMES

Enthesitis-Related Arthritis (ERA)	
ICD-10 Code	**Description**
M0880	OTHER JUVENILE ARTHRITIS UNSPECIFIED SITE

Generalized Pustular Psoriasis (GPP)	
ICD-10 Code	**Description**
L401	GENERALIZED PUSTULAR PSORIASIS

Giant Cell Arteritis (GCA)	
ICD-10 Code	**Description**
M315	GIANT CELL ARTERITIS WITH POLYMYALGIA RHEUMATICA
M316	OTHER GIANT CELL ARTERITIS

Hidradenitis Suppurativa (HS)	
ICD-10 Code	**Description**
L732	HIDRADENITIS SUPPURATIVA

Juvenile Idiopathic Arthritis (JIA)	
ICD-10 Code	**Description**
M0800	UNSPECIFIED JUVENILE RHEUMATOID ARTHRITIS OF UNSPECIFIED SITE
M08011	UNSPECIFIED JUVENILE RHEUMATOID ARTHRITIS, RIGHT SHOULDER
M08012	UNSPECIFIED JUVENILE RHEUMATOID ARTHRITIS, LEFT SHOULDER
M08019	UNSPECIFIED JUVENILE RHEUMATOID ARTHRITIS, UNSPECIFIED SHOULDER
M08021	UNSPECIFIED JUVENILE RHEUMATOID ARTHRITIS, RIGHT ELBOW
M08022	UNSPECIFIED JUVENILE RHEUMATOID ARTHRITIS, LEFT ELBOW
M08029	UNSPECIFIED JUVENILE RHEUMATOID ARTHRITIS, UNSPECIFIED ELBOW
M08031	UNSPECIFIED JUVENILE RHEUMATOID ARTHRITIS, RIGHT WRIST
M08032	UNSPECIFIED JUVENILE RHEUMATOID ARTHRITIS, LEFT WRIST
M08039	UNSPECIFIED JUVENILE RHEUMATOID ARTHRITIS, UNSPECIFIED WRIST
M08041	UNSPECIFIED JUVENILE RHEUMATOID ARTHRITIS, RIGHT HAND
M08042	UNSPECIFIED JUVENILE RHEUMATOID ARTHRITIS, LEFT HAND
M08049	UNSPECIFIED JUVENILE RHEUMATOID ARTHRITIS, UNSPECIFIED HAND
M08051	UNSPECIFIED JUVENILE RHEUMATOID ARTHRITIS, RIGHT HIP
M08052	UNSPECIFIED JUVENILE RHEUMATOID ARTHRITIS, LEFT HIP

Juvenile Idiopathic Arthritis (JIA)	
ICD-10 Code	**Description**
M08059	UNSPECIFIED JUVENILE RHEUMATOID ARTHRITIS, UNSPECIFIED HIP
M08061	UNSPECIFIED JUVENILE RHEUMATOID ARTHRITIS, RIGHT KNEE
M08062	UNSPECIFIED JUVENILE RHEUMATOID ARTHRITIS, LEFT KNEE
M08069	UNSPECIFIED JUVENILE RHEUMATOID ARTHRITIS, UNSPECIFIED KNEE
M08071	UNSPECIFIED JUVENILE RHEUMATOID ARTHRITIS, RIGHT ANKLE AND FOOT
M08072	UNSPECIFIED JUVENILE RHEUMATOID ARTHRITIS, LEFT ANKLE AND FOOT
M08079	UNSPECIFIED JUVENILE RHEUMATOID ARTHRITIS, UNSPECIFIED ANKLE AND FOOT
M0808	UNSPECIFIED JUVENILE RHEUMATOID ARTHRITIS VERTEBRAE
M0809	UNSPECIFIED JUVENILE RHEUMATOID ARTHRITIS MULTIPLE SITES
M081	JUVENILE ANKYLOSING SPONDYLITIS
M0820	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET UNSPECIFIED SITE
M08211	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, RIGHT SHOULDER
M08212	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, LEFT ELBOW
M08219	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, UNSPECIFIED SHOULDER
M08221	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, RIGHT ELBOW
M08222	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, LEFT ELBOW
M08229	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, UNSPECIFIED ELBOW
M08231	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, RIGHT WRIST
M08232	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, LEFT WRIST
M08239	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, UNSPECIFIED WRIST
M08241	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, RIGHT HAND
M08242	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, LEFT HAND

Juvenile Idiopathic Arthritis (JIA)	
ICD-10 Code	**Description**
M08249	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, UNSPECIFIED HAND
M08251	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, RIGHT HIP
M08252	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, LEFT HIP
M08259	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, UNSPECIFIED HIP
M08261	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, RIGHT KNEE
M08262	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, LEFT KNEE
M08269	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, UNSPECIFIED KNEE
M08271	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, RIGHT ANKLE AND FOOT
M08272	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, LEFT ANKLE AND FOOT
M08279	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, UNSPECIFIED ANKLE AND FOOT
M0828	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET VERTEBRAE
M0829	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET MULTIPLE SITES
M083	JUVENILE RHEUMATOID POLYARTHRITIS (SERONEGATIVE)
M0840	PAUCIARTICULAR JUVENILE RHEUMATOID ARTHRITIS UNSPECIFIED SITE
M08411	PAUCIARTICULAR JUVENILE RHEUMATOID ARTHRITIS, RIGHT SHOULDER
M08412	PAUCIARTICULAR JUVENILE RHEUMATOID ARTHRITIS, LEFT SHOULDER
M08419	PAUCIARTICULAR JUVENILE RHEUMATOID ARTHRITIS, UNSPECIFIED SHOULDER
M08421	PAUCIARTICULAR JUVENILE RHEUMATOID ARTHRITIS, RIGHT ELBOW
M08422	PAUCIARTICULAR JUVENILE RHEUMATOID ARTHRITIS, LEFT ELBOW
M08429	PAUCIARTICULAR JUVENILE RHEUMATOID ARTHRITIS, UNSPECIFIED ELBOW
M08431	PAUCIARTICULAR JUVENILE RHEUMATOID ARTHRITIS, RIGHT WRIST

Juvenile Idiopathic Arthritis (JIA)	
ICD-10 Code	**Description**
M08432	PAUCIARTICULAR JUVENILE RHEUMATOID ARTHRITIS, LEFT WRIST
M08439	PAUCIARTICULAR JUVENILE RHEUMATOID ARTHRITIS, UNSPECIFIED WRIST
M08441	PAUCIARTICULAR JUVENILE RHEUMATOID ARTHRITIS, RIGHT HAND
M08442	PAUCIARTICULAR JUVENILE RHEUMATOID ARTHRITIS, LEFT HAND
M08449	PAUCIARTICULAR JUVENILE RHEUMATOID ARTHRITIS, UNSPECIFIED HAND
M08451	PAUCIARTICULAR JUVENILE RHEUMATOID ARTHRITIS, RIGHT HIP
M08452	PAUCIARTICULAR JUVENILE RHEUMATOID ARTHRITIS, LEFT HIP
M08459	PAUCIARTICULAR JUVENILE RHEUMATOID ARTHRITIS, UNSPECIFIED HIP
M08461	PAUCIARTICULAR JUVENILE RHEUMATOID ARTHRITIS, RIGHT KNEE
M08462	PAUCIARTICULAR JUVENILE RHEUMATOID ARTHRITIS, LEFT KNEE
M08469	PAUCIARTICULAR JUVENILE RHEUMATOID ARTHRITIS, UNSPECIFIED KNEE
M08471	PAUCIARTICULAR JUVENILE RHEUMATOID ARTHRITIS, RIGHT ANKLE AND FOOT
M08472	PAUCIARTICULAR JUVENILE RHEUMATOID ARTHRITIS, LEFT ANKLE AND FOOT
M08479	PAUCIARTICULAR JUVENILE RHEUMATOID ARTHRITIS, UNSPECIFIED ANKLE AND FOOT
M0848	PAUCIARTICULAR JUVENILE RHEUMATOID ARTHRITIS VERTEBRAE
M0880	OTHER JUVENILE ARTHRITIS, UNSPECIFIED SITE
M08811	OTHER JUVENILE ARTHRITIS, RIGHT SHOULDER
M08812	OTHER JUVENILE ARTHRITIS, LEFT SHOULDER
M08819	OTHER JUVENILE ARTHRITIS, UNSPECIFIED SHOULDER
M08821	OTHER JUVENILE ARTHRITIS, RIGHT ELBOW
M08822	OTHER JUVENILE ARTHRITIS, LEFT ELBOW
M08829	OTHER JUVENILE ARTHRITIS, UNSPECIFIED ELBOW
M08831	OTHER JUVENILE ARTHRITIS, RIGHT WRIST

Juvenile Idiopathic Arthritis (JIA)	
ICD-10 Code	**Description**
M08832	OTHER JUVENILE ARTHRITIS, LEFT WRIST
M08839	OTHER JUVENILE ARTHRITIS, UNSPECIFIED WRIST
M08841	OTHER JUVENILE ARTHRITIS, RIGHT HAND
M08842	OTHER JUVENILE ARTHRITIS, LEFT HAND
M08849	OTHER JUVENILE ARTHRITIS, UNSPECIFIED HAND
M08851	OTHER JUVENILE ARTHRITIS, RIGHT HIP
M08852	OTHER JUVENILE ARTHRITIS, LEFT HIP
M08859	OTHER JUVENILE ARTHRITIS, UNSPECIFIED HIP
M08861	OTHER JUVENILE ARTHRITIS, RIGHT KNEE
M08862	OTHER JUVENILE ARTHRITIS, LEFT KNEE
M08869	OTHER JUVENILE ARTHRITIS, UNSPECIFIED KNEE
M08871	OTHER JUVENILE ARTHRITIS, RIGHT ANKLE AND FOOT
M08872	OTHER JUVENILE ARTHRITIS, LEFT ANKLE AND FOOT
M08879	OTHER JUVENILE ARTHRITIS, UNSPECIFIED ANKLE AND FOOT
M0888	OTHER JUVENILE ARTHRITIS, OTHER SPECIFIED SITE
M0889	OTHER JUVENILE ARTHRITIS, MULTIPLE SITES
M0890	JUVENILE ARTHRITIS, UNSPECIFIED SITE
M08911	JUVENILE ARTHRITIS, UNSPECIFIED, RIGHT SHOULDER
M08912	JUVENILE ARTHRITIS, UNSPECIFIED, LEFT SHOULDER
M08919	JUVENILE ARTHRITIS, UNSPECIFIED, UNSPECIFIED SHOULDER
M08921	JUVENILE ARTHRITIS, UNSPECIFIED, RIGHT ELBOW
M08922	JUVENILE ARTHRITIS, UNSPECIFIED, LEFT ELBOW
M08929	JUVENILE ARTHRITIS, UNSPECIFIED, UNSPECIFIED ELBOW
M08931	JUVENILE ARTHRITIS, UNSPECIFIED, RIGHT WRIST

Juvenile Idiopathic Arthritis (JIA)	
ICD-10 Code	**Description**
M08932	JUVENILE ARTHRITIS, UNSPECIFIED, LEFT WRIST
M08939	JUVENILE ARTHRITIS, UNSPECIFIED, UNSPECIFIED WRIST
M08941	JUVENILE ARTHRITIS, UNSPECIFIED, RIGHT HAND
M08942	JUVENILE ARTHRITIS, UNSPECIFIED, LEFT HAND
M08949	JUVENILE ARTHRITIS, UNSPECIFIED, UNSPECIFIED HAND
M08951	JUVENILE ARTHRITIS, UNSPECIFIED, RIGHT HIP
M08952	JUVENILE ARTHRITIS, UNSPECIFIED, LEFT HIP
M08959	JUVENILE ARTHRITIS, UNSPECIFIED, UNSPECIFIED HIP
M08961	JUVENILE ARTHRITIS, UNSPECIFIED, RIGHT KNEE
M08962	JUVENILE ARTHRITIS, UNSPECIFIED, LEFT KNEE
M08969	JUVENILE ARTHRITIS, UNSPECIFIED, UNSPECIFIED KNEE
M08971	JUVENILE ARTHRITIS, UNSPECIFIED, RIGHT ANKLE AND FOOT
M08972	JUVENILE ARTHRITIS, UNSPECIFIED, LEFT ANKLE AND FOOT
M08979	JUVENILE ARTHRITIS, UNSPECIFIED, UNSPECIFIED ANKLE AND FOOT
M0898	JUVENILE ARTHRITIS, VERTEBRAE
M0899	JUVENILE ARTHRITIS, MULTIPLE SITES

Neuromyelitis Optica Spectrum Disorder (NMOSD)	
ICD-10 Code	**Description**
G360	NEUROMYELITIS OPTICA [DEVIC]

Non-Radiographic Axial Spondyloarthritis (nr-axSpA)	
ICD-10 Code	**Description**
M4680	NR-AXSPA, SITE UNSPECIFIED

Non-Radiographic Axial Spondyloarthritis (nr-axSpA)	
ICD-10 Code	**Description**
M4681	NR-AXSPA, OCCIPITO-ATLANTO-AXIAL REGION
M4682	NR-AXSPA, CERVICAL REGION
M4683	NR-AXSPA, CERVICOTHORACIC REGION
M4684	NR-AXSPA, THORACIC REGION
M4685	NR-AXSPA, THORACOLUMBAR REGION
M4686	NR-AXSPA, LUMBAR REGION
M4687	NR-AXSPA, LUMBOSACRAL REGION
M4688	NR-AXSPA, SACRAL AND SACROCOCCYGEAL REGION
M4689	NR-AXSPA, MULTIPLE SITES IN SPINE

Pericarditis	
ICD-10 Code	**Description**
I310	CHRONIC ADHESIVE PERICARDITIS
I311	CHRONIC CONSTRICTIVE PERICARDITIS
I319	DISEASE OF PERICARDIUM, UNSPECIFIED

Plaque Psoriasis (PS)	
ICD-10 Code	**Description**
L400	PSORIASIS VULGARIS
L401	GENERALIZED PUSTULAR PSORIASIS
L402	ACRODERMATITIS CONTINUA
L403	PUSTULOSIS PALMARIS ET PLANTARIS
L404	GUTTATE PSORIASIS
L408	OTHER PSORIASIS

Plaque Psoriasis (PS)	
ICD-10 Code	**Description**
L409	PSORIASIS, UNSPECIFIED

Polyarticular Juvenile Idiopathic Arthritis (PJIA)	
ICD-10 Code	**Description**
M083	JUVENILE RHEUMATOID POLYARTHRITIS (SERONEGATIVE)

Polymyalgia Rheumatica (PMR)	
ICD-10 Code	**Description**
M315	GIANT CELL ARTERITIS WITH POLYMYALGIA RHEUMATICA
M353	POLYMYALGIA RHEUMATICA

Progressive Multifocal Leukoencephalopathy (PML)	
ICD-10 Code	**Description**
A812	PROGRESSIVE MULTIFOCAL LEUKOENCEPHALOPATHY

Psoriatic Arthritis (PsA)	
ICD-10 Code	**Description**
L405	ARTHROPATHIC PSORIASIS
L4050	ARTHROPATHIC PSORIASIS UNSPECIFIED
L4051	DISTAL INTERPHALANGEAL PSORIATIC ARTHROPATHY
L4052	PSORIATIC ARTHRITIS MUTILANS
L4053	PSORIATIC SPONDYLITIS
L4054	PSORIATIC JUVENILE ARTHROPATHY
L4059	OTHER PSORIATIC ARTHROPATHY

Rheumatoid Arthritis (RA)	
ICD-10 Code	**Description**
M0500	FELTY'S SYNDROME OR UNSPECIFIED SITE
M05011	FELTY'S SYNDROME, RIGHT SHOULDER
M05012	FELTY'S SYNDROME, LEFT SHOULDER
M05019	FELTY'S SYNDROME, UNSPECIFIED SHOULDER
M05021	FELTY'S SYNDROME, RIGHT ELBOW
M05022	FELTY'S SYNDROME, LEFT ELBOW
M05029	FELTY'S SYNDROME, UNSPECIFIED ELBOW
M05031	FELTY'S SYNDROME, RIGHT WRIST
M05032	FELTY'S SYNDROME, LEFT WRIST
M05039	FELTY'S SYNDROME, UNSPECIFIED WRIST
M05041	FELTY'S SYNDROME, RIGHT HAND
M05042	FELTY'S SYNDROME, LEFT HAND
M05049	FELTY'S SYNDROME, UNSPECIFIED HAND
M05051	FELTY'S SYNDROME, RIGHT HIP
M05052	FELTY'S SYNDROME, LEFT HIP
M05059	FELTY'S SYNDROME, UNSPECIFIED HIP
M05061	FELTY'S SYNDROME, RIGHT KNEE
M05062	FELTY'S SYNDROME, LEFT KNEE
M05069	FELTY'S SYNDROME, UNSPECIFIED KNEE
M05071	FELTY'S SYNDROME, RIGHT ANKLE AND FOOT
M05072	FELTY'S SYNDROME, LEFT ANKLE AND FOOT
M05079	FELTY'S SYNDROME, UNSPECIFIED ANKLE AND FOOT
M0509	FELTY'S SYNDROME, MULTIPLE SITES

Rheumatoid Arthritis (RA)	
ICD-10 Code	**Description**
M0510	RHEUMATOID LUNG DISEASE WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED SITE
M05111	RHEUMATOID LUNG DISEASE WITH RHEUMATOID ARTHRITIS OF RIGHT SHOULDER
M05112	RHEUMATOID LUNG DISEASE WITH RHEUMATOID ARTHRITIS OF LEFT SHOULDER
M05119	RHEUMATOID LUNG DISEASE WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED SHOULDER
M05121	RHEUMATOID LUNG DISEASE WITH RHEUMATOID ARTHRITIS OF RIGHT ELBOW
M05122	RHEUMATOID LUNG DISEASE WITH RHEUMATOID ARTHRITIS OF LEFT ELBOW
M05129	RHEUMATOID LUNG DISEASE WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED ELBOW
M05131	RHEUMATOID LUNG DISEASE WITH RHEUMATOID ARTHRITIS OF RIGHT WRIST
M05132	RHEUMATOID LUNG DISEASE WITH RHEUMATOID ARTHRITIS OF LEFT WRIST
M05139	RHEUMATOID LUNG DISEASE WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED WRIST
M05141	RHEUMATOID LUNG DISEASE WITH RHEUMATOID ARTHRITIS OF RIGHT HAND
M05142	RHEUMATOID LUNG DISEASE WITH RHEUMATOID ARTHRITIS OF LEFT HAND
M05149	RHEUMATOID LUNG DISEASE WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED HAND
M05151	RHEUMATOID LUNG DISEASE WITH RHEUMATOID ARTHRITIS OF RIGHT HIP
M05152	RHEUMATOID LUNG DISEASE WITH RHEUMATOID ARTHRITIS OF LEFT HIP
M05159	RHEUMATOID LUNG DISEASE WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED HIP
M05161	RHEUMATOID LUNG DISEASE WITH RHEUMATOID ARTHRITIS OF RIGHT KNEE
M05162	RHEUMATOID LUNG DISEASE WITH RHEUMATOID ARTHRITIS OF LEFT KNEE

Rheumatoid Arthritis (RA)	
ICD-10 Code	**Description**
M05169	RHEUMATOID LUNG DISEASE WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED KNEE
M05171	RHEUMATOID LUNG DISEASE WITH RHEUMATOID ARTHRITIS OF RIGHT ANKLE AND FOOT
M05172	RHEUMATOID LUNG DISEASE WITH RHEUMATOID ARTHRITIS OF LEFT ANKLE AND FOOT
M05179	RHEUMATOID LUNG DISEASE WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED ANKLE AND FOOT
M0519	RHEUMATOID LUNG DISEASE WITH RHEUMATOID ARTHRITIS OF MULTIPLE SITES
M0520	RHEUMATOID VASCULITIS WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED SITE
M05211	RHEUMATOID VASCULITIS WITH RHEUMATOID ARTHRITIS OF RIGHT SHOULDER
M05212	RHEUMATOID VASCULITIS WITH RHEUMATOID ARTHRITIS OF LEFT SHOULDER
M05219	RHEUMATOID VASCULITIS WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED SHOULDER
M05221	RHEUMATOID VASCULITIS WITH RHEUMATOID ARTHRITIS OF RIGHT ELBOW
M05222	RHEUMATOID VASCULITIS WITH RHEUMATOID ARTHRITIS OF LEFT ELBOW
M05229	RHEUMATOID VASCULITIS WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED ELBOW
M05231	RHEUMATOID VASCULITIS WITH RHEUMATOID ARTHRITIS OF RIGHT WRIST
M05232	RHEUMATOID VASCULITIS WITH RHEUMATOID ARTHRITIS OF LEFT WRIST
M05239	RHEUMATOID VASCULITIS WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED WRIST
M05241	RHEUMATOID VASCULITIS WITH RHEUMATOID ARTHRITIS OF RIGHT HAND
M05242	RHEUMATOID VASCULITIS WITH RHEUMATOID ARTHRITIS OF LEFT HAND
M05249	RHEUMATOID VASCULITIS WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED HAND
M05251	RHEUMATOID VASCULITIS WITH RHEUMATOID ARTHRITIS OF RIGHT HIP

Rheumatoid Arthritis (RA)	
ICD-10 Code	**Description**
M05252	RHEUMATOID VASCULITIS WITH RHEUMATOID ARTHRITIS OF LEFT HIP
M05259	RHEUMATOID VASCULITIS WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED HIP
M05261	RHEUMATOID VASCULITIS WITH RHEUMATOID ARTHRITIS OF RIGHT KNEE
M05262	RHEUMATOID VASCULITIS WITH RHEUMATOID ARTHRITIS OF LEFT KNEE
M05269	RHEUMATOID VASCULITIS WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED KNEE
M05271	RHEUMATOID VASCULITIS WITH RHEUMATOID ARTHRITIS OF RIGHT ANKLE AND FOOT
M05272	RHEUMATOID VASCULITIS WITH RHEUMATOID ARTHRITIS OF LEFT ANKLE AND FOOT
M05279	RHEUMATOID VASCULITIS WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED ANKLE AND FOOT
M0529	RHEUMATOID VASCULITIS WITH RHEUMATOID ARTHRITIS OF MULTIPLE SITES
M0530	RHEUMATOID HEART DISEASE WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED SITE
M05311	RHEUMATOID HEART DISEASE WITH RHEUMATOID ARTHRITIS OF RIGHT SHOULDER
M05312	RHEUMATOID HEART DISEASE WITH RHEUMATOID ARTHRITIS OF LEFT SHOULDER
M05319	RHEUMATOID HEART DISEASE WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED SHOULDER
M05321	RHEUMATOID HEART DISEASE WITH RHEUMATOID ARTHRITIS OF RIGHT ELBOW
M05322	RHEUMATOID HEART DISEASE WITH RHEUMATOID ARTHRITIS OF LEFT ELBOW
M05329	RHEUMATOID HEART DISEASE WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED ELBOW
M05331	RHEUMATOID HEART DISEASE WITH RHEUMATOID ARTHRITIS OF RIGHT WRIST

Rheumatoid Arthritis (RA)	
ICD-10 Code	**Description**
M05332	RHEUMATOID HEART DISEASE WITH RHEUMATOID ARTHRITIS OF LEFT WRIST
M05339	RHEUMATOID HEART DISEASE WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED WRIST
M05341	RHEUMATOID HEART DISEASE WITH RHEUMATOID ARTHRITIS OF RIGHT HAND
M05342	RHEUMATOID HEART DISEASE WITH RHEUMATOID ARTHRITIS OF LEFT HAND
M05349	RHEUMATOID HEART DISEASE WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED HAND
M05351	RHEUMATOID HEART DISEASE WITH RHEUMATOID ARTHRITIS OF RIGHT HIP
M05352	RHEUMATOID HEART DISEASE WITH RHEUMATOID ARTHRITIS OF LEFT HIP
M05359	RHEUMATOID HEART DISEASE WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED HIP
M05361	RHEUMATOID HEART DISEASE WITH RHEUMATOID ARTHRITIS OF RIGHT KNEE
M05362	RHEUMATOID HEART DISEASE WITH RHEUMATOID ARTHRITIS OF LEFT KNEE
M05369	RHEUMATOID HEART DISEASE WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED KNEE
M05371	RHEUMATOID HEART DISEASE WITH RHEUMATOID ARTHRITIS OF RIGHT ANKLE AND FOOT
M05372	RHEUMATOID HEART DISEASE WITH RHEUMATOID ARTHRITIS OF LEFT ANKLE AND FOOT
M05379	RHEUMATOID HEART DISEASE WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED ANKLE AND FOOT
M0539	RHEUMATOID HEART DISEASE WITH RHEUMATOID ARTHRITIS OF MULTIPLE SITES
M0540	RHEUMATOID MYOPATHY WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED SITE
M05411	RHEUMATOID MYOPATHY WITH RHEUMATOID ARTHRITIS OF RIGHT SHOULDER

Rheumatoid Arthritis (RA)	
ICD-10 Code	**Description**
M05412	RHEUMATOID MYOPATHY WITH RHEUMATOID ARTHRITIS OF LEFT SHOULDER
M05419	RHEUMATOID MYOPATHY WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED SHOULDER
M05421	RHEUMATOID MYOPATHY WITH RHEUMATOID ARTHRITIS OF RIGHT ELBOW
M05422	RHEUMATOID MYOPATHY WITH RHEUMATOID ARTHRITIS OF LEFT ELBOW
M05429	RHEUMATOID MYOPATHY WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED ELBOW
M05431	RHEUMATOID MYOPATHY WITH RHEUMATOID ARTHRITIS OF RIGHT WRIST
M05432	RHEUMATOID MYOPATHY WITH RHEUMATOID ARTHRITIS OF LEFT WRIST
M05439	RHEUMATOID MYOPATHY WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED WRIST
M05441	RHEUMATOID MYOPATHY WITH RHEUMATOID ARTHRITIS OF RIGHT HAND
M05442	RHEUMATOID MYOPATHY WITH RHEUMATOID ARTHRITIS OF LEFT HAND
M05449	RHEUMATOID MYOPATHY WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED HAND
M05451	RHEUMATOID MYOPATHY WITH RHEUMATOID ARTHRITIS OF RIGHT HIP
M05452	RHEUMATOID MYOPATHY WITH RHEUMATOID ARTHRITIS OF LEFT HIP
M05459	RHEUMATOID MYOPATHY WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED HIP
M05461	RHEUMATOID MYOPATHY WITH RHEUMATOID ARTHRITIS OF RIGHT KNEE
M05462	RHEUMATOID MYOPATHY WITH RHEUMATOID ARTHRITIS OF LEFT KNEE
M05469	RHEUMATOID MYOPATHY WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED KNEE
M05471	RHEUMATOID MYOPATHY WITH RHEUMATOID ARTHRITIS OF RIGHT ANKLE AND FOOT
M05472	RHEUMATOID MYOPATHY WITH RHEUMATOID ARTHRITIS OF LEFT ANKLE AND FOOT
M05479	RHEUMATOID MYOPATHY WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED ANKLE AND FOOT

Rheumatoid Arthritis (RA)	
ICD-10 Code	**Description**
M0549	RHEUMATOID MYOPATHY WITH RHEUMATOID ARTHRITIS OF MULTIPLE SITES
M0550	RHEUMATOID POLYNEUROPATHY WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED SITE
M05511	RHEUMATOID POLYNEUROPATHY WITH RHEUMATOID ARTHRITIS OF RIGHT SHOULDER
M05512	RHEUMATOID POLYNEUROPATHY WITH RHEUMATOID ARTHRITIS OF LEFT SHOULDER
M05519	RHEUMATOID POLYNEUROPATHY WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED SHOULDER
M05521	RHEUMATOID POLYNEUROPATHY WITH RHEUMATOID ARTHRITIS OF RIGHT ELBOW
M05522	RHEUMATOID POLYNEUROPATHY WITH RHEUMATOID ARTHRITIS OF LEFT ELBOW
M05529	RHEUMATOID POLYNEUROPATHY WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED ELBOW
M05531	RHEUMATOID POLYNEUROPATHY WITH RHEUMATOID ARTHRITIS OF RIGHT WRIST
M05532	RHEUMATOID POLYNEUROPATHY WITH RHEUMATOID ARTHRITIS OF LEFT WRIST
M05539	RHEUMATOID POLYNEUROPATHY WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED WRIST
M05541	RHEUMATOID POLYNEUROPATHY WITH RHEUMATOID ARTHRITIS OF RIGHT HAND
M05542	RHEUMATOID POLYNEUROPATHY WITH RHEUMATOID ARTHRITIS OF LEFT HAND
M05549	RHEUMATOID POLYNEUROPATHY WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED HAND
M05551	RHEUMATOID POLYNEUROPATHY WITH RHEUMATOID ARTHRITIS OF RIGHT HIP
M05552	RHEUMATOID POLYNEUROPATHY WITH RHEUMATOID ARTHRITIS OF LEFT HIP

Rheumatoid Arthritis (RA)	
ICD-10 Code	**Description**
M05559	RHEUMATOID POLYNEUROPATHY WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED HIP
M05561	RHEUMATOID POLYNEUROPATHY WITH RHEUMATOID ARTHRITIS OF RIGHT KNEE
M05562	RHEUMATOID POLYNEUROPATHY WITH RHEUMATOID ARTHRITIS OF LEFT KNEE
M05569	RHEUMATOID POLYNEUROPATHY WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED KNEE
M05571	RHEUMATOID POLYNEUROPATHY WITH RHEUMATOID ARTHRITIS OF RIGHT ANKLE AND FOOT
M05572	RHEUMATOID POLYNEUROPATHY WITH RHEUMATOID ARTHRITIS OF LEFT ANKLE AND FOOT
M05579	RHEUMATOID POLYNEUROPATHY WITH RHEUMATOID ARTHRITIS OF UNSPECIFIED ANKLE AND FOOT
M0559	RHEUMATOID POLYNEUROPATHY WITH RHEUMATOID ARTHRITIS OF MULTIPLE SITES
M0560	RHEUMATOID ARTHRITIS OF UNSPECIFIED SITE WITH INVOLVEMENT OF OTHER ORGANS AND SYSTEMS
M05611	RHEUMATOID ARTHRITIS OF RIGHT SHOULDER WITH INVOLVEMENT OF OTHER ORGANS AND SYSTEMS
M05612	RHEUMATOID ARTHRITIS OF LEFT SHOULDER WITH INVOLVEMENT OF OTHER ORGANS AND SYSTEMS
M05619	RHEUMATOID ARTHRITIS OF UNSPECIFIED SHOULDER WITH INVOLVEMENT OF OTHER ORGANS AND SYSTEMS
M05621	RHEUMATOID ARTHRITIS OF RIGHT ELBOW WITH INVOLVEMENT OF OTHER ORGANS AND SYSTEMS
M05622	RHEUMATOID ARTHRITIS OF LEFT ELBOW WITH INVOLVEMENT OF OTHER ORGANS AND SYSTEMS
M05629	RHEUMATOID ARTHRITIS OF UNSPECIFIED ELBOW WITH INVOLVEMENT OF OTHER ORGANS AND SYSTEMS
M05631	RHEUMATOID ARTHRITIS OF RIGHT WRIST WITH INVOLVEMENT OF OTHER ORGANS AND SYSTEMS

Rheumatoid Arthritis (RA)	
ICD-10 Code	**Description**
M05632	RHEUMATOID ARTHRITIS OF LEFT WRIST WITH INVOLVEMENT OF OTHER ORGANS AND SYSTEMS
M05639	RHEUMATOID ARTHRITIS OF UNSPECIFIED WRIST WITH INVOLVEMENT OF OTHER ORGANS AND SYSTEMS
M05641	RHEUMATOID ARTHRITIS OF RIGHT HAND WITH INVOLVEMENT OF OTHER ORGANS AND SYSTEMS
M05642	RHEUMATOID ARTHRITIS OF LEFT HAND WITH INVOLVEMENT OF OTHER ORGANS AND SYSTEMS
M05649	RHEUMATOID ARTHRITIS OF UNSPECIFIED HAND WITH INVOLVEMENT OF OTHER ORGANS AND SYSTEMS
M05651	RHEUMATOID ARTHRITIS OF RIGHT HIP WITH INVOLVEMENT OF OTHER ORGANS AND SYSTEMS
M05652	RHEUMATOID ARTHRITIS OF LEFT HIP WITH INVOLVEMENT OF OTHER ORGANS AND SYSTEMS
M05659	RHEUMATOID ARTHRITIS OF UNSPECIFIED HIP WITH INVOLVEMENT OF OTHER ORGANS AND SYSTEMS
M05661	RHEUMATOID ARTHRITIS OF RIGHT KNEE WITH INVOLVEMENT OF OTHER ORGANS AND SYSTEMS
M05662	RHEUMATOID ARTHRITIS OF LEFT KNEE WITH INVOLVEMENT OF OTHER ORGANS AND SYSTEMS
M05669	RHEUMATOID ARTHRITIS OF UNSPECIFIED KNEE WITH INVOLVEMENT OF OTHER ORGANS AND SYSTEMS
M05671	RHEUMATOID ARTHRITIS OF RIGHT ANKLE AND FOOT WITH INVOLVEMENT OF OTHER ORGANS AND SYSTEMS
M05672	RHEUMATOID ARTHRITIS OF LEFT ANKLE AND FOOT WITH INVOLVEMENT OF OTHER ORGANS AND SYSTEMS
M05679	RHEUMATOID ARTHRITIS OF UNSPECIFIED ANKLE AND FOOT WITH INVOLVEMENT OF OTHER ORGANS AND SYSTEMS
M0569	RHEUMATOID ARTHRITIS OF MULTIPLE SITES WITH INVOLVEMENT OF OTHER ORGANS AND SYSTEMS
M0570	RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF UNSPECIFIED SITE WITHOUT ORGAN OR SYSTEMS INVOLVEMENT

Rheumatoid Arthritis (RA)	
ICD-10 Code	**Description**
M05711	RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF RIGHT SHOULDER WITHOUT ORGAN OR SYSTEMS INVOLVEMENT
M05712	RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF LEFT SHOULDER WITHOUT ORGAN OR SYSTEMS INVOLVEMENT
M05719	RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF UNSPECIFIED SHOULDER WITHOUT ORGAN OR SYSTEMS INVOLVEMENT
M05721	RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF RIGHT ELBOW WITHOUT ORGAN OR SYSTEMS INVOLVEMENT
M05722	RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF LEFT ELBOW WITHOUT ORGAN OR SYSTEMS INVOLVEMENT
M05729	RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF UNSPECIFIED ELBOW WITHOUT ORGAN OR SYSTEMS INVOLVEMENT
M05731	RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF RIGHT WRIST WITHOUT ORGAN OR SYSTEMS INVOLVEMENT
M05732	RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF LEFT WRIST WITHOUT ORGAN OR SYSTEMS INVOLVEMENT
M05739	RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF UNSPECIFIED WRIST WITHOUT ORGAN OR SYSTEMS INVOLVEMENT
M05741	RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF RIGHT HAND WITHOUT ORGAN OR SYSTEMS INVOLVEMENT
M05742	RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF LEFT HAND WITHOUT ORGAN OR SYSTEMS INVOLVEMENT
M05749	RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF UNSPECIFIED HAND WITHOUT ORGAN OR SYSTEMS INVOLVEMENT
M05751	RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF RIGHT HIP WITHOUT ORGAN OR SYSTEMS INVOLVEMENT
M05752	RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF LEFT HIP WITHOUT ORGAN OR SYSTEMS INVOLVEMENT
M05759	RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF UNSPECIFIED HIP WITHOUT ORGAN OR SYSTEMS INVOLVEMENT
M05761	RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF RIGHT KNEE WITHOUT ORGAN OR SYSTEMS INVOLVEMENT

Rheumatoid Arthritis (RA)	
ICD-10 Code	**Description**
M05762	RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF LEFT KNEE WITHOUT ORGAN OR SYSTEMS INVOLVEMENT
M05769	RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF UNSPECIFIED KNEE WITHOUT ORGAN OR SYSTEMS INVOLVEMENT
M05771	RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF RIGHT ANKLE AND FOOT WITHOUT ORGAN OR SYSTEMS INVOLVEMENT
M05772	RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF LEFT ANKLE AND FOOT WITHOUT ORGAN OR SYSTEMS INVOLVEMENT
M05779	RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF UNSPECIFIED ANKLE AND FOOT WITHOUT ORGAN OR SYSTEMS INVOLVEMENT
M0579	RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF MULTIPLE SITES WITHOUT ORGAN OR SYSTEMS INVOLVEMENT
M0580	OTHER RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF UNSPECIFIED SITE
M05811	OTHER RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF RIGHT SHOULDER
M05812	OTHER RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF LEFT SHOULDER
M05819	OTHER RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF UNSPECIFIED SHOULDER
M05821	OTHER RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF RIGHT ELBOW
M05822	OTHER RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF LEFT ELBOW
M05829	OTHER RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF UNSPECIFIED ELBOW
M05831	OTHER RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF RIGHT WRIST
M05832	OTHER RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF LEFT WRIST
M05839	OTHER RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF UNSPECIFIED WRIST

Rheumatoid Arthritis (RA)	
ICD-10 Code	**Description**
M05841	OTHER RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF RIGHT HAND
M05842	OTHER RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF LEFT HAND
M05849	OTHER RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF UNSPECIFIED HAND
M05851	OTHER RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF RIGHT HIP
M05852	OTHER RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF LEFT HIP
M05859	OTHER RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF UNSPECIFIED HIP
M05861	OTHER RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF RIGHT KNEE
M05862	OTHER RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF LEFT KNEE
M05869	OTHER RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF UNSPECIFIED KNEE
M05871	OTHER RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF RIGHT ANKLE AND FOOT
M05872	OTHER RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF LEFT ANKLE AND FOOT
M05879	OTHER RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF UNSPECIFIED ANKLE AND FOOT
M0589	OTHER RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF MULTIPLE SITES
M059	RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR, UNSPECIFIED
M0600	RHEUMATOID ARTHRITIS WITHOUT RHEUMATOID FACTOR UNSPECIFIED SITE
M06011	RHEUMATOID ARTHRITIS WITHOUT RHEUMATOID FACTOR, RIGHT SHOULDER
M06012	RHEUMATOID ARTHRITIS WITHOUT RHEUMATOID FACTOR, LEFT SHOULDER
M06019	RHEUMATOID ARTHRITIS WITHOUT RHEUMATOID FACTOR, UNSPECIFIED SHOULDER

Rheumatoid Arthritis (RA)	
ICD-10 Code	**Description**
M06021	RHEUMATOID ARTHRITIS WITHOUT RHEUMATOID FACTOR, RIGHT ELBOW
M06022	RHEUMATOID ARTHRITIS WITHOUT RHEUMATOID FACTOR, LEFT ELBOW
M06029	RHEUMATOID ARTHRITIS WITHOUT RHEUMATOID FACTOR, UNSPECIFIED ELBOW
M06031	RHEUMATOID ARTHRITIS WITHOUT RHEUMATOID FACTOR, RIGHT WRIST
M06032	RHEUMATOID ARTHRITIS WITHOUT RHEUMATOID FACTOR, LEFT WRIST
M06039	RHEUMATOID ARTHRITIS WITHOUT RHEUMATOID FACTOR, UNSPECIFIED WRIST
M06041	RHEUMATOID ARTHRITIS WITHOUT RHEUMATOID FACTOR, RIGHT HAND
M06042	RHEUMATOID ARTHRITIS WITHOUT RHEUMATOID FACTOR, LEFT HAND
M06049	RHEUMATOID ARTHRITIS WITHOUT RHEUMATOID FACTOR, UNSPECIFIED HAND
M06051	RHEUMATOID ARTHRITIS WITHOUT RHEUMATOID FACTOR, RIGHT HIP
M06052	RHEUMATOID ARTHRITIS WITHOUT RHEUMATOID FACTOR, LEFT HIP
M06059	RHEUMATOID ARTHRITIS WITHOUT RHEUMATOID FACTOR, UNSPECIFIED HIP
M06061	RHEUMATOID ARTHRITIS WITHOUT RHEUMATOID FACTOR, RIGHT KNEE
M06062	RHEUMATOID ARTHRITIS WITHOUT RHEUMATOID FACTOR, LEFT KNEE
M06069	RHEUMATOID ARTHRITIS WITHOUT RHEUMATOID FACTOR, UNSPECIFIED KNEE
M06071	RHEUMATOID ARTHRITIS WITHOUT RHEUMATOID FACTOR, RIGHT ANKLE AND FOOT
M06072	RHEUMATOID ARTHRITIS WITHOUT RHEUMATOID FACTOR, LEFT ANKLE AND FOOT
M06079	RHEUMATOID ARTHRITIS WITHOUT RHEUMATOID FACTOR, UNSPECIFIED ANKLE AND FOOT
M0608	RHEUMATOID ARTHRITIS WITHOUT RHEUMATOID FACTOR VERTEBRAE
M0609	RHEUMATOID ARTHRITIS WITHOUT RHEUMATOID FACTOR MULTIPLE SITES
M061	ADULT-ONSET STILL'S DISEASE

Rheumatoid Arthritis (RA)	
ICD-10 Code	**Description**
M062	RHEUMATOID BURSITIS
M0620	RHEUMATOID BURSITIS OF UNSPECIFIED SITE
M06211	RHEUMATOID BURSITIS OF RIGHT SHOULDER
M06212	RHEUMATOID BURSITIS OF LEFT SHOULDER
M06219	RHEUMATOID BURSITIS OF UNSPECIFIED SHOULDER
M06221	RHEUMATOID BURSITIS OF RIGHT ELBOW
M06222	RHEUMATOID BURSITIS OF LEFT ELBOW
M06229	RHEUMATOID BURSITIS OF UNSPECIFIED ELBOW
M06231	RHEUMATOID BURSITIS OF RIGHT WRIST
M06232	RHEUMATOID BURSITIS OF LEFT WRIST
M06239	RHEUMATOID BURSITIS OF UNSPECIFIED WRIST
M06241	RHEUMATOID BURSITIS OF RIGHT HAND
M06242	RHEUMATOID BURSITIS OF LEFT HAND
M06249	RHEUMATOID BURSITIS OF UNSPECIFIED HAND
M06251	RHEUMATOID BURSITIS OF RIGHT HIP
M06252	RHEUMATOID BURSITIS OF LEFT HIP
M06259	RHEUMATOID BURSITIS OF UNSPECIFIED HIP
M06261	RHEUMATOID BURSITIS OF RIGHT KNEE
M06262	RHEUMATOID BURSITIS OF LEFT KNEE
M06269	RHEUMATOID BURSITIS OF UNSPECIFIED KNEE
M06271	RHEUMATOID BURSITIS OF RIGHT ANKLE AND FOOT
M06272	RHEUMATOID BURSITIS OF LEFT ANKLE AND FOOT
M06279	RHEUMATOID BURSITIS OF UNSPECIFIED ANKLE AND FOOT
M0628	RHEUMATOID BURSITIS OF VERTEBRAE

Rheumatoid Arthritis (RA)	
ICD-10 Code	**Description**
M0629	RHEUMATOID BURSITIS OF MULTIPLE SITES
M0630	RHEUMATOID NODULE OF UNSPECIFIED SITE
M06311	RHEUMATOID NODULE OF RIGHT SHOULDER
M06312	RHEUMATOID NODULE OF LEFT SHOULDER
M06319	RHEUMATOID NODULE OF UNSPECIFIED SHOULDER
M06321	RHEUMATOID NODULE OF RIGHT ELBOW
M06322	RHEUMATOID NODULE OF LEFT ELBOW
M06329	RHEUMATOID NODULE OF UNSPECIFIED ELBOW
M06331	RHEUMATOID NODULE OF RIGHT WRIST
M06332	RHEUMATOID NODULE OF LEFT WRIST
M06339	RHEUMATOID NODULE OF UNSPECIFIED WRIST
M06341	RHEUMATOID NODULE OF RIGHT HAND
M06342	RHEUMATOID NODULE OF LEFT HAND
M06349	RHEUMATOID NODULE OF UNSPECIFIED HAND
M06351	RHEUMATOID NODULE OF RIGHT HIP
M06352	RHEUMATOID NODULE OF LEFT HIP
M06359	RHEUMATOID NODULE OF UNSPECIFIED HIP
M06361	RHEUMATOID NODULE OF RIGHT KNEE
M06362	RHEUMATOID NODULE OF LEFT KNEE
M06369	RHEUMATOID NODULE OF UNSPECIFIED KNEE
M06371	RHEUMATOID NODULE OF RIGHT ANKLE AND FOOT
M06372	RHEUMATOID NODULE OF LEFT ANKLE AND FOOT
M06379	RHEUMATOID NODULE OF UNSPECIFIED ANKLE AND FOOT
M0638	RHEUMATOID NODULE OF VERTEBRAE

Rheumatoid Arthritis (RA)	
ICD-10 Code	**Description**
M0639	RHEUMATOID NODULE OF MULTIPLE SITES
M064	INFLAMMATORY POLYARTROPATHY
M0680	OTHER SPECIFIED RHEUMATOID ARTHRITIS UNSPECIFIED SITE
M06811	OTHER SPECIFIED RHEUMATOID ARTHRITIS, RIGHT SHOULDER
M06812	OTHER SPECIFIED RHEUMATOID ARTHRITIS, UNSPECIFIED SHOULDER
M06819	OTHER SPECIFIED RHEUMATOID ARTHRITIS, UNSPECIFIED SHOULDER
M06821	OTHER SPECIFIED RHEUMATOID ARTHRITIS, RIGHT ELBOW
M06822	OTHER SPECIFIED RHEUMATOID ARTHRITIS, LEFT ELBOW
M06829	OTHER SPECIFIED RHEUMATOID ARTHRITIS, UNSPECIFIED ELBOW
M06831	OTHER SPECIFIED RHEUMATOID ARTHRITIS, RIGHT WRIST
M06832	OTHER SPECIFIED RHEUMATOID ARTHRITIS, LEFT WRIST
M06839	OTHER SPECIFIED RHEUMATOID ARTHRITIS, UNSPECIFIED WRIST
M06841	OTHER SPECIFIED RHEUMATOID ARTHRITIS, RIGHT HAND
M06842	OTHER SPECIFIED RHEUMATOID ARTHRITIS, LEFT HAND
M06849	OTHER SPECIFIED RHEUMATOID ARTHRITIS, UNSPECIFIED HAND
M06851	OTHER SPECIFIED RHEUMATOID ARTHRITIS, RIGHT HIP
M06852	OTHER SPECIFIED RHEUMATOID ARTHRITIS, LEFT HIP
M06859	OTHER SPECIFIED RHEUMATOID ARTHRITIS, UNSPECIFIED HIP
M06861	OTHER SPECIFIED RHEUMATOID ARTHRITIS, RIGHT KNEE
M06862	OTHER SPECIFIED RHEUMATOID ARTHRITIS, LEFT KNEE
M06869	OTHER SPECIFIED RHEUMATOID ARTHRITIS, UNSPECIFIED KNEE
M06871	OTHER SPECIFIED RHEUMATOID ARTHRITIS, RIGHT ANKLE AND FOOT
M06872	OTHER SPECIFIED RHEUMATOID ARTHRITIS, LEFT ANKLE AND FOOT
M06879	OTHER SPECIFIED RHEUMATOID ARTHRITIS, UNSPECIFIED ANKLE AND FOOT

Rheumatoid Arthritis (RA)	
ICD-10 Code	**Description**
M0688	OTHER SPECIFIED RHEUMATOID ARTHRITIS VERTEBRAE
M0689	OTHER SPECIFIED RHEUMATOID ARTHRITIS MULTIPLE SITES
M069	RHEUMATOID ARTHRITIS, UNSPECIFIED

Suicidal Ideation	
ICD-10 Code	**Description**
R45851	SUICIDAL IDEATIONS

Systemic Juvenile Idiopathic Arthritis (SJIA)	
ICD-10 Code	**Description**
M0820	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET UNSPECIFIED SITE
M08211	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, RIGHT SHOULDER
M08212	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, LEFT ELBOW
M08219	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, UNSPECIFIED SHOULDER
M08221	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, RIGHT ELBOW
M08222	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, LEFT ELBOW
M08229	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, UNSPECIFIED ELBOW
M08231	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, RIGHT WRIST
M08232	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, LEFT WRIST
M08239	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, UNSPECIFIED WRIST
M08241	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, RIGHT HAND
M08242	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, LEFT HAND

Systemic Juvenile Idiopathic Arthritis (SJIA)	
ICD-10 Code	**Description**
M08249	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, UNSPECIFIED HAND
M08251	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, RIGHT HIP
M08252	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, LEFT HIP
M08259	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, UNSPECIFIED HIP
M08261	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, RIGHT KNEE
M08262	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, LEFT KNEE
M08269	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, UNSPECIFIED KNEE
M08271	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, RIGHT ANKLE AND FOOT
M08272	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, LEFT ANKLE AND FOOT
M08279	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET, UNSPECIFIED ANKLE AND FOOT
M0828	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET VERTEBRAE
M0829	JUVENILE RHEUMATOID ARTHRITIS WITH SYSTEMIC ONSET MULTIPLE SITES

Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD)	
ICD-10 Code	**Description**
M3481	SYSTEMIC SCLEROSIS WITH LUNG INVOLVEMENT

Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS), Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD) and Familial Mediterranean Fever (FMF)	
ICD-10 Code	**Description**
M041	PERIODIC FEVER SYNDROMES (INCLUDING TRAPS, HIDS/MKD AND FMF)

Ulcerative Colitis (UC)	
ICD-10 Code	**Description**
K5100	ULCERATIVE (CHRONIC) PANCOLITIS WITHOUT COMPLICATIONS
K51011	ULCERATIVE (CHRONIC) PANCOLITIS WITH RECTAL BLEEDING
K51012	ULCERATIVE (CHRONIC) PANCOLITIS WITH INTESTINAL OBSTRUCTION
K51013	ULCERATIVE (CHRONIC) PANCOLITIS WITH FISTULA
K51014	ULCERATIVE (CHRONIC) PANCOLITIS WITH ABSCESS
K51018	ULCERATIVE (CHRONIC) PANCOLITIS WITH OTHER COMPLICATION
K51019	ULCERATIVE (CHRONIC) PANCOLITIS WITH UNSPECIFIED COMPLICATIONS
K5120	ULCERATIVE (CHRONIC) PROCTITIS WITHOUT COMPLICATIONS
K51211	ULCERATIVE (CHRONIC) PROCTITIS WITH RECTAL BLEEDING
K51212	ULCERATIVE (CHRONIC) PROCTITIS WITH INTESTINAL OBSTRUCTION
K51213	ULCERATIVE (CHRONIC) PROCTITIS WITH FISTULA
K51214	ULCERATIVE (CHRONIC) PROCTITIS WITH ABSCESS
K51218	ULCERATIVE (CHRONIC) PROCTITIS WITH OTHER COMPLICATION
K51219	ULCERATIVE (CHRONIC) PROCTITIS WITH UNSPECIFIED COMPLICATIONS
K5130	ULCERATIVE (CHRONIC) RECTOSIGMOIDITIS WITHOUT COMPLICATIONS
K51311	ULCERATIVE (CHRONIC) RECTOSIGMOIDITIS WITH RECTAL BLEEDING
K51312	ULCERATIVE (CHRONIC) RECTOSIGMOIDITIS WITH INTESTINAL OBSTRUCTION
K51313	ULCERATIVE (CHRONIC) RECTOSIGMOIDITIS WITH FISTULA
K51314	ULCERATIVE (CHRONIC) RECTOSIGMOIDITIS WITH ABSCESS

Ulcerative Colitis (UC)	
ICD-10 Code	**Description**
K51318	ULCERATIVE (CHRONIC) RECTOSIGMOIDITIS WITH OTHER COMPLICATION
K51319	ULCERATIVE (CHRONIC) RECTOSIGMOIDITIS WITH UNSPECIFIED COMPLICATIONS
K5180	OTHER ULCERATIVE COLITIS WITHOUT COMPLICATIONS
K51811	OTHER ULCERATIVE COLITIS WITH RECTAL BLEEDING
K51812	OTHER ULCERATIVE COLITIS WITH INTESTINAL OBSTRUCTION
K51813	OTHER ULCERATIVE COLITIS WITH FISTULA
K51814	OTHER ULCERATIVE COLITIS WITH ABSCESS
K51818	OTHER ULCERATIVE COLITIS WITH OTHER COMPLICATION
K51819	OTHER ULCERATIVE COLITIS WITH UNSPECIFIED COMPLICATIONS
K5190	ULCERATIVE COLITIS, UNSPECIFIED WITHOUT COMPLICATIONS
K51911	ULCERATIVE COLITIS, UNSPECIFIED WITH RECTAL BLEEDING
K51912	ULCERATIVE COLITIS, UNSPECIFIED WITH INTESTINAL OBSTRUCTION
K51913	ULCERATIVE COLITIS, UNSPECIFIED WITH FISTULA
K51914	ULCERATIVE COLITIS, UNSPECIFIED WITH ABSCESS
K51918	ULCERATIVE COLITIS, UNSPECIFIED WITH OTHER COMPLICATION
K51919	ULCERATIVE COLITIS, UNSPECIFIED WITH UNSPECIFIED COMPLICATIONS

Uveitis (UV)	
ICD-10 Code	**Description**
H2000	UNSPECIFIED ACUTE AND SUBACUTE IRIDOCYCLITIS
H20011	PRIMARY IRIDOCYCLITIS RIGHT EYE
H20012	PRIMARY IRIDOCYCLITIS LEFT EYE
H20013	PRIMARY IRIDOCYCLITIS BILATERAL
H20019	PRIMARY IRIDOCYCLITIS UNSPECIFIED EYE

Uveitis (UV)	
ICD-10 Code	**Description**
H20021	RECURRENT ACUTE IRIDOCYCLITIS RIGHT EYE
H20022	RECURRENT ACUTE IRIDOCYCLITIS LEFT EYE
H20023	RECURRENT ACUTE IRIDOCYCLITIS BILATERAL
H20029	RECURRENT ACUTE IRIDOCYCLITIS UNSPECIFIED EYE
H20031	SECONDARY INFECTIOUS IRIDOCYCLITIS RIGHT EYE
H20032	SECONDARY INFECTIOUS IRIDOCYCLITIS LEFT EYE
H20033	SECONDARY INFECTIOUS IRIDOCYCLITIS BILATERAL
H20039	SECONDARY INFECTIOUS IRIDOCYCLITIS UNSPECIFIED EYE
H20041	SECONDARY NONINFECTIOUS IRIDOCYCLITIS RIGHT EYE
H20042	SECONDARY NONINFECTIOUS IRIDOCYCLITIS LEFT EYE
H20043	SECONDARY NONINFECTIOUS IRIDOCYCLITIS BILATERAL
H20049	SECONDARY NONINFECTIOUS IRIDOCYCLITIS UNSPECIFIED EYE
H20051	HYPOPYON RIGHT EYE
H20052	HYPOPYON LEFT EYE
H20053	HYPOPYON BILATERAL
H20059	HYPOPYON UNSPECIFIED EYE
H2010	CHRONIC IRIDOCYCLITIS RIGHT EYE
H2011	CHRONIC IRIDOCYCLITIS LEFT EYE
H2012	CHRONIC IRIDOCYCLITIS BILATERAL
H2013	CHRONIC IRIDOCYCLITIS UNSPECIFIED EYE
H2020	LENS-INDUCED IRIDOCYCLITIS RIGHT EYE
H2021	LENS-INDUCED IRIDOCYCLITIS LEFT EYE
H2022	LENS-INDUCED IRIDOCYCLITIS BILATERAL
H2023	LENS-INDUCED IRIDOCYCLITIS UNSPECIFIED EYE

Uveitis (UV)	
ICD-10 Code	**Description**
H20811	FUCHS' HETEROCHROMIC CYCLITIS RIGHT EYE
H20812	FUCHS' HETEROCHROMIC CYCLITIS LEFT EYE
H20813	FUCHS' HETEROCHROMIC CYCLITIS BILATERAL
H20819	FUCHS' HETEROCHROMIC CYCLITIS UNSPECIFIED EYE
H20821	VOGT-KOYANAGI SYNDROME RIGHT EYE
H20822	VOGT-KOYANAGI SYNDROME LEFT EYE
H20823	VOGT-KOYANAGI SYNDROME BILATERAL
H20829	VOGT-KOYANAGI SYNDROME UNSPECIFIED EYE

Demyelinating Disease	
ICD-10 Code	**Description**
G35	MULTIPLE SCLEROSIS
H4600	OPTIC PAPILLITIS UNSPECIFIED EYE
H4601	OPTIC PAPILLITIS RIGHT EYE
H4602	OPTIC PAPILLITIS LEFT EYE
H4603	OPTIC PAPILLITIS BILATERAL
H4610	RETROBULBAR NEURITIS UNSPECIFIED EYE
H4611	RETROBULBAR NEURITIS RIGHT EYE
H4612	RETROBULBAR NEURITIS LEFT EYE
H4613	RETROBULBAR NEURITIS BILATERAL
H462	NUTRITIONAL OPTIC NEUROPATHY
H463	TOXIC OPTIC NEUROPATHY
H468	OTHER OPTIC NEURITIS
H469	UNSPECIFIED OPTIC NEURITIS

Demyelinating Disease	
ICD-10 Code	**Description**
G610	GUILLAIN-BARRE SYNDROME

Diagnosis indicating increased risk of GI perforation, thrombosis, or malignancy	
ICD-10 Code	**Description**
K5700	DIVERTICULITIS OF SMALL INTESTINE WITH PERFORATION AND ABSCESS WITHOUT BLEEDING
K5701	DIVERTICULITIS OF SMALL INTESTINE WITH PERFORATION AND ABSCESS WITH BLEEDING
K5710	DIVERTICULOSIS OF SMALL INTESTINE WITHOUT PERFORATION OR ABSCESS WITHOUT BLEEDING
K5711	DIVERTICULOSIS OF SMALL INTESTINE WITHOUT PERFORATION OR ABSCESS WITH BLEEDING
K5712	DIVERTICULITIS OF SMALL INTESTINE WITHOUT PERFORATION OR ABSCESS WITHOUT BLEEDING
K5713	DIVERTICULITIS OF SMALL INTESTINE WITHOUT PERFORATION OR ABSCESS WITH BLEEDING
K5720	DIVERTICULITIS OF LARGE INTESTINE WITH PERFORATION AND ABSCESS WITHOUT BLEEDING
K5721	DIVERTICULITIS OF LARGE INTESTINE WITH PERFORATION AND ABSCESS WITH BLEEDING
K5730	DIVERTICULOSIS OF LARGE INTESTINE WITHOUT PERFORATION OR ABSCESS WITHOUT BLEEDING
K5731	DIVERTICULOSIS OF LARGE INTESTINE WITHOUT PERFORATION OR ABSCESS WITH BLEEDING
K5732	DIVERTICULITIS OF LARGE INTESTINE WITHOUT PERFORATION OR ABSCESS WITHOUT BLEEDING
K5733	DIVERTICULITIS OF LARGE INTESTINE WITHOUT PERFORATION OR ABSCESS WITHOUT BLEEDING
K5740	DIVERTICULITIS OF BOTH SMALL AND LARGE INTESTINE WITH PERFORATION AND ABSCESS WITHOUT BLEEDING

Diagnosis indicating increased risk of GI perforation, thrombosis, or malignancy	
ICD-10 Code	**Description**
K5741	DIVERTICULITIS OF BOTH SMALL AND LARGE INTESTINE WITH PERFORATION AND ABSCESS WITH BLEEDING
K5750	DIVERTICULOSIS OF BOTH SMALL AND LARGE INTESTINE WITHOUT PERFORATION OR ABSCESS WITHOUT BLEEDING
K5751	DIVERTICULOSIS OF BOTH SMALL AND LARGE INTESTINE WITHOUT PERFORATION OR ABSCESS WITH BLEEDING
K5752	DIVERTICULITIS OF BOTH SMALL AND LARGE INTESTINE WITHOUT PERFORATION OR ABSCESS WITHOUT BLEEDING
K5753	DIVERTICULITIS OF BOTH SMALL AND LARGE INTESTINE WITHOUT PERFORATION OR ABSCESS WITH BLEEDING
K5780	DIVERTICULITIS OF INTESTINE, PART UNSPECIFIED, WITH PERFORATION AND ABSCESS WITHOUT BLEEDING
K5781	DIVERTICULITIS OF INTESTINE, PART UNSPECIFIED, WITH PERFORATION AND ABSCESS WITH BLEEDING
K5790	DIVERTICULOSIS OF INTESTINE, PART UNSPECIFIED, WITHOUT PERFORATION OR ABSCESS WITHOUT BLEEDING
K5791	DIVERTICULOSIS OF INTESTINE, PART UNSPECIFIED, WITHOUT PERFORATION OR ABSCESS WITH BLEEDING
K5792	DIVERTICULITIS OF INTESTINE, PART UNSPECIFIED, WITHOUT PERFORATION OR ABSCESS WITHOUT BLEEDING
K5793	DIVERTICULITIS OF INTESTINE, PART UNSPECIFIED, WITHOUT PERFORATION OR ABSCESS WITH BLEEDING
I2601	SEPTIC PULMONARY EMBOLISM WITH ACUTE COR PULMONALE
I2602	SADDLE EMBOLUS OF PULMONARY ARTERY WITH ACUTE COR PULMONALE
I2609	OTHER PULMONARY EMBOLISM WITH ACUTE COR PULMONALE
I2690	SEPTIC PULMONARY EMBOLISM WITHOUT ACUTE COR PULMONALE
I2692	SADDLE EMBOLUS OF PULMONARY ARTERY WITHOUT ACUTE COR PULMONALE
I2699	OTHER PULMONARY EMBOLISM WITHOUT ACUTE COR PULMONALE

Heart Failure Diagnoses	
ICD-10 Code	**Description**
I2583	CORONARY ATHEROSCLEROSIS DUE TO LIPID RICH PLAQUE
I2584	CORONARY ATHEROSCLEROSIS DUE TO CALCIFIED CORONARY LESION
I2589	OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE
I259	CHRONIC ISCHEMIC HEART DISEASE, UNSPECIFIED
I501	LEFT VENTRICULAR FAILURE
I5020	UNSPECIFIED SYSTOLIC (CONGESTIVE) HEART FAILURE
I5021	ACUTE SYSTOLIC (CONGESTIVE) HEART FAILURE
I5022	CHRONIC SYSTOLIC (CONGESTIVE) HEART FAILURE
I5023	ACUTE ON CHRONIC SYSTOLIC (CONGESTIVE) HEART FAILURE
I5030	UNSPECIFIED DIASTOLIC (CONGESTIVE) HEART FAILURE
I5031	ACUTE DIASTOLIC (CONGESTIVE) HEART FAILURE
I5032	CHRONIC DIASTOLIC (CONGESTIVE) HEART FAILURE
I5033	ACUTE ON CHRONIC DIASTOLIC (CONGESTIVE) HEART FAILURE
I5040	UNSPECIFIED COMBINED SYSTOLIC (CONGESTIVE) AND DIASTOLIC (CONGESTIVE) HEART FAILURE
I5041	ACUTE COMBINED SYSTOLIC (CONGESTIVE) AND DIASTOLIC (CONGESTIVE) HEART FAILURE
I5042	CHRONIC COMBINED SYSTOLIC (CONGESTIVE) AND DIASTOLIC (CONGESTIVE) HEART FAILURE
I5043	ACUTE ON CHRONIC COMBINED SYSTOLIC (CONGESTIVE) AND DIASTOLIC (CONGESTIVE) HEART FAILURE
I509	HEART FAILURE, UNSPECIFIED

Hematologic Abnormalities	
ICD-10 Code	**Description**
D6101	APLASTIC ANEMIA, UNSPECIFIED

Hematologic Abnormalities	
ICD-10 Code	**Description**
D6109	OTHER CONSTITUTIONAL APLASTIC ANEMIA
D611	DRUG-INDUCED APLASTIC ANEMIA
D612	APLASTIC ANEMIA DUE TO OTHER EXTERNAL AGENTS
D613	IDIOPATHIC APLASTIC ANEMIA
D61810	ANTINEOPLASTIC CHEMOTHERAPY INDUCED PANCYTOPENIA
D61811	OTHER DRUG-INDUCED PANCYTOPENIA
D61818	OTHER PANCYTOPENIA
D6189	OTHER SPECIFIED APLASTIC ANEMIAS AND OTHER BONE MARROW FAILURE SYNDROMES
D619	APLASTIC ANEMIA, UNSPECIFIED
D693	IMMUNE THROMBOCYTOPENIC PURPURA
D6941	EVANS SYNDROME
D6942	CONGENITAL AND HEREDITARY THROMBOCYTOPENIA PURPURA
D6949	OTHER PRIMARY THROMBOCYTOPENIA
D6951	POSTTRANSFUSION PURPURA
D6959	OTHER SECONDARY THROMBOCYTOPENIA
D696	THROMBOCYTOPENIA, UNSPECIFIED
D700	CONGENITAL AGRANULOCYTOSIS
D701	AGRANULOCYTOSIS SECONDARY TO CANCER CHEMOTHERAPY
D702	OTHER DRUG-INDUCED AGRANULOCYTOSIS
D703	NEUTROPENIA DUE TO INFECTION
D704	CYCLIC NEUTROPENIA
D708	OTHER NEUTROPENIA
D709	NEUTROPENIA, UNSPECIFIED
D72810	LYMPHOCYTOPENIA

Hematologic Abnormalities	
ICD-10 Code	**Description**
D72818	OTHER DECREASED WHITE BLOOD CELL COUNT
D72819	DECREASED WHITE BLOOD CELL COUNT UNSPECIFIED

Hepatic Disease/Impairment	
ICD-10 Code	**Description**
B160	ACUTE HEPATITIS B WITH DELTA-AGENT WITH HEPATIC COMA
B161	ACUTE HEPATITIS B WITH DELTA-AGENT WITHOUT HEPATIC COMA
B162	ACUTE HEPATITIS B WITHOUT DELTA-AGENT WITH HEPATIC COMA
B169	ACUTE HEPATITIS B WITHOUT DELTA-AGENT AND WITHOUT HEPATIC COMA
B170	ACUTE DELTA-(SUPER) INFECTION OF HEPATITIS B CARRIER
B1710	ACUTE HEPATITIS C WITHOUT HEPATIC COMA
B1711	ACUTE HEPATITIS C WITH HEPATIC COMA
B172	ACUTE HEPATITIS E
B178	OTHER SPECIFIED ACUTE VIRAL HEPATITIS
B179	ACUTE VIRAL HEPATITIS, UNSPECIFIED
B180	CHRONIC VIRAL HEPATITIS B WITH DELTA-AGENT
B181	CHRONIC VIRAL HEPATITIS B WITHOUT DELTA-AGENT
B182	CHRONIC VIRAL HEPATITIS C
B188	OTHER CHRONIC VIRAL HEPATITIS
B189	CHRONIC VIRAL HEPATITIS, UNSPECIFIED
B190	UNSPECIFIFED VIRAL HEPATITIS WITH HEPATIC COMA
B1910	UNSPECIFIED VIRAL HEPATITIS B WITHOUT HEPATIC COMA
B1911	UNSPECIFIED VIRAL HEPATITIS B WITH HEPATIC COMA
B1920	UNSPECIFIED VIRAL HEPATITIS C WITHOUT HEPATIC COMA

Hepatic Disease/Impairment	
ICD-10 Code	**Description**
B1921	UNSPECIFIED VIRAL HEPATITIS C WITH HEPATIC COMA
B199	UNSPECIFIED VIRAL HEPATITIS WITHOUT HEPATIC COMA
K700	ALCOHOLIC FATTY LIVER
K7010	ALCOHOLIC HEPATITIS WITHOUT ASCITES
K7011	ALCOHOLIC HEPATITIS WITH ASCITES
K702	ALCOHOLIC FIBROSIS AND SCLEROSIS OF LIVER
K7030	ALCOHOLIC CIRRHOSIS OF LIVER WITHOUT ASCITES
K7031	ALCOHOLIC CIRRHOSIS OF LIVER WITH ASCITES
K7040	ALCOHOLIC HEPATIC FAILURE WITHOUT COMA
K7041	ALCOHOLIC HEPATIC FAILURE WITH COMA
K709	ALCOHOLIC LIVER DISEASE, UNSPECIFIED
K710	TOXIC LIVER DISEASE WITH CHOLESTASIS
K7110	TOXIC LIVER DISEASE WITH HEPATIC NECROSIS WITHOUT COMA
K7111	TOXIC LIVER DISEASE WITH HEPATIC NECROSIS WITH COMA
K712	TOXIC LIVER DISEASE WITH ACUTE HEPATITIS
K713	TOXIC LIVER DISEASE WITH CHRONIC PERSISTENT HEPATITIS
K714	TOXIC LIVER DISEASE WITH CHRONIC LOBULAR HEPATITIS
K7150	TOXIC LIVER DISEASE WITH CHRONIC ACTIVE HEPATITIS WITHOUT ASCITES
K7151	TOXIC LIVER DISEASE WITH CHRONIC ACTIVE HEPATITIS WITH ASCITES
K716	TOXIC LIVER DISEASE WITH HEPATITIS, NOT ELSEWHERE CLASSIFIED
K717	TOXIC LIVER DISEASE WITH FIBROSIS AND CIRRHOSIS OF LIVER
K718	TOXIC LIVER DISEASE WITH OTHER DISORDERS OF LIVER
K719	TOXIC LIVER DISEASE, UNSPECIFIED
K7200	ACUTE AND SUBACUTE HEPATIC FAILURE WITHOUT COMA

Hepatic Disease/Impairment	
ICD-10 Code	**Description**
K7201	ACUTE AND SUBACUTE HEPATIC FAILURE WITH COMA
K7210	CHRONIC HEPATIC FAILURE WITHOUT COMA
K7211	CHRONIC HEPATIC FAILURE WITH COMA
K7290	HEPATIC FAILURE, UNSPECIFIED WITHOUT COMA
K7291	HEPATIC FAILURE, UNSPECIFIED WITH COMA
K730	CHRONIC PERSISTENT HEPATITIS, NOT ELSEWHERE CLASSIFIED
K731	CHRONIC LOBULAR HEPATITIS, NOT ELSEWHERE CLASSIFIED
K732	CHRONIC ACTIVE HEPATITIS, NOT ELSEWHERE CLASSIFIED
K738	OTHER CHRONIC HEPATITIS, NOT ELSEWHERE CLASSIFIED
K739	CHRONIC HEPATITIS, UNSPECIFIED
K740	HEPATIC FIBROSIS
K741	HEPATIC SCLEROSIS
K742	HEPATIC FIBROSIS WITH HEPATIC SCLEROSIS
K743	PRIMARY BILIARY CIRRHOSIS
K744	SECONDARY BILIARY CIRRHOSIS
K745	BILIARY CIRRHOSIS, UNSPECIFIED
K7460	UNSPECIFIED CIRRHOSIS OF LIVER
K7469	OTHER CIRRHOSIS OF LIVER
K750	ABSCESS OF LIVER
K751	PHLEBITIS OF PORTAL VEIN
K752	NONSPECIFIC REACTIVE HEPATITIS
K753	GRANULOMATOUS HEPATITIS, NOT ELSEWHERE CLASSIFIED
K754	AUTOIMMUNE HEPATITIS
K7581	NONALCOHOLIC STEATOHEPATITIS (NASH)

Hepatic Disease/Impairment	
ICD-10 Code	**Description**
K7589	OTHER SPECIFIED INFLAMMATORY LIVER DISEASES
K759	INFLAMMATORY LIVER DISEASE, UNSPECIFIED
K761	CHRONIC PASSIVE CONGESTION OF LIVER
K763	INFARCTION OF LIVER
K7689	OTHER SPECIFIED DISEASES OF LIVER
K769	LIVER DISEASE, UNSPECIFIED
K77	LIVER DISORDERS IN DISEASES CLASSIFIED ELSEWHERE

Mild to Moderate Renal Impairment	
ICD-10 Code	**Description**
N182	CHRONIC KIDNEY DISEASE, STAGE 2 (MILD) (eGFR 89-60 mL/min)
N1830	CHRONIC KIDNEY DISEASE, STAGE 3 UNSPECIFIED (eGFR 59-30 mL/min)
N1831	CHRONIC KIDNEY DISEASE, STAGE 3A (eGFR 59-45 mL/min)
N1832	CHRONIC KIDNEY DISEASE, STAGE 3B (eGFR 44-30 mL/min)

Severe Renal Impairment	
ICD-10 Code	**Description**
N184	CHRONIC KIDNEY DISEASE, STAGE 4 (SEVERE) (eGFR 29-15 mL/min)
N185	CHRONIC KIDNEY DISEASE, STAGE 5 (eGFR < 15 mL/min)
N186	END STAGE RENAL DISEASE

Chronic Renal Disease	
ICD-10 Code	**Description**
N184	CHRONIC KIDNEY DISEASE, STAGE 4 (SEVERE) (eGFR 29-15 mL/min)

Chronic Renal Disease	
ICD-10 Code	**Description**
N185	CHRONIC KIDNEY DISEASE, STAGE 5 (eGFR < 15 mL/min)
N186	END STAGE RENAL DISEASE

Serious Active Infection	
ICD-10 Code	**Description**
B160	ACUTE HEPATITIS B WITH DELTA-AGENT WITH HEPATIC COMA
B161	ACUTE HEPATITIS B WITH DELTA-AGENT WITHOUT HEPATIC COMA
B162	ACUTE HEPATITIS B WITHOUT DELTA-AGENT WITH HEPATIC COMA
B169	ACUTE HEPATITIS B WITHOUT DELTA-AGENT AND WITHOUT HEPATIC COMA
B180	CHRONIC VIRAL HEPATITIS B WITH DELTA-AGENT
B181	CHRONIC VIRAL HEPATITIS B WITHOUT DELTA-AGENT
B1910	UNSPECIFIED VIRAL HEPATITIS B WITHOUT HEPATIC COMA
B1911	UNSPECIFIED VIRAL HEPATITIS B WITH HEPATIC COMA
A150	TUBERCULOSIS OF LUNG
A154	TUBERCULOSIS OF INTRATHORACIC LYMPH NODES
A155	TUBERCULOSIS OF LARYNX, TRACHEA AND BRONCHUS
A156	TUBERCULOUS PLEURISY
A157	PRIMARY RESPIRATORY TUBERCULOSIS
A158	OTHER RESPIRATORY TUBERCULOSIS
A159	RESPIRATORY TUBERCULOSIS UNSPECIFIED
B440	INVASIVE PULMONARY ASPERGILLOSIS
B441	OTHER PULMONARY ASPERGILLOSIS
B447	DISSEMINATED ASPERGILLOSIS
B449	ASPERGILLOSIS, UNSPECIFIED

Serious Active Infection	
ICD-10 Code	**Description**
B59	PNEUMOCYSTOSIS

Atopic dermatitis, Systemic Therapies	
GCN	**Label Name**
46771	AZATHIOPRINE 50 MG TABLET
47563	CELLCEPT 200 MG/ML ORAL SUSP
47560	CELLCEPT 250 MG CAPSULE
47561	CELLCEPT 500 MG TABLET
26781	CORTEF 10 MG TABLET
26782	CORTEF 20 MG TABLET
26783	CORTEF 5 MG TABLET
13910	CYCLOSPORINE 100 MG CAPSULE
13917	CYCLOSPORINE 100 MG/ML
13911	CYCLOSPORINE 25 MG CAPSULE
13919	CYCLOSPORINE MODIFIED 100 MG
13918	CYCLOSPORINE MODIFIED 25 MG
13916	CYCLOSPORINE MODIFIED 50 MG
27422	DEXAMETHASONE 0.5 MG TABLET
27400	DEXAMETHASONE 0.5 MG/5 ML ELX
27411	DEXAMETHASONE 0.5 MG/5 ML LIQ
27425	DEXAMETHASONE 0.75 MG TABLET
27424	DEXAMETHASONE 1 MG TABLET
27427	DEXAMETHASONE 1.5 MG TABLET
27426	DEXAMETHASONE 2 MG TABLET

Atopic dermatitis, Systemic Therapies	
GCN	**Label Name**
27428	DEXAMETHASONE 4 MG TABLET
27429	DEXAMETHASONE 6 MG TABLET
27412	DEXAMETHASONE INTENSOL 1 MG/ 1 ML
45522	DUPIXENT 200 MG/1.14 ML SYRINGE
48277	DUPIXENT 300 MG/2 ML PEN
43222	DUPIXENT 300 MG/2 ML SYRINGE
13917	GENGRAF 100 MG/ML SOLN
13918	GENGRAF 25 MG CAPSULE
13916	GENGRAF 50 MG CAPSULE
26781	HYDROCORTISONE 10 MG TABLET
26782	HYDROCORTISONE 20 MG TABLET
26783	HYDROCORTISONE 5 MG TABLET
46771	IMURAN 50 MG TABLET
27051	MEDROL 16 MG TABLET
27055	MEDROL 32 MG TABLET
27056	MEDROL 4 MG TABLET
27058	MEDROL 8 MG TABLET
38489	METHOTREXATE 2.5 MG TABLET
38466	METHOTREXATE 50 MG/ 2 ML VIAL
18936	METHOTREXATE 50 MG/2 ML VIAL
27051	METHYLPREDNISOLONE 16 MG TABLET
27055	METHYLPREDNISOLONE 32 MG TABLET
27056	METHYLPREDNISOLONE 4 MG TABLET
27058	METHYLPREDNISOLONE 8 MG TABLET

Atopic dermatitis, Systemic Therapies	
GCN	**Label Name**
99610	MILLIPRED 10 MG/5 ML SOLUTION
26963	MILLIPRED 5 MG TABLET
47563	MYCOPHENOLATE 200 MG/ML SUSP
47560	MYCOPHENOLATE 250 MG CAPSULE
47561	MYCOPHENOLATE 500 MG TABLET
19646	MYCOPHENOLIC ACID DR 180 MG TAB
19647	MYCOPHENOLIC ACID DR 360 MG TAB
19646	MYFORTIC 180 MG TABLET
19647	MYFORTIC 360 MG TABLET
13919	NEORAL 100 MG CAPSULE
13917	NEORAL 100 MG/ML SOLN
13918	NEORAL 25 MG CAPSULE
35427	OTREXUP 10 MG/0.4 ML AUTO-INJ
35428	OTREXUP 15 MG/0.4 ML AUTO-INJ
35437	OTREXUP 20 MG/0.4 ML AUTO-INJ
35438	OTREXUP 25 MG/0.4 ML AUTO-INJ
26800	PREDNISOLONE 15 MG/5 ML SOLN
33806	PREDNISOLONE 15 MG/5 ML SOLN
09115	PREDNISOLONE 5 MG/5 ML SOLN
27108	PREDNISOLONE ODT 10 MG TABLET
27109	PREDNISOLONE ODT 15 MG TABLET
27114	PREDNISOLONE ODT 30 MG TABLET
27171	PREDNISONE 1 MG TABLET
27172	PREDNISONE 10 MG TABLET

Atopic dermatitis, Systemic Therapies	
GCN	**Label Name**
27173	PREDNISONE 2.5 MG TABLET
27174	PREDNISONE 20 MG TABLET
27176	PREDNISONE 5 MG TABLET
27160	PREDNISONE 5 MG/5 ML SOLUTION
27161	PREDNISONE 5 MG/5 ML SOLUTION
27177	PREDNISONE 50 MG TABLET
13910	SANDIMMUNE 100 MG CAPSULE
08220	SANDIMMUNE 100 MG/ML SOLN
13911	SANDIMMUNE 25 MG CAPSULE
06484	TREXALL 10MG TABLET
13135	TREXALL 15MG TABLET
13134	TREXALL 5MG TABLET
38485	TREXALL 7.5MG TABLET
14565	VERIPRED 20 MG/5 ML SOLN
43319	XATMEP 2.5MG/ML ORAL SOLUTION

Biologic DMARDs	
GCN	**Label Name**
35486	ACTEMRA 162MG/0.9ML SYRINGE
56164	ADALIMUMAB-AACF (CF) SYR 40 MG
53875	ADALIMUMAB-ADAZ (CF) PEN 40 MG
53884	ADALIMUMAB-ADAZ(CF) 40 MG SYRNG
48318	ADALIMUMAB-FKJP (CF) 20 MG SYRG
48336	ADALIMUMAB-FKJP (CF) 40 MG SYRG

Biologic DMARDs	
GCN	**Label Name**
48317	ADALIMUMAB-FKJP (CF) PEN 40 MG
55665	ADALIMUMAB-ADBM (CF) 40 MG SYRNG
55668	ADALIMUMAB-ADBM (CF) CRHN 40 MG
55668	ADALIMUMAB-ADBM (CF) PEN 40 MG
55668	ADALIMUMAB-ADBM (CF) PEN PSORIA-UV 40 MG
55332	ADALIMUMAB-RYVK (CF) AI 40 MG
56016	ADALIMUMAB-RYVK (CF) 40 MG SYRG
54007	AMJEVITA 10 MG/0.2 ML SYRINGE
42592	AMJEVITA 20 MG/0.4 ML SYRINGE
42639	AMJEVITA 40 MG/0.8 ML AUTOINJ
42637	AMJEVITA 40 MG/0.8 ML SYRINGE
23471	CIMZIA 200MG/ML STARTER KIT
23471	CIMZIA 200MG/ML SYRINGE KIT
37789	COSENTYX 150MG/ML PEN INJECT
37788	COSENTYX 150MG/ML SYRINGE
53841	CYLTEZO (CF) 10 MG/0.2 ML SYRNG
53842	CYLTEZO (CF) 20 MG/0.4 ML SYRNG
43789	CYLTEZO (CF) 40 MG/0.8 ML SYRNG
54205	CYLTEZO (CF) PEN 40 MG/0.8 ML
54205	CYLTEZO (CF) PEN CRH-UC-HS 40 MG
54205	CYLTEZO (CF) PEN PSORIA-UV 40 MG
55665	CYLTEZO (CF) 40 MG/0.4 ML SYRNG
55668	CYLTEZO (CF) PEN 40 MG/0.4 ML
55668	CYLTEZO (CF) PEN CRH-UC-HS 40 MG

Biologic DMARDs	
GCN	**Label Name**
55668	CYLTEZO (CF) PEN PSORIA-UV 40 MG
52651	ENBREL 25MG KIT
98398	ENBREL 25MG/0.5ML SYRINGE
43294	ENBREL 50 MG/ML MINI CARTRIDGE
97724	ENBREL 50MG/ML SURECLICK SYRINGE
23574	ENBREL 50MG/ML SYRINGE
53846	HADLIMA (CF) 40 MG/0.4 ML SYRNG
53848	HADLIMA (CF) PUSHTOUCH 40MG/0.4
46718	HADLIMA 40 MG/0.8 ML SYRINGE
46717	HADLIMA PUSHTOUCH 40 MG/0.8 ML
48318	HULIO (CF) 20 MG/0.4 ML SYRINGE
48336	HULIO (CF) 40MG/0.8 ML SYRINGE
48317	HULIO (CF) PEN 40 MG/0.8 ML
55235	HULIO (CF) 20 MG/0.4 ML SYRINGE
55694	HULIO (CF) 40MG/0.8 ML SYRINGE
55693	HULIO (CF) PEN 40 MG/0.8 ML
44659	HUMIRA (CF) 10 MG/0.1 ML SYRINGE
44664	HUMIRA (CF) 20 MG/0.2 ML SYRINGE
43505	HUMIRA (CF) 40 MG/0.4 ML SYRINGE
43506	HUMIRA PEN 40 MG/0.4 ML
97005	HUMIRA PEN 40 MG/0.8 ML
97005	HUMIRA PEN CROHN-UC-HS 40 MG
97005	HUMIRA PEN PS-UV-ADOL HS 40 MG
43904	HUMIRA (CF) PEDI CROHN 80 MG/0.8

Biologic DMARDs	
GCN	**Label Name**
44677	HUMIRA (CF) PEDI CROHN 80-40MG
44014	HUMIRA (CF) PEN CRHN-UC-HS 80 MG
44954	HUMIRA (CF) PEN PS-UV-AHS 80-40 MG
37262	HUMIRA 10 MG/0.2 ML SYRINGE
99439	HUMIRA 20 MG/0.4 ML SYRINGE
18924	HUMIRA 40 MG/0.8 ML SYRINGE
18924	HUMIRA PEDI CROHN 40 MG/0.8 ML
53885	HYRIMOZ (CF) 10 MG/0.1 ML SYRNG
53883	HYRIMOZ (CF) 20 MG/0.2 ML SYRNG
53884	HYRIMOZ (CF) 40 MG/0.4 ML SYRNG
53899	HYRIMOZ (CF) PEDI CROHN 80 MG
53891	HYRIMOZ (CF) PEDI CROHN 80-40 MG
53875	HYRIMOZ (CF) PEN 40 MG/0.4 ML
53887	HYRIMOZ (CF) PEN 80 MG/0.8 ML
53887	HYRIMOZ (CF) PEN CROHN-UC 80 MG
53878	HYRIMOZ (CF) PEN PSORIA 80-40 MG
53387	IDACIO (CF) PEN 40 MG/0.8 ML
53387	IDACIO (CF) PEN PSORIASIS 40 MG
53387	IDACIO (CF) PEN CROHNS-UC 40 MG
53386	IDACIO (CF) 40 MG/0.8 ML SYRINGE
56152	IDACIO (CF) PEN 40 MG/0.8 ML
43148	ILARIS 150MG/ML VIAL
27445	ILARIS 180MG VIAL
44269	KEVZARA 150 MG/1.14 ML PEN INJ

Biologic DMARDs	
GCN	**Label Name**
43223	KEVZARA 150 MG/1.14 ML SYRINGE
44277	KEVZARA 200 MG/1.14 ML PEN INJ
43224	KEVZARA 200 MG/1.14 ML SYRINGE
14867	KINERET 100MG/0.67ML SYRINGE
30289	ORENCIA 125MG/ML SYRINGE
43389	ORENCIA 50MG/0.4ML SYRINGE
43397	ORENCIA 87.5MG/0.7ML SYRINGE
41656	ORENCIA CLICKJECT 125MG/ML
37765	OTEZLA 28 DAY STARTER PACK
36172	OTEZLA 30 MG TABLET
56084	OTEZLA 10-20 MG STARTER 28 DAY
56083	OTEZLA 20 MG TABLET
56286	OTULFI 45 MG/0.5 ML SYRINGE
56287	OTULFI 90 MG/ML SYRINGE
55583	SELARSDI 45 MG/0.5 ML SYRINGE
55584	SELARSDI 90 MG/ML SYRINGE
43055	SILIQ 210 MG/1.5 ML SYRINGE
55332	SIMLANDI (CF) AI 40 MG/0.4 ML
57361	SIMLANDI (CF) AI 80 MG/0.8 ML
56047	SIMLANDI (CF) 20 MG/0.2 ML SYRG
56048	SIMLANDI (CF) 80 MG/0.8 ML SYRG
35001	SIMPONI 100MG/ML PEN INJECTOR
34697	SIMPONI 100MG/ML SYRINGE
22533	SIMPONI 50MG/0.5ML PEN INJECTOR

Biologic DMARDs	
GCN	**Label Name**
22536	SIMPONI 50MG/0.5ML SYRINGE
34983	SIMPONI ARIA 50MG/4ML VIAL
28158	STELARA 45 MG/0.5 ML SYRINGE
56753	STEQEYMA 45 MG/0.5 ML SYRINGE
56754	STEQEYMA 90 MG/ML SYRINGE
40848	TALTZ 80 MG/ML AUTOINJ
40848	TALTZ 80 MG/ML SYRINGE
55341	TALTZ 20 MG/0.25 ML SYRINGE
55342	TALTZ 40 MG/ 0.5 ML SYRINGE
40849	TALTZ 80 MG/ML SYRINGE
46024	TREMFYA 100 MG/ML INJECTOR
57417	TREMFYA 100 MG/ML PEN
43612	TREMFYA 100 MG/ML SYRINGE
56229	TREMFYA 200 MG/2 ML PEN
56228	TREMFYA 200 MG/2 ML SYRINGE
55373	TYENNE 162MG/0.9ML AUTOINJECT
55374	TYENNE 162MG/0.9ML SYRINGE
55956	USTEKINUMAB-TTWE 45 MG/0.5ML SYRINGE
55957	USTEKINUMAB-TTWE 90 MG/ML SYRINGE
56599	YESINTEK 45 MG/0.5 ML SYRINGE
56607	YESINTEK 45 MG/0.5 ML VIAL
56603	YESINTEK 90 MG/ML SYRINGE

Calcineurin Inhibitors	
GCN	**Label Name**
98662	ASTAGRAF XL 0.5 MG CAPSULE
98663	ASTAGRAF XL 1 MG CAPSULE
98664	ASTAGRAF XL 5 MG CAPSULE
13910	CYCLOSPORINE 100 MG CAPSULE
13917	CYCLOSPORINE 100 MG/ML
13911	CYCLOSPORINE 25 MG CAPSULE
13919	CYCLOSPORINE MODIFIED 100 MG
13918	CYCLOSPORINE MODIFIED 25 MG
13916	CYCLOSPORINE MODIFIED 50 MG
39120	ENVARSUS XR 0.75 MG TABLET
39123	ENVARSUS XR 1 MG TABLET
39124	ENVARSUS XR 4 MG TABLET
13919	GENGRAF 100 MG CAPSULE
13917	GENGRAF 100 MG/ML SOLN
13918	GENGRAF 25 MG CAPSULE
13916	GENGRAF 50 MG CAPSULE
13919	NEORAL 100 MG CAPSULE
13917	NEORAL 100 MG/ML SOLN
13918	NEORAL 25 MG CAPSULE
28495	PROGRAF 0.5 MG CAPSULE
28491	PROGRAF 1 MG CAPSULE
28492	PROGRAF 5 MG CAPSULE
13910	SANDIMMUNE 100 MG CAPSULE
08220	SANDIMMUNE 100 MG/ML SOLN

Calcineurin Inhibitors	
GCN	**Label Name**
13911	SANDIMMUNE 25 MG CAPSULE

Cibinqo – Contraindicated drugs	
GCN	**Label Name**
60822	DIFLUCAN 10 MG/ML SUSPENSION
42190	DIFLUCAN 100 MG TABLET
42193	DIFLUCAN 150 MG TABLET
42191	DIFLUCAN 200 MG TABLET
60821	DIFLUCAN 40 MG/ML SUSPENSION
48192	DIFLUCAN 50 MG TABLET
60822	FLUCONAZOLE 10 MG/ML SUSP
42190	FLUCONAZOLE 100 MG TABLET
42193	FLUCONAZOLE 150 MG TABLET
42191	FLUCONAZOLE 200 MG TABLET
60821	FLUCONAZOLE 40 MG/ML SUSP
42192	FLUCONAZOLE 50 MG TABLET
69790	FLUCONAZOLE-NACL 200 MG/100 ML
69791	FLUCONAZOLE-NACL 400 MG/200 ML
16357	FLUOXETINE 20 MG/5 ML SOLUTION
12929	FLUOXETINE DR 90 MG CAPSULE
16353	FLUOXETINE HCL 10 MG CAPSULE
16356	FLUOXETINE HCL 10 MG TABLET
16354	FLUOXETINE HCL 20 MG CAPSULE
16359	FLUOXETINE HCL 20 MG TABLET

Cibinqo – Contraindicated drugs	
GCN	**Label Name**
16355	FLUOXETINE HCL 40 MG CAPSULE
30817	FLUOXETINE HCL 60 MG TABLET
99481	FLUVOXAMINE ER 100 MG CAPSULE
99482	FLUVOXAMINE ER 150 MG CAPSULE
16349	FLUVOXAMINE MALEATE 100 MG TABLET
16347	FLUVOXAMINE MALEATE 25 MG TABLET
16348	FLUVOXAMINE MALEATE 50 MG TABLET
20870	OLANZAPINE-FLUOXETINE 12-25 MG
20872	OLANZAPINE-FLUOXETINE 12-50 MG
98648	OLANZAPINE-FLUOXETINE 3-25 MG
20868	OLANZAPINE-FLUOXETINE 6-25 MG
20869	OLANZAPINE-FLUOXETINE 6-50 MG
16353	PROZAC 10 MG PULVULE
16354	PROZAC 20 MG PULVULE
16355	PROZAC 40 MG PULVULE
41470	RIFADIN IV 600 MG VIAL
41260	RIFAMPIN 150 MG CAPSULE
41261	RIFAMPIN 300 MG CAPSULE
41470	RIFAMPIN IV 600 MG VIAL
98648	SYMBYAX 3-25 MG CAPSULE
20868	SYMBYAX 6-25 MG CAPSULE

Cibinqo Dosing Guidelines	
Label Name	**Maximum Recommended Dose**
Mild renal impairment eGFR 60-89 mL/min	1 – 100 mg tablet daily
Moderate renal impairment eGFR 30-59 mL/min	1 – 50 mg tablet daily
Use with strong CYP2C19 inhibitor	1 – 100 mg tablet daily
CYP2C19 poor metabolizers	1 – 100 mg tablet daily

Cimzia – Contraindicated Drugs	
GCN	**Label Name**
14867	KINERET 100 MG/0.67 ML SYRINGE
30289	ORENCIA 125 MG/ML SYRINGE
70151	RITUXAN 10 MG/ML VIAL
23805	TYSABRI 300 MG/15 ML VIAL

Conventional Therapy – Crohn's Disease	
GCN	**Label Name**
46771	AZATHIOPRINE 50 MG TABLET
26781	CORTEF 10 MG TABLET
26782	CORTEF 20 MG TABLET
26783	CORTEF 5 MG TABLET
13910	CYCLOSPORINE 100 MG CAPSULE
13917	CYCLOSPORINE 100 MG/ML
13911	CYCLOSPORINE 25 MG CAPSULE
13919	CYCLOSPORINE MODIFIED 100 MG
13918	CYCLOSPORINE MODIFIED 25 MG

Conventional Therapy – Crohn's Disease	
GCN	**Label Name**
13916	CYCLOSPORINE MODIFIED 50 MG
27422	DEXAMETHASONE 0.5 MG TABLET
27400	DEXAMETHASONE 0.5 MG/5 ML ELX
27411	DEXAMETHASONE 0.5 MG/5 ML LIQ
27425	DEXAMETHASONE 0.75 MG TABLET
27424	DEXAMETHASONE 1 MG TABLET
27427	DEXAMETHASONE 1.5 MG TABLET
27426	DEXAMETHASONE 2 MG TABLET
27428	DEXAMETHASONE 4 MG TABLET
27429	DEXAMETHASONE 6 MG TABLET
27412	DEXAMETHASONE INTENSOL 1 MG/ 1 ML
13919	GENGRAF 100 MG CAPSULE
13917	GENGRAF 100 MG/ML SOLN
13918	GENGRAF 25 MG CAPSULE
13916	GENGRAF 50 MG CAPSULE
26781	HYDROCORTISONE 10 MG TABLET
26782	HYDROCORTISONE 20 MG TABLET
26783	HYDROCORTISONE 5 MG TABLET
46771	IMURAN 50 MG TABLET
27051	MEDROL 16 MG TABLET
27055	MEDROL 32 MG TABLET
27056	MEDROL 4 MG TABLET
27058	MEDROL 8 MG TABLET
38520	MERCAPTOPURINE 50 MG TABLET

Conventional Therapy – Crohn's Disease	
GCN	**Label Name**
38489	METHOTREXATE 2.5 MG TABLET
38466	METHOTREXATE 50 MG/ 2 ML VIAL
18936	METHOTREXATE 50 MG/2 ML VIAL
27051	METHYLPREDNISOLONE 16 MG TABLET
27055	METHYLPREDNISOLONE 32 MG TABLET
27056	METHYLPREDNISOLONE 4 MG TABLET
27058	METHYLPREDNISOLONE 8 MG TABLET
99610	MILLIPRED 10 MG/5 ML SOLUTION
26963	MILLIPRED 5 MG TABLET
13919	NEORAL 100 MG CAPSULE
13917	NEORAL 100 MG/ML SOLN
13918	NEORAL 25 MG CAPSULE
35427	OTREXUP 10 MG/0.4 ML AUTO-INJ
35428	OTREXUP 15 MG/0.4 ML AUTO-INJ
35437	OTREXUP 20 MG/0.4 ML AUTO-INJ
35438	OTREXUP 25 MG/0.4 ML AUTO-INJ
26800	PREDNISOLONE 15 MG/5 ML SOLN
33806	PREDNISOLONE 15 MG/5 ML SOLN
09115	PREDNISOLONE 5 MG/5 ML SOLN
27108	PREDNISOLONE ODT 10 MG TABLET
27109	PREDNISOLONE ODT 15 MG TABLET
27114	PREDNISOLONE ODT 30 MG TABLET
27171	PREDNISONE 1 MG TABLET
27172	PREDNISONE 10 MG TABLET

Conventional Therapy – Crohn's Disease	
GCN	**Label Name**
27173	PREDNISONE 2.5 MG TABLET
27174	PREDNISONE 20 MG TABLET
27176	PREDNISONE 5 MG TABLET
27160	PREDNISONE 5 MG/5 ML SOLUTION
27161	PREDNISONE 5 MG/5 ML SOLUTION
27177	PREDNISONE 50 MG TABLET
33277	PURIXAN 20 MG/ML ORAL SUSP
13910	SANDIMMUNE 100 MG CAPSULE
08220	SANDIMMUNE 100 MG/ML SOLN
13911	SANDIMMUNE 25 MG CAPSULE
06484	TREXALL 10MG TABLET
13135	TREXALL 15MG TABLET
13134	TREXALL 5MG TABLET
38485	TREXALL 7.5MG TABLET
14565	VERIPRED 20 MG/5 ML SOLN
43319	XATMEP 2.5MG/ML ORAL SOLUTION

Conventional Therapy – Plaque Psoriasis	
GCN	**Label Name**
56164	ADALIMUMAB-AACF (CF) SYR 40 MG
53875	ADALIMUMAB-ADAZ (CF) PEN 40 MG
53884	ADALIMUMAB-ADAZ(CF) 40 MG SYRNG
48318	ADALIMUMAB-FKJP (CF) 20 MG SYRG
48336	ADALIMUMAB-FKJP (CF) 40 MG SYRG

Conventional Therapy – Plaque Psoriasis	
GCN	**Label Name**
48317	ADALIMUMAB-FKJP (CF) PEN 40 MG
55665	ADALIMUMAB-ADBM (CF) 40 MG SYRNG
55668	ADALIMUMAB-ADBM (CF) CRHN 40 MG
55668	ADALIMUMAB-ADBM (CF) PEN 40 MG
55668	ADALIMUMAB-ADBM (CF) PEN PSORIA-UV 40 MG
55332	ADALIMUMAB-RYVK (CF) AI 40 MG
56016	ADALIMUMAB-RYVK (CF) 40 MG SYRG
54007	AMJEVITA 10 MG/0.2 ML SYRINGE
42592	AMJEVITA 20 MG/0.4 ML SYRINGE
42639	AMJEVITA 40 MG/0.8 ML AUTOINJ
42637	AMJEVITA 40 MG/0.8 ML SYRINGE
98662	ASTAGRAF XL 0.5 MG CAPSULE
98663	ASTAGRAF XL 1 MG CAPSULE
98664	ASTAGRAF XL 5 MG CAPSULE
46771	AZATHIOPRINE 50 MG TABLET
01851	CALCIPOTRIENE 0.005% CREAM
01850	CALCIPOTRIENE 0.005% OINTMENT
01852	CALCIPOTRIENE 0.005% SOLUTION
13785	CALCIPOTRIENE-BETAMETH DP OINT
47563	CELLCEPT 200 MG/ML ORAL SUSP
47560	CELLCEPT 250 MG CAPSULE
47561	CELLCEPT 500 MG TABLET
23471	CIMZIA 200MG/ML STARTER KIT
23471	CIMZIA 200MG/ML SYRINGE KIT

Conventional Therapy – Plaque Psoriasis	
GCN	**Label Name**
13910	CYCLOSPORINE 100 MG CAPSULE
13917	CYCLOSPORINE 100 MG/ML
13911	CYCLOSPORINE 25 MG CAPSULE
13919	CYCLOSPORINE MODIFIED 100 MG
13918	CYCLOSPORINE MODIFIED 25 MG
13916	CYCLOSPORINE MODIFIED 50 MG
53841	CYLTEZO (CF) 10 MG/0.2 ML SYRNG
53842	CYLTEZO (CF) 20 MG/0.4 ML SYRNG
55665	CYLTEZO (CF) 40 MG/0.4 ML SYRNG
43789	CYLTEZO (CF) 40 MG/0.8 ML SYRNG
55668	CYLTEZO (CF) PEN 40 MG/0.4 ML
54205	CYLTEZO (CF) PEN 40 MG/0.8 ML
54205	CYLTEZO (CF) PEN CRH-UC-HS 40 MG
54205	CYLTEZO (CF) PEN PSORIA-UV 40 MG
55668	CYLTEZO (CF) PEN CRH-UC-HS 40 MG
55668	CYLTEZO (CF) PEN PSORIA-UV 40 MG
01851	DOVONEX 0.005% CREAM
52651	ENBREL 25MG KIT
98398	ENBREL 25MG/0.5ML SYRINGE
43294	ENBREL 50 MG/ML MINI CARTRIDGE
97724	ENBREL 50MG/ML SURECLICK SYRINGE
23574	ENBREL 50MG/ML SYRINGE
39120	ENVARSUS XR 0.75 MG TABLET
39123	ENVARSUS XR 1 MG TABLET

Conventional Therapy – Plaque Psoriasis	
GCN	**Label Name**
39124	ENVARSUS XR 4 MG TABLET
32178	FABIOR 0.1% FOAM
13919	GENGRAF 100 MG CAPSULE
13917	GENGRAF 100 MG/ML SOLN
13918	GENGRAF 25 MG CAPSULE
13916	GENGRAF 50 MG CAPSULE
53846	HADLIMA (CF) 40 MG/0.4 ML SYRNG
53848	HADLIMA (CF) PUSHTOUCH 40MG/0.4
46718	HADLIMA 40 MG/0.8 ML SYRINGE
46717	HADLIMA PUSHTOUCH 40 MG/0.8 ML
48318	HULIO (CF) 20 MG/0.4 ML SYRINGE
55235	HULIO (CF) 20 MG/0.4 ML SYRINGE
48336	HULIO (CF) 40MG/0.8 ML SYRINGE
48317	HULIO (CF) PEN 40 MG/0.8 ML
55694	HULIO (CF) 40MG/0.8 ML SYRINGE
55693	HULIO (CF) PEN 40 MG/0.8 ML
44659	HUMIRA (CF) 10 MG/0.1 ML SYRINGE
44664	HUMIRA (CF) 20 MG/0.2 ML SYRINGE
43505	HUMIRA (CF) 40 MG/0.4 ML SYRINGE
43904	HUMIRA (CF) PEDI CROHN 80 MG/0.8
44677	HUMIRA (CF) PEDI CROHN 80-40MG
44014	HUMIRA (CF) PEN CRHN-UC-HS 80 MG
44954	HUMIRA (CF) PEN PS-UV-AHS 80-40 MG
37262	HUMIRA 10 MG/0.2 ML SYRINGE

Conventional Therapy – Plaque Psoriasis	
GCN	**Label Name**
99439	HUMIRA 20 MG/0.4 ML SYRINGE
18924	HUMIRA 40 MG/0.8 ML SYRINGE
18924	HUMIRA PEDI CROHN 40 MG/0.8 ML
43506	HUMIRA PEN 40 MG/0.4 ML
97005	HUMIRA PEN 40 MG/0.8 ML
97005	HUMIRA PEN CROHN-UC-HS 40 MG
97005	HUMIRA PEN PS-UV-ADOL HS 40 MG
53885	HYRIMOZ (CF) 10 MG/0.1 ML SYRNG
53883	HYRIMOZ (CF) 20 MG/0.2 ML SYRNG
53884	HYRIMOZ (CF) 40 MG/0.4 ML SYRNG
53899	HYRIMOZ (CF) PEDI CROHN 80 MG
53891	HYRIMOZ (CF) PEDI CROHN 80-40 MG
53875	HYRIMOZ (CF) PEN 40 MG/0.4 ML
53887	HYRIMOZ (CF) PEN 80 MG/0.8 ML
53887	HYRIMOZ (CF) PEN CROHN-UC 80 MG
53878	HYRIMOZ (CF) PEN PSORIA 80-40 MG
53387	IDACIO (CF) PEN 40 MG/0.8 ML
53387	IDACIO (CF) PEN PSORIASIS 40 MG
53387	IDACIO (CF) PEN CROHNS-UC 40 MG
53386	IDACIO (CF) 40 MG/0.8 ML SYRINGE
56152	IDACIO (CF) PEN 40 MG/0.8 ML
46771	IMURAN 50 MG TABLET
38489	METHOTREXATE 2.5 MG TABLET
38466	METHOTREXATE 50 MG/ 2 ML VIAL

Conventional Therapy – Plaque Psoriasis	
GCN	**Label Name**
18936	METHOTREXATE 50 MG/2 ML VIAL
47563	MYCOPHENOLATE 200 MG/ML SUSP
47560	MYCOPHENOLATE 250 MG CAPSULE
47561	MYCOPHENOLATE 500 MG TABLET
19646	MYCOPHENOLIC ACID DR 180 MG TAB
19647	MYCOPHENOLIC ACID DR 360 MG TAB
19646	MYFORTIC 180 MG TABLET
19647	MYFORTIC 360 MG TABLET
13919	NEORAL 100 MG CAPSULE
13917	NEORAL 100 MG/ML SOLN
13918	NEORAL 25 MG CAPSULE
35427	OTREXUP 10 MG/0.4 ML AUTO-INJ
35428	OTREXUP 15 MG/0.4 ML AUTO-INJ
35437	OTREXUP 20 MG/0.4 ML AUTO-INJ
35438	OTREXUP 25 MG/0.4 ML AUTO-INJ
56286	OTULFI 45 MG/0.5 ML SYRINGE
56287	OTULFI 90 MG/ML SYRINGE
28495	PROGRAF 0.5 MG CAPSULE
28491	PROGRAF 1 MG CAPSULE
28492	PROGRAF 5 MG CAPSULE
13910	SANDIMMUNE 100 MG CAPSULE
08220	SANDIMMUNE 100 MG/ML SOLN
13911	SANDIMMUNE 25 MG CAPSULE
55583	SELARSDI 45 MG/0.5 ML SYRINGE

Conventional Therapy – Plaque Psoriasis	
GCN	**Label Name**
55584	SELARSDI 90 MG/ML SYRINGE
55332	SIMLANDI (CF) AI 40 MG/0.4 ML
57361	SIMLANDI (CF) AI 80 MG/0.8 ML
56047	SIMLANDI (CF) 20 MG/0.2 ML SYRG
56048	SIMLANDI (CF) 80 MG/0.8 ML SYRG
32228	SORILUX 0.005% FOAM
42351	STELARA 130 MG/26 ML VIAL
28158	STELARA 45 MG/0.5 ML SYRINGE
19903	STELARA 45 MG/0.5 ML VIAL
28159	STELARA 90 MG/ML SYRINGE
56753	STEQEYMA 45 MG/0.5 ML SYRINGE
56754	STEQEYMA 90 MG/ML SYRINGE
10290	TABLOID 40 MG TABLE
99699	TACLONEX 0.005%-0.064% SUSP
13785	TACLONEX OINTMENT
28495	TACROLIMUS 0.5 MG CAPSULE
28491	TACROLIMUS 1 MG CAPSULE
28492	TACROLIMUS 5 MG CAPSULE
85363	TAZAROTENE 0.1% CREAM
85362	TAZORAC 0.05% CREAM
29221	TAZORAC 0.05% GEL
85363	TAZORAC 0.1% CREAM
29222	TAZORAC 0.1% GEL
06484	TREXALL 10MG TABLET

Conventional Therapy – Plaque Psoriasis	
GCN	**Label Name**
13135	TREXALL 15MG TABLET
13134	TREXALL 5MG TABLET
38485	TREXALL 7.5MG TABLET
55956	USTEKINUMAB-TTWE 45 MG/0.5ML SYRINGE
55957	USTEKINUMAB-TTWE 90 MG/ML SYRINGE
43319	XATMEP 2.5MG/ML ORAL SOLUTION
56599	YESINTEK 45 MG/0.5 ML SYRINGE
56607	YESINTEK 45 MG/0.5 ML VIAL
56603	YESINTEK 90 MG/ML SYRINGE

Conventional Therapy – Ulcerative Colitis	
GCN	**Label Name**
16159	APRISO ER 0.375 GRAM CAPSULE
46771	AZATHIOPRINE 50 MG TABLET
28680	BUDESONIDE DR 3 MG CAPSULE
34063	BUDESONIDE ER 9 MG TABLET
26781	CORTEF 10 MG TABLET
26782	CORTEF 20 MG TABLET
26783	CORTEF 5 MG TABLET
13910	CYCLOSPORINE 100 MG CAPSULE
13917	CYCLOSPORINE 100 MG/ML
13911	CYCLOSPORINE 25 MG CAPSULE
13919	CYCLOSPORINE MODIFIED 100 MG
13918	CYCLOSPORINE MODIFIED 25 MG

Conventional Therapy – Ulcerative Colitis	
GCN	**Label Name**
13916	CYCLOSPORINE MODIFIED 50 MG
41428	DELZICOL DR 400 MG CAPSULE
27422	DEXAMETHASONE 0.5 MG TABLET
27400	DEXAMETHASONE 0.5 MG/5 ML ELX
27411	DEXAMETHASONE 0.5 MG/5 ML LIQ
27425	DEXAMETHASONE 0.75 MG TABLET
27424	DEXAMETHASONE 1 MG TABLET
27427	DEXAMETHASONE 1.5 MG TABLET
27426	DEXAMETHASONE 2 MG TABLET
27428	DEXAMETHASONE 4 MG TABLET
27429	DEXAMETHASONE 6 MG TABLET
27412	DEXAMETHASONE INTENSOL 1 MG/ 1 ML
33401	DIPENTUM 250 MG CAPSULE
13919	GENGRAF 100 MG CAPSULE
13917	GENGRAF 100 MG/ML SOLN
13918	GENGRAF 25 MG CAPSULE
13916	GENGRAF 50 MG CAPSULE
26781	HYDROCORTISONE 10 MG TABLET
26782	HYDROCORTISONE 20 MG TABLET
26783	HYDROCORTISONE 5 MG TABLET
46771	IMURAN 50 MG TABLET
97842	LIALDA DR 1.2 GM TABLET
27051	MEDROL 16 MG TABLET
27055	MEDROL 32 MG TABLET

Conventional Therapy – Ulcerative Colitis	
GCN	**Label Name**
27056	MEDROL 4 MG TABLET
27058	MEDROL 8 MG TABLET
38520	MERCAPTOPURINE 50 MG TABLET
21663	MESALAMINE 800 MG DR TABLET
97842	MESALAMINE DR 1.2 GM TABLET
41428	MESALAMINE DR 400 MG CAPSULE
16159	MESALAMINE ER 0.375 GRAM CAP
38489	METHOTREXATE 2.5 MG TABLET
38466	METHOTREXATE 50 MG/ 2 ML VIAL
18936	METHOTREXATE 50 MG/2 ML VIAL
27051	METHYLPREDNISOLONE 16 MG TABLET
27055	METHYLPREDNISOLONE 32 MG TABLET
27056	METHYLPREDNISOLONE 4 MG TABLET
27058	METHYLPREDNISOLONE 8 MG TABLET
99610	MILLIPRED 10 MG/5 ML SOLUTION
26963	MILLIPRED 5 MG TABLET
13919	NEORAL 100 MG CAPSULE
13917	NEORAL 100 MG/ML SOLN
13918	NEORAL 25 MG CAPSULE
35427	OTREXUP 10 MG/0.4 ML AUTO-INJ
35428	OTREXUP 15 MG/0.4 ML AUTO-INJ
35437	OTREXUP 20 MG/0.4 ML AUTO-INJ
35438	OTREXUP 25 MG/0.4 ML AUTO-INJ
30220	PENTASA 250 MG CAPSULE

Conventional Therapy – Ulcerative Colitis	
GCN	**Label Name**
23422	PENTASA 500 MG CAPSULE
26800	PREDNISOLONE 15 MG/5 ML SOLN
33806	PREDNISOLONE 15 MG/5 ML SOLN
09115	PREDNISOLONE 5 MG/5 ML SOLN
27108	PREDNISOLONE ODT 10 MG TABLET
27109	PREDNISOLONE ODT 15 MG TABLET
27114	PREDNISOLONE ODT 30 MG TABLET
27171	PREDNISONE 1 MG TABLET
27172	PREDNISONE 10 MG TABLET
27173	PREDNISONE 2.5 MG TABLET
27174	PREDNISONE 20 MG TABLET
27176	PREDNISONE 5 MG TABLET
27160	PREDNISONE 5 MG/5 ML SOLUTION
27161	PREDNISONE 5 MG/5 ML SOLUTION
27177	PREDNISONE 50 MG TABLET
33277	PURIXAN 20 MG/ML ORAL SUSP
13910	SANDIMMUNE 100 MG CAPSULE
08220	SANDIMMUNE 100 MG/ML SOLN
13911	SANDIMMUNE 25 MG CAPSULE
41611	SULFASALAZINE 500MG TABLET
41620	SULFASALAZINE DR 500 MG TABLET
06484	TREXALL 10MG TABLET
13135	TREXALL 15MG TABLET
13134	TREXALL 5MG TABLET

Conventional Therapy – Ulcerative Colitis	
GCN	**Label Name**
38485	TREXALL 7.5MG TABLET
34063	UCERIS 9 MG ER TABLET
14565	VERIPRED 20 MG/5 ML SOLN
43319	XATMEP 2.5MG/ML ORAL SOLUTION

Corticosteroids	
GCN	**Label Name**
26781	CORTEF 10 MG TABLET
26782	CORTEF 20 MG TABLET
26783	CORTEF 5 MG TABLET
27422	DEXAMETHASONE 0.5 MG TABLET
27400	DEXAMETHASONE 0.5 MG/5 ML ELX
27411	DEXAMETHASONE 0.5 MG/5 ML LIQ
27425	DEXAMETHASONE 0.75 MG TABLET
27424	DEXAMETHASONE 1 MG TABLET
27427	DEXAMETHASONE 1.5 MG TABLET
27426	DEXAMETHASONE 2 MG TABLET
27428	DEXAMETHASONE 4 MG TABLET
27429	DEXAMETHASONE 6 MG TABLET
27412	DEXAMETHASONE INTENSOL 1 MG/ 1 ML
26781	HYDROCORTISONE 10 MG TABLET
26782	HYDROCORTISONE 20 MG TABLET
26783	HYDROCORTISONE 5 MG TABLET
27051	MEDROL 16 MG TABLET

Corticosteroids	
GCN	**Label Name**
27055	MEDROL 32 MG TABLET
27056	MEDROL 4 MG TABLET
27058	MEDROL 8 MG TABLET
27051	METHYLPREDNISOLONE 16 MG TABLET
27055	METHYLPREDNISOLONE 32 MG TABLET
27056	METHYLPREDNISOLONE 4 MG TABLET
27058	METHYLPREDNISOLONE 8 MG TABLET
99610	MILLIPRED 10 MG/5 ML SOLUTION
26963	MILLIPRED 5 MG TABLET
26800	PREDNISOLONE 15 MG/5 ML SOLN
33806	PREDNISOLONE 15 MG/5 ML SOLN
09115	PREDNISOLONE 5 MG/5 ML SOLN
27108	PREDNISOLONE ODT 10 MG TABLET
27109	PREDNISOLONE ODT 15 MG TABLET
27114	PREDNISOLONE ODT 30 MG TABLET
27171	PREDNISONE 1 MG TABLET
27172	PREDNISONE 10 MG TABLET
27173	PREDNISONE 2.5 MG TABLET
27174	PREDNISONE 20 MG TABLET
27176	PREDNISONE 5 MG TABLET
27160	PREDNISONE 5 MG/5 ML SOLUTION
27161	PREDNISONE 5 MG/5 ML SOLUTION
27177	PREDNISONE 50 MG TABLET
14565	VERIPRED 20 MG/5 ML SOLN

Cytokine and CAM Antagonists	
GCN	**Label Name**
35486	ACTEMRA 162MG/0.9ML SYRINGE
45082	ACTEMRA ACTPEN 162 MG/0.9 ML
99473	ARCALYST 220MG INJECTION
54007	AMJEVITA 10 MG/0.2 ML SYRINGE
42592	AMJEVITA 20 MG/0.4 ML SYRINGE
42639	AMJEVITA 40 MG/0.8 ML AUTOINJ
42637	AMJEVITA 40 MG/0.8 ML SYRINGE
51827	CIBINQO 100 MG TABLET
51828	CIBINQO 200 MG TABLET
51825	CIBINQO 50 MG TABLET
23471	CIMZIA 200MG/ML SYRINGE KIT
23471	CIMZIA 200MG/ML STARTER KIT
37789	COSENTYX 300 MG DOSE-2 PENS
37789	COSENTYX 150 MG/ML PEN INJECT
37788	COSENTYX 150 MG/ML SYRINGE
37788	COSENTYX 300 MG DOSE-2 SYRINGES
49732	COSENTYX 75 MG/0.5ML SYRINGE
52651	ENBREL 25 MG KIT
23574	ENBREL 50 MG/ML SYRINGE
97724	ENBREL 50 MG/ML SURECLICK SYR
98398	ENBREL 25 MG/0.5 ML SYRINGE
43924	ENBREL 50 MG/ML MINI CARTRIDGE
48417	ENBREL 25 MG/0.5 ML VIAL
48477	ENSPRYNG 120 MG/ML SYRINGE

Cytokine and CAM Antagonists	
GCN	**Label Name**
44659	HUMIRA (CF) 10 MG/0.1 ML SYRINGE
44664	HUMIRA (CF) 20 MG/0.2 ML SYRINGE
43505	HUMIRA (CF) 40 MG/0.4 ML SYRINGE
44014	HUMIRA (CF) PEN 80 MG/0.8 ML
43904	HUMIRA (CF) PEDI CROHN 80 MG/0.8
44014	HUMIRA (CF) PEN PEDI UC 80 MG
44677	HUMIRA (CF) PEDI CROHN 80-40MG
43506	HUMIRA (CF) PEN 40 MG/0.4 ML
44014	HUMIRA (CF) PEN CRHN-UC-HS 80 MG
44954	HUMIRA (CF) PEN PS-UV-AHS 80-40 MG
18924	HUMIRA 40 MG/0.8 ML SYRINGE
97005	HUMIRA PEN 40 MG/0.8 ML
97005	HUMIRA PEN CROHN-UC-HS 40 MG
97005	HUMIRA PEN PS-UV-ADOL HS 40 MG
54007	AMJEVITA 10 MG/0.2 ML SYRINGE
42592	AMJEVITA 20 MG/0.4 ML SYRINGE
42639	AMJEVITA 40 MG/0.8 ML AUTOINJ
42637	AMJEVITA 40 MG/0.8 ML SYRINGE
43148	ILARIS 150MG/ML VIAL
44553	ILUMYA 100 MG/ML SYRINGE
43223	KEVZARA 150 MG/1.14 ML SYRINGE
43224	KEVZARA 200 MG/1.14 ML SYRINGE
44269	KEVZARA 150 MG/1.14 ML PEN INJ
44277	KEVZARA 200 MG/1.14 ML PEN INJ

Cytokine and CAM Antagonists	
GCN	**Label Name**
14867	KINERET 100MG/0.67ML SYRINGE
47205	OLUMIANT 1 MG TABLET
43468	OLUMIANT 2 MG TABLET
30289	ORENCIA 125 MG/ML SYRINGE
41656	ORENCIA CLICKJECT 125MG/ML
43389	ORENCIA 50 MG/0.4 ML SYRINGE
43397	ORENCIA 87.5 MG/0.7 ML SYRINGE
36172	OTEZLA 30 MG TABLET
37765	OTEZLA 28 DAY STARTER PACK
46822	RINVOQ ER 15 MG TABLET
51719	RINVOQ ER 30 MG TABLET
52085	RINVOQ ER 45 MG TABLET
43055	SILIQ 210 MG/1.5 ML SYRINGE
35001	SIMPONI 100 MG/ML PEN INJECTOR
34697	SIMPONI 100 MG/ML SYRINGE
22533	SIMPONI 50 MG/0.5 ML PEN INJECTOR
22536	SIMPONI 50MG/0.5 ML SYRINGE
34983	SIMPONI ARIA 50 MG/4 ML VIAL
46215	SKYRIZI 150 MG DOSE KIT – 2 SYRN
49617	SKYRIZI 150 MG/ML SYRINGE
49591	SKYRIZI 150 MG/ML PEN
53397	SKYRIZI 180 MG/1.2 ML ON-BODY
52475	SKYRIZI 360 MG/2.4 ML ON-BODY
52879	SOTYKTU 6 MG TABLET

Cytokine and CAM Antagonists	
GCN	**Label Name**
28158	STELARA 45 MG/0.5 ML SYRINGE
19903	STELARA 45 MG/0.5 ML VIAL
28159	STELARA 90 MG/ML SYRINGE
40848	TALTZ 80 MG/ML AUTOINJECTOR (3-PK)
40848	TALTZ 80 MG/ML AUTOINJECTOR
40848	TALTZ 80 MG/ML AUTOIN (2-PK)
40849	TALTZ 80 MG/ML SYRINGE
43612	TREMFYA 100 MG/ML SYRINGE
46024	TREMFYA 100 MG/ML INJECTOR
48684	XELJANZ 1 MG/ML SOLUTION
33617	XELJANZ 5 MG TABLET
44882	XELJANZ 10 MG TABLET
38086	XELJANZ XR 11 MG TABLET

Strong CYP3A4 Inducer	
GCN	**Label Name**
25445	ACTOPLUS MED 15-850MG TABLET
25444	ACTOPLUS MET 15-500MG TABLET
28620	ACTOPLUS MET XR 15-1000MG TABLET
28622	ACTOPLUS MET XR 30-1000MG TABLET
92991	ACTOS 15MG TABLET
93001	ACTOS 30MG TABLET
93011	ACTOS 45MG TABLET
36098	APTIOM 200MG TABLET

Strong CYP3A4 Inducer	
GCN	**Label Name**
36099	APTIOM 400MG TABLET
36106	APTIOM 600MG TABLET
27409	APTIOM 800MG TABLET
27346	ATRIPLA TABLET
92373	BEXAROTENE 75MG CAPSULE
17460	CARBAMAZEPINE 100 MG TAB CHEW
47500	CARBAMAZEPINE 100 MG/5 ML SUSP
17450	CARBAMAZEPINE 200 MG TABLET
23934	CARBAMAZEPINE ER 100 MG CAP
23932	CARBAMAZEPINE ER 200 MG CAP
27821	CARBAMAZEPINE ER 200 MG TABLET
23933	CARBAMAZEPINE ER 300 MG CAP
27822	CARBAMAZEPINE ER 400 MG TABLET
23934	CARBATROL ER 100 MG CAPSULE
23932	CARBATROL ER 200 MG CAPSULE
23933	CARBATROL ER 300 MG CAPSULE
17700	DILANTIN 100 MG CAPSULE
17241	DILANTIN 125 MG/5 ML SUSP
17701	DILANTIN 30 MG CAPSULE
17250	DILANTIN 50 MG INFATAB
97181	DUETACT 30-2MG TABLET
97180	DUETACT 30-4MG TABLET
17450	EPITOL 200 MG TABLET
13781	EQUETRO 100 MG CAPSULE

Strong CYP3A4 Inducer	
GCN	**Label Name**
13805	EQUETRO 200 MG CAPSULE
13818	EQUETRO 300 MG CAPSULE
99318	INTELENCE 100MG TABLET
29424	INTELENCE 200MG TABLET
32035	INTELENCE 25MG TABLET
37810	LYSODREN 500MG TABLET
26101	MODAFINIL 100MG TABLET
26102	MODAFINIL 200MG TABLET
29810	MYCOBUTIN 150 MG CAPSULE
17321	MYSOLINE 250MG TABLET
17322	MYSOLINE 50MG TABLET
31420	NEVIRAPINE 200MG TABLET
31421	NEVIRAPINE 50MG/5ML SUSPENSION
29767	NEVIRAPINE ER 400MG TABLET
42366	ORKAMBI 100-125MG TABLET
39008	ORKAMBI 200-125MG TABLET
34080	OSENI 12.5-15MG TABLET
34083	OSENI 12.5-30MG TABLET
34084	OSENI 12.5-45MG TABLET
34077	OSENI 25-15MG TABLET
34078	OSENI 25-30MG TABLET
34079	OSENI 25-45MG TABLET
12975	PHENOBARBITAL 100 MG TABLET
12892	PHENOBARBITAL 130 MG/ML VIAL

Strong CYP3A4 Inducer	
GCN	**Label Name**
12971	PHENOBARBITAL 15 MG TABLET
97706	PHENOBARBITAL 16.2 MG TABLET
12956	PHENOBARBITAL 20 MG/5 ML ELIX
12973	PHENOBARBITAL 30 MG TABLET
97965	PHENOBARBITAL 32.4 MG TABLET
12972	PHENOBARBITAL 60 MG TABLET
97966	PHENOBARBITAL 64.8 MG TABLET
12894	PHENOBARBITAL 65 MG/ML VIAL
97967	PHENOBARBITAL 97.2 MG TABLET
15038	PHENYTEK 200 MG CAPSULE
15037	PHENYTEK 300 MG CAPSULE
17241	PHENYTOIN 125 MG/5 ML SUSP
17250	PHENYTOIN 50 MG TABLET CHEW
17200	PHENYTOIN 50 MG/ML VIAL
17700	PHENYTOIN SOD EXT 100 MG CAP
15038	PHENYTOIN SOD EXT 200 MG CAP
15037	PHENYTOIN SOD EXT 300 MG CAP
92991	PIOGLITAZONE HCL 15 MG TABLET
93001	PIOGLITAZONE HCL 30 MG TABLET
93011	PIOGLITAZONE HCL 45 MG TABLET
97181	PIOGLITAZONE-GLIMEPIRIDE 30-2
97180	PIOGLITAZONE-GLIMEPIRIDE 30-4
25444	PIOGLITAZONE-METFORMIN 15-500
25445	PIOGLITAZONE-METFORMIN 15-850

Strong CYP3A4 Inducer	
GCN	**Label Name**
45911	PRIFTIN 150MG TABLET
17321	PRIMIDONE 250MG TABLET
17322	PRIMIDONE 50MG TABLET
26101	PROVIGIL 100MG TABLET
26102	PROVIGIL 200MG TABLET
29810	RIFABUTIN 150 MG CAPSULE
41260	RIFADIN 150 MG CAPSULE
41261	RIFADIN 300 MG CAPSULE
41470	RIFADIN IV 600 MG VIAL
89800	RIFAMATE CAPSULE
41260	RIFAMPIN 150 MG CAPSULE
41261	RIFAMPIN 300 MG CAPSULE
41470	RIFAMPIN IV 600 MG VIAL
14142	RIFATER TABLET
43303	SUSTIVA 200MG CAPSULE
43301	SUSTIVA 50MG CAPSULE
15555	SUSTIVA 600MG TABLET
34723	TAFINLAR 50MG CAPSULE
34724	TAFINLAR 75MG CAPSULE
92373	TARGRETIN 75MG CAPSULE
47500	TEGRETOL 100 MG/5 ML SUSP
17450	TEGRETOL 200 MG TABLET
27820	TEGRETOL XR 100 MG TABLET
27821	TEGRETOL XR 200 MG TABLET

Strong CYP3A4 Inducer	
GCN	**Label Name**
27822	TEGRETOL XR 400 MG TABLET
14979	TRACLEER 125MG TABLET
14978	TRACLEER 62.5MG TABLET
31420	VIRAMUNE 200MG TABLET
31421	VIRAMUNE 50MG/5ML SUSPENSION
30935	VIRAMUNE XR 100MG TABLET
29767	VIRAMUNE XR 400MG TABLET
33183	XTANDI 40MG CAPSULE

DMARDs	
GCN	**Label Name**
67031	ARAVA 10 MG TABLET
67032	ARAVA 20 MG TABLET
46771	AZATHIOPRINE 50 MG TABLET
41611	AZULFIDINE 500 MG TABLET
41620	AZULFIDINE ENTAB 500 MG
13910	CYCLOSPORINE 100 MG CAPSULE
13917	CYCLOSPORINE 100 MG/ML
13911	CYCLOSPORINE 25 MG CAPSULE
13919	CYCLOSPORINE MODIFIED 100 MG
13918	CYCLOSPORINE MODIFIED 25 MG
13916	CYCLOSPORINE MODIFIED 50 MG
13919	GENGRAF 100 MG CAPSULE
13917	GENGRAF 100 MG/ML SOLN

DMARDs	
GCN	**Label Name**
13918	GENGRAF 25 MG CAPSULE
13916	GENGRAF 50 MG CAPSULE
42940	HYDROXYCHLOROQUINE 200 MG TABLET
46771	IMURAN 50 MG TABLET
67031	LEFLUNOMIDE 10 MG TABLET
67032	LEFLUNOMIDE 20 MG TABLET
38489	METHOTREXATE 2.5 MG TABLET
38466	METHOTREXATE 50 MG/ 2 ML VIAL
18936	METHOTREXATE 50 MG/2 ML VIAL
13919	NEORAL 100 MG CAPSULE
13917	NEORAL 100 MG/ML SOLN
13918	NEORAL 25 MG CAPSULE
35427	OTREXUP 10 MG/0.4 ML AUTO-INJ
35428	OTREXUP 15 MG/0.4 ML AUTO-INJ
35437	OTREXUP 20 MG/0.4 ML AUTO-INJ
35438	OTREXUP 25 MG/0.4 ML AUTO-INJ
42940	PLAQUENIL 200 MG TABLET
13910	SANDIMMUNE 100 MG CAPSULE
08220	SANDIMMUNE 100 MG/ML SOLN
13911	SANDIMMUNE 25 MG CAPSULE
41611	SULFASALAZINE 500 MG TABLET
41620	SULFASALAZINE DR 500 MG TABLET
06484	TREXALL 10MG TABLET
13135	TREXALL 15MG TABLET

DMARDs	
GCN	**Label Name**
13134	TREXALL 5MG TABLET
38485	TREXALL 7.5MG TABLET
43319	XATMEP 2.5MG/ML ORAL SOLUTION

Enbrel – Contraindicated Drugs	
GCN	**Label Name**
35317	CYCLOPHOSPHAMIDE 25 MG CAPSULE
35318	CYCLOPHOSPHAMIDE 50 MG CAPSULE
14867	KINERET 100 MG/0.67 ML SYRINGE
30289	ORENCIA 125 MG/ML SYRINGE

Enspryng – Duplicate Therapy	
GCN	**Label Name**
35486	ACTEMRA 162MG/0.9ML SYRINGE
45082	ACTEMRA ACTPEN 162 MG/0.9 ML
33262	AUBAGIO 14 MG TABLET
33259	AUBAGIO 7 MG TABLET
30222	AVONEX PEN 30 MCG/0.5 ML KIT
20147	AVONEX PREFILLED SYR 30 MCG KIT
48156	BAFIERTAM DR 95 MG CAPSULE
98376	BETASERON 0.3 MG KIT
17178	COPAXONE 20 MG/ML SYRINGE
35983	COPAXONE 40 MG/ML SYRINGE
34433	DIMETHYL FUMARATE 30D START PK

Enspryng – Duplicate Therapy	
GCN	**Label Name**
34434	DIMETHYL FUMARATE DR 120 MG CP
34435	DIMETHYL FUMARATE DR 240 MG CP
98376	EXTAVIA 0.3 MG KIT
29073	GILENYA 0.5 MG CAPSULE
17178	GLATIRAMER 20 MG/ML SYRINGE
35983	GLATIRAMER 40 MG/ML SYRINGE
17178	GLATOPA 20 MG/ML SYRINGE
35983	GLATOPA 40 MG/ML SYRINGE
48513	KESIMPTA 20 MG/0.4 ML PEN
44269	KEVZARA 150 MG/1.14 ML PEN INJ
43223	KEVZARA 150 MG/1.14 ML SYRINGE
44277	KEVZARA 200 MG/1.14 ML PEN INJ
43224	KEVZARA 200 MG/1.14 ML SYRINGE
46135	MAYZENT 0.25 MG STARTER PACK
46134	MAYZENT 0.25 MG TABLET
46133	MAYZENT 2 MG TABLET
07544	MITOXANTRONE 20 MG/10 ML VL
07544	MITOXANTRONE 25 MG/12.5 ML VL
07544	MITOXANTRONE 30 MG/15 ML VL
36958	PLEGRIDY 125 MCG/0.5 ML PEN
36948	PLEGRIDY 125 MCG/0.5 ML SYRINGE
36956	PLEGRIDY PEN INJ STARTER PACK
36947	PLEGRIDY SYRINGE STARTER PACK
15914	REBIF 22 MCG/0.5 ML SYRINGE

Enspryng – Duplicate Therapy	
GCN	**Label Name**
15918	REBIF 44 MCG/0.5 ML SYRINGE
34167	REBIF REBIDOSE 22 MCG/0.5 ML
34168	REBIF REBIDOSE 44 MCG/0.5 ML
34166	REBIF REBIDOSE TITRATION PACK
24286	REBIF TITRATION PACK
70151	RITUXAN 100MG/10ML VIAL
70151	RITUXAN 500MG/50ML VIAL
46734	RUXIENCE 100MG/10ML VIAL
46734	RUXIENCE 500MG/50ML VIAL
98255	SOLIRIS 300MG/30ML VIAL
34434	TECFIDERA DR 120 MG CAPSULE
34435	TECFIDERA DR 240 MG CAPSULE
34433	TECFIDERA STARTER PACK
45822	TRUXIMA 100MG/10ML VIAL
45822	TRUXIMA 500MG/50ML VIAL
48233	UPLIZNA 100MG/10ML VIAL
47209	VUMERITY DR 230 MG CAPSULE
47864	ZEPOSIA 0.23-0.46 MG START PCK
47865	ZEPOSIA 0.23-0.46-0.92 MG KIT
47863	ZEPOSIA 0.92 MG CAPSULE

IL-1 inhibitor	
GCN	**Label Name**
99473	ARCALYST 220 MG INJECTION

IL-1 inhibitor	
GCN	**Label Name**
43148	ILARIS 150MG/ML VIAL
27445	ILARIS 180MG VIAL

IL-17 inhibitor	
GCN	**Label Name**
37789	COSENTYX 150MG/ML PEN INJECT
37788	COSENTYX 150MG/ML SYRINGE
40848	TALTZ 80 MG/ML AUTOINJ (3-PK)
40848	TALTZ 80 MG/ML AUTOINJECTOR
40848	TALTZ 80 MG/ML AUTOINJ (2-PK)
40849	TALTZ 80 MG/ML SYRINGE
55341	TALTZ 20 MG/0.25 ML SYRINGE
55342	TALTZ 40 MG/ 0.5 ML SYRINGE
40849	TALTZ 80 MG/ML SYRINGE

JAK Inhibitors	
GCN	**Label Name**
51827	CIBINQO 100 MG TABLET
51828	CIBINQO 200 MG TABLET
51825	CIBINQO 50 MG TABLET
30893	JAKAFI 10 MG TABLET
30894	JAKAFI 15 MG TABLET
30895	JAKAFI 20 MG TABLET
30896	JAKAFI 25 MG TABLET

JAK Inhibitors	
GCN	**Label Name**
30892	JAKAFI 5 MG TABLET
47205	OLUMIANT 1 MG TABLET
43468	OLUMIANT 2 MG TABLET
46822	RINVOQ ER 15 MG TABLET
48684	XELJANZ 1 MG/ML SOLUTION
44882	XELJANZ 10 MG TABLET
33617	XELJANZ 5 MG TABLET
38086	XELJANZ XR 11 MG TABLET

Potent Immunosuppressants*	
GCN	**Label Name**
98662	ASTAGRAF XL 0.5 MG CAPSULE
98663	ASTAGRAF XL 1 MG CAPSULE
98664	ASTAGRAF XL 5 MG CAPSULE
46771	AZATHIOPRINE 50 MG TABLET
47563	CELLCEPT 200 MG/ML ORAL SUSP
13910	CYCLOSPORINE 100 MG CAPSULE
13917	CYCLOSPORINE 100 MG/ML
13911	CYCLOSPORINE 25 MG CAPSULE
13919	CYCLOSPORINE MODIFIED 100 MG
13918	CYCLOSPORINE MODIFIED 25 MG
13916	CYCLOSPORINE MODIFIED 50 MG
13919	GENGRAF 100 MG CAPSULE
13917	GENGRAF 100 MG/ML SOLN

Potent Immunosuppressants*	
GCN	**Label Name**
13918	GENGRAF 25 MG CAPSULE
13916	GENGRAF 50 MG CAPSULE
46771	IMURAN 50 MG TABLET
47560	MYCOPHENOLATE 250 MG CAPSULE
47561	MYCOPHENOLATE 500 MG TABLET
19646	MYCOPHENOLIC ACID DR 180 MG TAB
19647	MYCOPHENOLIC ACID DR 360 MG TAB
13919	NEORAL 100 MG CAPSULE
13917	NEORAL 100 MG/ML SOLN
13918	NEORAL 25 MG CAPSULE
13910	SANDIMMUNE 100 MG CAPSULE
08220	SANDIMMUNE 100 MG/ML SOLN
13911	SANDIMMUNE 25 MG CAPSULE
28495	TACROLIMUS 0.5 MG CAPSULE
28491	TACROLIMUS 1 MG CAPSULE
28492	TACROLIMUS 5 MG CAPSULE
*Potent immunosuppressants also include clients who have ≥ 14 days therapy with doses ≥ 80 mg per day of prednisone. Equivalent doses include ≥ 400 mg/day cortisone, 320 mg/day hydrocortisone, 80 mg/day prednisolone, 64 mg/day methylprednisolone and 12 mg/day dexamethasone.	

JAK inhibitors	
GCN	**Label Name**
30893	JAKAFI 10 MG TABLET
30894	JAKAFI 15 MG TABLET
30895	JAKAFI 20 MG TABLET

JAK inhibitors	
GCN	**Label Name**
30896	JAKAFI 25 MG TABLET
30892	JAKAFI 5 MG TABLET
47205	OLUMIANT 1 MG TABLET
43468	OLUMIANT 2 MG TABLET
46822	RINVOQ ER 15 MG TABLET
48684	XELJANZ 1 MG/ML SOLUTION
33617	XELJANZ 5 MG TABLET
44882	XELJANZ 10 MG TABLET
38086	XELJANZ XR 11 MG TABLET

Methotrexate	
GCN	**Label Name**
38489	METHOTREXATE 2.5 MG TABLET
38466	METHOTREXATE 50 MG/ 2 ML VIAL
18936	METHOTREXATE 50 MG/2 ML VIAL
35427	OTREXUP 10 MG/0.4 ML AUTO-INJ
35428	OTREXUP 15 MG/0.4 ML AUTO-INJ
35437	OTREXUP 20 MG/0.4 ML AUTO-INJ
35438	OTREXUP 25 MG/0.4 ML AUTO-INJ
06484	TREXALL 10MG TABLET
13135	TREXALL 15MG TABLET
13134	TREXALL 5MG TABLET
38485	TREXALL 7.5MG TABLET
43319	XATMEP 2.5MG/ML ORAL SOLUTION

Simponi – Contraindicated drugs	
GCN	**Label Name**
56164	ADALIMUMAB-AACF (CF) SYR 40 MG
53875	ADALIMUMAB-ADAZ (CF) PEN 40 MG
53884	ADALIMUMAB-ADAZ(CF) 40 MG SYRNG
55665	ADALIMUMAB-ADBM (CF) 40 MG SYRNG
55668	ADALIMUMAB-ADBM (CF) CRHN 40 MG
55668	ADALIMUMAB-ADBM (CF) PEN 40 MG
55668	ADALIMUMAB-ADBM (CF) PEN PSORIA-UV 40 MG
48318	ADALIMUMAB-FKJP (CF) 20 MG SYRG
48336	ADALIMUMAB-FKJP (CF) 40 MG SYRG
48317	ADALIMUMAB-FKJP (CF) PEN 40 MG
55332	ADALIMUMAB-RYVK (CF) AI 40 MG
56016	ADALIMUMAB-RYVK (CF) 40 MG SYRG
54007	AMJEVITA 10 MG/0.2 ML SYRINGE
42592	AMJEVITA 20 MG/0.4 ML SYRINGE
42639	AMJEVITA 40 MG/0.8 ML AUTOINJ
42637	AMJEVITA 40 MG/0.8 ML SYRINGE
23471	CIMZIA 200MG/ML STARTER KIT
23471	CIMZIA 200MG/ML SYRINGE KIT
53841	CYLTEZO (CF) 10 MG/0.2 ML SYRNG
53842	CYLTEZO (CF) 20 MG/0.4 ML SYRNG
55665	CYLTEZO (CF) 40 MG/0.4 ML SYRNG
43789	CYLTEZO (CF) 40 MG/0.8 ML SYRNG
55668	CYLTEZO (CF) PEN CRH-UC-HS 40 MG
55668	CYLTEZO (CF) PEN PSORIA-UV 40 MG

Simponi – Contraindicated drugs	
GCN	**Label Name**
55668	CYLTEZO (CF) PEN 40 MG/0.4 ML
54205	CYLTEZO (CF) PEN 40 MG/0.8 ML
54205	CYLTEZO (CF) PEN CRH-UC-HS 40 MG
54205	CYLTEZO (CF) PEN PSORIA-UV 40 MG
53846	HADLIMA (CF) 40 MG/0.4 ML SYRNG
53848	HADLIMA (CF) PUSHTOUCH 40MG/0.4
46718	HADLIMA 40 MG/0.8 ML SYRINGE
46717	HADLIMA PUSHTOUCH 40 MG/0.8 ML
48318	HULIO (CF) 20 MG/0.4 ML SYRINGE
48336	HULIO (CF) 40MG/0.8 ML SYRINGE
48317	HULIO (CF) PEN 40 MG/0.8 ML
55235	HULIO (CF) 20 MG/0.4 ML SYRINGE
55694	HULIO (CF) 40MG/0.8 ML SYRINGE
55693	HULIO (CF) PEN 40 MG/0.8 ML
44659	HUMIRA (CF) 10 MG/0.1 ML SYRINGE
44664	HUMIRA (CF) 20 MG/0.2 ML SYRINGE
43505	HUMIRA (CF) 40 MG/0.4 ML SYRINGE
43506	HUMIRA PEN 40 MG/0.4 ML
43904	HUMIRA (CF) PEDI CROHN 80 MG/0.8
44677	HUMIRA (CF) PEDI CROHN 80-40MG
44014	HUMIRA (CF) PEN CRHN-UC-HS 80 MG
44014	HUMIRA (CF) PEN PEDI UC 80 MG
44954	HUMIRA (CF) PEN PS-UV-AHS 80-40 MG
37262	HUMIRA 10 MG/0.2 ML SYRINGE

Simponi – Contraindicated drugs	
GCN	**Label Name**
99439	HUMIRA 20 MG/0.4 ML SYRINGE
18924	HUMIRA 40 MG/0.8 ML SYRINGE
97005	HUMIRA PEN 40 MG/0.8 ML
97005	HUMIRA PEN CROHN-UC-HS 40 MG
97005	HUMIRA PEN PS-UV-ADOL HS 40 MG
18924	HUMIRA PEDI CROHN 40 MG/0.8 ML
53885	HYRIMOZ (CF) 10 MG/0.1 ML SYRNG
53883	HYRIMOZ (CF) 20 MG/0.2 ML SYRNG
53884	HYRIMOZ (CF) 40 MG/0.4 ML SYRNG
53899	HYRIMOZ (CF) PEDI CROHN 80 MG
53891	HYRIMOZ (CF) PEDI CROHN 80-40 MG
53875	HYRIMOZ (CF) PEN 40 MG/0.4 ML
53887	HYRIMOZ (CF) PEN 80 MG/0.8 ML
53887	HYRIMOZ (CF) PEN CROHN-UC 80 MG
53878	HYRIMOZ (CF) PEN PSORIA 80-40 MG
53387	IDACIO (CF) PEN 40 MG/0.8 ML
53387	IDACIO (CF) PEN PSORIASIS 40 MG
53387	IDACIO (CF) PEN CROHNS-UC 40 MG
53386	IDACIO (CF) 40 MG/0.8 ML SYRINGE
56152	IDACIO (CF) PEN 40 MG/0.8 ML
14867	KINERET 100MG/0.67ML SYRINGE
30289	ORENCIA 125MG/ML SYRINGE
43389	ORENCIA 50MG/0.4ML SYRINGE
43397	ORENCIA 87.5MG/0.7ML SYRINGE

Simponi – Contraindicated drugs	
GCN	**Label Name**
41656	ORENCIA CLICKJECT 125MG/ML
55332	SIMLANDI (CF) AI 40 MG/0.4 ML
57361	SIMLANDI (CF) AI 80 MG/0.8 ML
56047	SIMLANDI (CF) 20 MG/0.2 ML SYRG
56048	SIMLANDI (CF) 80 MG/0.8 ML SYRG
22536	SIMPONI 50MG/0.5ML SYRINGE
34983	SIMPONI ARIA 50MG/4ML VIAL

TNF Blocker	
GCN	**Label Name**
56164	ADALIMUMAB-AACF (CF) SYR 40 MG
53875	ADALIMUMAB-ADAZ (CF) PEN 40 MG
53884	ADALIMUMAB-ADAZ(CF) 40 MG SYRNG
48318	ADALIMUMAB-FKJP (CF) 20 MG SYRG
48336	ADALIMUMAB-FKJP (CF) 40 MG SYRG
48317	ADALIMUMAB-FKJP (CF) PEN 40 MG
55665	ADALIMUMAB-ADBM (CF) 40 MG SYRNG
55668	ADALIMUMAB-ADBM (CF) CRHN 40 MG
55668	ADALIMUMAB-ADBM (CF) PEN 40 MG
55668	ADALIMUMAB-ADBM (CF) PEN PSORIA-UV 40 MG
55332	ADALIMUMAB-RYVK (CF) AI 40 MG
56016	ADALIMUMAB-RYVK (CF) 40 MG SYRG
53884	ADALIMUMAB-ADAZ (CF) 40 MG SYRNG
54007	AMJEVITA 10 MG/0.2 ML SYRINGE

TNF Blocker	
GCN	**Label Name**
42592	AMJEVITA 20 MG/0.4 ML SYRINGE
42639	AMJEVITA 40 MG/0.8 ML AUTOINJ
42637	AMJEVITA 40 MG/0.8 ML SYRINGE
23471	CIMZIA 200MG/ML STARTER KIT
23471	CIMZIA 200MG/ML SYRINGE KIT
53841	CYLTEZO (CF) 10 MG/0.2 ML SYRNG
53842	CYLTEZO (CF) 20 MG/0.4 ML SYRNG
43789	CYLTEZO (CF) 40 MG/0.8 ML SYRNG
54205	CYLTEZO (CF) PEN 40 MG/0.8 ML
54205	CYLTEZO (CF) PEN CRH-UC-HS 40 MG
54205	CYLTEZO (CF) PEN PSORIA-UV 40 MG
55665	CYLTEZO (CF) 40 MG/0.4 ML SYRNG
55668	CYLTEZO (CF) PEN 40 MG/0.4 ML
55668	CYLTEZO (CF) PEN CRH-UC-HS 40 MG
55668	CYLTEZO (CF) PEN PSORIA-UV 40 MG
52651	ENBREL 25 MG KIT
23574	ENBREL 50 MG/ML SYRINGE
97724	ENBREL 50 MG/ML SURECLICK SYR
98398	ENBREL 25 MG/0.5 ML SYRINGE
43924	ENBREL 50 MG/ML MINI CARTRIDGE
48417	ENBREL 25 MG/0.5 ML VIAL
53846	HADLIMA (CF) 40 MG/0.4 ML SYRNG
53848	HADLIMA (CF) PUSHTOUCH 40MG/0.4
46718	HADLIMA 40 MG/0.8 ML SYRINGE

TNF Blocker	
GCN	**Label Name**
46717	HADLIMA PUSHTOUCH 40 MG/0.8 ML
48318	HULIO (CF) 20 MG/0.4 ML SYRINGE
48336	HULIO (CF) 40MG/0.8 ML SYRINGE
48317	HULIO (CF) PEN 40 MG/0.8 ML
55235	HULIO (CF) 20 MG/0.4 ML SYRINGE
55694	HULIO (CF) 40MG/0.8 ML SYRINGE
55693	HULIO (CF) PEN 40 MG/0.8 ML
44659	HUMIRA (CF) 10 MG/0.1 ML SYRINGE
44664	HUMIRA (CF) 20 MG/0.2 ML SYRINGE
43505	HUMIRA (CF) 40 MG/0.4 ML SYRINGE
43506	HUMIRA PEN 40 MG/0.4 ML
43904	HUMIRA (CF) PEDI CROHN 80 MG/0.8
44677	HUMIRA (CF) PEDI CROHN 80-40MG
44014	HUMIRA (CF) PEN CRHN-UC-HS 80 MG
44014	HUMIRA (CF) PEN PEDI UC 80 MG
44954	HUMIRA (CF) PEN PS-UV-AHS 80-40 MG
37262	HUMIRA 10 MG/0.2 ML SYRINGE
99439	HUMIRA 20 MG/0.4 ML SYRINGE
18924	HUMIRA 40 MG/0.8 ML SYRINGE
97005	HUMIRA PEN 40 MG/0.8 ML
97005	HUMIRA PEN CROHN-UC-HS 40 MG
97005	HUMIRA PEN PS-UV-ADOL HS 40 MG
18924	HUMIRA PEDI CROHN 40 MG/0.8 ML
53885	HYRIMOZ (CF) 10 MG/0.1 ML SYRNG

TNF Blocker	
GCN	**Label Name**
53883	HYRIMOZ (CF) 20 MG/0.2 ML SYRNG
53884	HYRIMOZ (CF) 40 MG/0.4 ML SYRNG
53899	HYRIMOZ (CF) PEDI CROHN 80 MG
53891	HYRIMOZ (CF) PEDI CROHN 80-40 MG
53875	HYRIMOZ (CF) PEN 40 MG/0.4 ML
53887	HYRIMOZ (CF) PEN 80 MG/0.8 ML
53887	HYRIMOZ (CF) PEN CROHN-UC 80 MG
53878	HYRIMOZ (CF) PEN PSORIA 80-40 MG
53387	IDACIO (CF) PEN 40 MG/0.8 ML
53387	IDACIO (CF) PEN PSORIASIS 40 MG
53387	IDACIO (CF) PEN CROHNS-UC 40 MG
53386	IDACIO (CF) 40 MG/0.8 ML SYRINGE
56152	IDACIO (CF) PEN 40 MG/0.8 ML
55332	SIMLANDI (CF) AI 40 MG/0.4 ML
57361	SIMLANDI (CF) AI 80 MG/0.8 ML
56047	SIMLANDI (CF) 20 MG/0.2 ML SYRG
56048	SIMLANDI (CF) 80 MG/0.8 ML SYRG
35001	SIMPONI 100MG/ML PEN INJECTOR
34697	SIMPONI 100MG/ML SYRINGE
22533	SIMPONI 50MG/0.5ML PEN INJECTOR
22536	SIMPONI 50MG/0.5ML SYRINGE
34983	SIMPONI ARIA 50MG/4ML VIAL

TNF Blocker (excluding adalimumab)	
GCN	**Label Name**
23471	CIMZIA 200MG/ML STARTER KIT
23471	CIMZIA 200MG/ML SYRINGE KIT
52651	ENBREL 25 MG KIT
23574	ENBREL 50 MG/ML SYRINGE
97724	ENBREL 50 MG/ML SURECLICK SYR
98398	ENBREL 25 MG/0.5 ML SYRINGE
43924	ENBREL 50 MG/ML MINI CARTRIDGE
48417	ENBREL 25 MG/0.5 ML VIAL
35001	SIMPONI 100MG/ML PEN INJECTOR
34697	SIMPONI 100MG/ML SYRINGE
22533	SIMPONI 50MG/0.5ML PEN INJECTOR
22536	SIMPONI 50MG/0.5ML SYRINGE
34983	SIMPONI ARIA 50MG/4ML VIAL

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Publication History

The Publication History records the publication iterations and revisions to this document. Notes for the *most current revision* are also provided in the Revision Notes on the first page of this document.

Publication Date	Notes
11/20/2014	• Presented to the DUR Board
11/25/2014	• Initial publication and posting to website
07/31/2015	• Review and update of ICD-9 and ICD-10 codes
02/25/2016	• Review and update ICD-10s and GCNs
05/12/2017	• Drugs Requiring PA - Added GCN for Ilaris 150mg/mL vial • Criteria Logic and Logic Diagram - Added TRAPS, HIDS/MKD and FMF diagnoses for children ≥ 2 years of age • Added ICD-9/10s for TRAPS, HIDS/MKD and FMF • Added GCNs for Cimzia Starter Kit, Humira Pen Psoriasis-Uveitis, Inflectra
07/18/2017	• Drugs Requiring PA - Added GCN for Xeljanz XR 11 mg tablet
09/11/2017	Actemra: • Added GCA as a diagnosis to criteria logic and logic diagram • Added Table for GCA ICD-10 codes • Updated DMARD table • Updated active infection table Cimzia: • Added question 7 (therapy with a contraindicated drug) to criteria logic and logic diagram • Updated demyelinating disease, heart failure and active infection table • Added table for contraindicated drugs Enbrel: • Added criteria logic and logic diagram • Added supporting tables for criteria Humira:

Publication Date	Notes
	• Added criteria logic and logic diagram • Added supporting tables for criteria Orencia: • Updated age for PJIA/SJIA in criteria logic and logic diagram Simponi: • Added question 9 (therapy with a contraindicated drug) to criteria logic and logic diagram • Updated methotrexate table • Added contraindicated drug table Stelara: • Added question 3 (check for Crohn's disease) and question 4 (history of prior therapy) to criteria logic and logic diagram • Added Crohn's disease diagnosis table • Added table containing conventional therapy for Crohn's disease Xeljanz: • Updated methotrexate table • Updated methotrexate/DMARD table • Updated biologic DMARD/potent immunosuppressant table • Updated References
11/16/2017	• Added criteria for Arcalyst, Kevzara, Otezla, Siliq, Taltz and Tremfya - Clinical PA criteria were approved for these agents at the November 2017 DUR Board meeting • Added ICD-9s and ICD-10s for uveitis for Humira • Added new GCNs for Orencia • Added psoriatic arthritis as an indication for Orencia
11/30/2017	• Updated Humira contraindicated drug table • Updated Simponi contraindicated drug table
03/19/2018	• Added cytokine release syndrome (CRS) to question 5 on the logic and logic diagram • Added CRS to diagnosis table
05/18/2018	• Added indication for plaque psoriasis in patients 12 and older to Stelara criteria

Publication Date	Notes
08/23/2018	• Added indication for psoriatic arthritis and ulcerative colitis to Xeljanz criteria logic and logic diagram, pages • Added table containing diagnosis codes for psoriatic arthritis and ulcerative colitis and table for methotrexate/DMARD GCNs • Updated references
10/17/2018	• Updated GCNs for Enbrel and Humira • Added diagnosis of psoriatic arthritis to Taltz criteria • Updated references
11/29/2018	• Removed Arcalyst criteria – drug is currently not on formulary • Added indication for plaque psoriasis to Cimzia criteria • Updated age check for Humira for hidradenitis suppurativa and uveitis • Added new Kevzara GCNs to Drugs Requiring PA • Added new Xeljanz GCN to Drugs Requiring PA • Added GCNs to biologic DMARDs table • Updated references
02/05/2019	• Added criteria for Olumiant • Updated references
03/20/2019	• Separated psoriatic arthritis and plaque psoriasis diagnoses for Stelara criteria
03/27/2019	• Updated to include formulary statement (The listed GCNS may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search.) on each ‘Drug Requiring PA’ table
04/30/2019	• Added new indication for Cimzia – updated criteria logic and logic diagram, pages – updated diagnosis table for Cimzia • Added new Humira GCNs to Drugs Requiring Prior Authorization • Added criteria set for Ilumya • Updated references
05/20/2019	• Added new GCN for Actemra in Drugs Requiring PA table
07/30/2019	• Added clinical criteria for Skyrizi as approved by the DUR Board at the July 2019 meeting • Added diagnosis of oral ulcers associated with Behcet’s disease to Otezla criteria logic and logic diagram • Updated Otezla diagnosis talbe

Publication Date	Notes
	• Added new GCN for Tremfya
08/07/2019	• Added GCN for Stelara 45mg vial to drug table
09/16/2019	• Added ankylosing spondylitis to diagnosis table for Taltz
10/30/2019	• Added criteria for Rinvoq as approved by the DUR Board
11/07/2019	• Added ulcerative colitis to Taltz criteria logic and logic diagram
06/26/2020	• Added diagnosis of non-radiographic axial spondyloarthritis to Cosentyx criteria • Updated references
08/27/2020	• Added GCN for Olumiant 1mg to drug table • Updated Taltz age and indications in criteria logic and logic diagram • Updated diagnosis tables for Taltz
10/20/2020	• Updated descriptions for ICD-10 codes for non-radiographic axial spondyloarthritis • Age change to 6 years and older for patients with plaque psoriasis – Stelara criteria logic and logic diagram • Added GCN for Taltz prefilled syringe to drug table • Added diagnosis of psoriatic arthritis – Tremfya criteria logic and logic diagram • Added diagnosis of juvenile idiopathic arthritis – Xeljanz criteria logic and logic diagram • Updated references
02/24/2021	• Removed cytokine releasing syndrome as a diagnosis for Actemra – medication is given by IV infusion for this diagnosis and administered by a healthcare practitioner • Added a check for conventional therapy for clients with a diagnosis of Crohn's disease for Cimzia • Added active Still's disease to criteria logic for Ilaris (diagnosis already included in ICD-10 table) • Added DIRA as an approval diagnosis to Kineret criteria • Updated Simponi Aria criteria: Added PJIA and PsA as approval diagnosis for patients ≥ 2 years of age • For criteria requiring prior use of different therapeutic agent, updated lookback to 180 days if the request is for initial therapy and updated criteria to reflect that prior therapy is not required for continuing therapy • Updated clinical criteria reference tables

Publication Date	Notes
	• Updated references
03/02/2021	• Updated age to ≥ 5 years for ulcerative colitis diagnosis for Humira
04/06/2021	• Added SSc-ILD as an approval diagnosis for Actemra
06/06/2021	• Added GCN for Enbrel vial (48417) to drug table
08/09/2021	• Updated age to ≥ 6 for clients requesting Cosentyx with moderate to severe plaque psoriasis
09/13/2021	• Added GCNs for Skyrizi (49617 and 49591) to drug table
09/21/2021	• Added GCN and criteria for Arcalyst (99473)
09/23/2021	• Added GCN for Xeljanz solution (48684) to drug table
11/16/2021	• Added criteria for Enspryng as approved by the DUR Board
12/02/2021	• Corrected Enbrel logic diagram (Step 6, renumbered and corrected age to 2 years)
12/20/2021	• Updated Xeljanz question 1 (is the client ≥ 2 years of age), so that 'no' leads to a denial
01/14/2022	• Added diagnosis of enthesitis-related arthritis for patients ≥ 4 years for Cosentyx • Added diagnosis of prophylaxis of acute graft versus host disease in patients ≥ 2 years in combination with a calcineurin inhibitor and methotrexate for Orencia • Removed 'moderate to severe' from plaque psoriasis for Otezla • Added diagnosis of psoriatic arthritis, removed check for methotrexate and added check for prior therapy with a TNF-blocker for Rinvoq • Added diagnosis of ankylosing spondylitis, removed check for methotrexate/DMARDs and added check for prior therapy with a TNF-blocker for Xeljanz
01/28/2022	• Added diagnosis of atopic dermatitis and added check for prior therapy with systemic agent for atopic dermatitis for Rinvoq • Added diagnosis of psoriatic arthritis for Skyrizi
04/20/2022	• Added diagnosis of ulcerative colitis for Rinvoq
04/27/2022	• Added criteria for Cibinqo as approved by the DUR Board • Updated systemic therapy list for treatment of atopic dermatitis for Rinvoq to include oral immunomodulators and oral glucocorticoids

Publication Date	Notes
05/23/2022	• Added GCNs for Rinvoq (51719, 52085) to PA table • Added diagnosis of ankylosing spondylitis for Rinvoq • Cibinqo and Rinvoq: clarified prior therapy criteria for clients with atopic dermatitis should be 30 continuous days in the last 90 days • Added renewal step for Cibinqo and Rinvoq – prior therapy requirements are not applicable to renewal requests
08/23/2022	• Added GCN for Cosentyx (49732) to PA table
08/31/2022	• Updated age to 6 years and older for psoriatic arthritis for Stelara
09/19/2022	• Updated age to 2 years and older for psoriatic arthritis for Cosentyx
12/01/2022	• Annual review by staff • Updated references
01/20/2023	• Added diagnosis of alopecia areata for Olumiant
02/13/2023	• Removed check for OAT3 inhibitors for Olumiant and revised check for severe renal impairment (from < 60 mL/min/1.73m3 to < 30 mL/min/1.73m3) per updated prescribing information
03/02/2023	• Updated age to include clients 12 years and older for Cibinqo
04/03/2023	• Added diagnosis of polymyalgia rheumatica for Kevzara • Updated Olumiant question 5, Rinvoq question 9, and Xeljanz question 6 to ask for concurrent therapy with a biological DMARD or potent immunosuppressant
04/28/2023	• Added diagnosis of nr-axSpA in adults to Rinvoq • Added GCNs for Skyrizi on-body cartridges (53397, 52475) to PA drugs • Added diagnosis of Crohn's disease in adults to Skyrizi • Added criteria for Sotyktu as approved by the DUR Board • Added therapy with 14 days or more of greater than 80mg/day prednisone or prednisone equivalent to potent immunosuppressant therapy • Updated references
05/15/2023	• Updated Cibinqo Recommended Dosing Table to "Maximum Recommended Dose" and added maximum recommended dose for CYP2C19 poor metabolizers
05/19/2023	• Added GCNs for Amjevita (42639, 42637, 42592, 54007) • Updated Humira criteria logic and logic diagram to include Amjevita

Publication Date	Notes
06/13/2023	• Added diagnosis of Crohn's disease in adults to Rinvoq
07/19/2023	• Added diagnosis of uveitis for Amjevita • Corrected criteria logic for diagnosis of ulcerative colitis for Amjevita
08/03/2023	• Separated Humira and Amjevita criteria
10/13/2023	• Added criteria for Litfulo as approved by the DUR Board
11/30/2023	• Added GCNs for Cyltezo (53842, 53841, 54205, 43789) to adalimumab biosimilars criteria • Added indication for hidradenitis suppurativa for Cosentyx. • Updated age to 2 years and older for plaque psoriasis for Enbrel • Updated age to 2 years and older for psoriatic arthritis for Orencia
12/18/2023	• Added GCNs for adalimumab-fkjp and Hulio (48317, 48336, 48318) and Hadlima (53848, 46718, 53846, 46717)
01/11/2024	• Corrected Humira criteria logic for Crohn's disease pathway to check for history of conventional therapy
01/26/2024	• Added criteria for Entyvio SC as approved by the DUR Board
01/31/2024	• Added table for conventional therapy for ulcerative colitis
02/13/2024	• Added GCNs for adalimumab-adaz (53875, 53884) and Hyrimoz (53887, 53899, 53875, 53884, 53883, 53885, 53878, 53891)
04/22/2024	• Added GCN for Simlandi (CF) (55332) to Adalimumab Biosimilars Drugs Requiring PA
05/15/2024	• Added GCNs for adalimumab-adaz (53875, 53884), adalimumab-adbm (55665, 55668), adalimumab-ryvk (55332), and Cyltezo (55665, 55668 to Adalimumab Biosimilars Drugs Requiring PA
05/29/2024	• Corrected numbering on criteria logic for Adalimumab Biosimilars
07/03/2024	• Updated GCNs for Hulio: new GCNs (55693, 55235, 55694); old GCNs (48317, 48318, 48336)
07/16/2024	• Updated age for plaque psoriasis to 6 years and older for Otezla
07/25/2024	• Updated Question 1 for Otezla to if no, go to question #3
07/26/2024	• Initial publication and presentation to the DUR Board – criteria for Spevigo and Tyenne • Added refill criteria for Xeljanz

Publication Date	Notes
08/12/2024	• Removed GCN for Skyrizi (46215) – product has been discontinued • Updated Skyrizi criteria logic and diagram step 4 to read 'Is the request for ≤ one 150mg syringe/pen or one 180mg or 360mg cartridge?' • Added diagnosis for Crohn's disease for Entyvio SC
08/16/2024	• Added GCNs for Adalimumab-ryvk (56016), Taltz (55341, 55342), and Otezla (56083, 56084) to Drugs Requiring PA and supporting tables • Added GCNs for adalimumab (55665, 55668, 55332, 56016), Cyltezo (55665, 55668), Hulio (55235, 55694, 55693), and Simlandi (55332) to supporting tables
09/06/2024	• Added GCNs for Idacio (53387, 53386, 56152) and adalimumab-aacf (56164) to Drugs Requiring PA and supporting tables • Updated TNF blocker and Simponi contraindicated drugs table to include adalimumab biosimilars • Added GCNs for Tyenne (55373, 55374) to biologic DMARD supporting table
10/01/2024	• Cimzia: Added diagnosis of polyarticular juvenile idiopathic arthritis (pJIA) for patients 2 years and older • Tremfya: Added diagnosis of ulcerative colitis (UC) in adult patients
10/25/2024	• Added criteria for Bimzelx, Omvoh, and Rinvoq LQ as approved by the DUR Board
11/07/2024	• Updated age for plaque psoriasis for Enbrel to 4 years and older
11/22/2024	• Added GCNs for Cimzia (23471) and Enbrel (52651, 23574, 97724, 98398, 43924, 48417) to TNF blocker (excluding adalimumab) supporting table
02/19/2025	• Updated Stelara (Ustekinumab) to Stelara (Ustekinumab) and Biosimilar Agents • Added GCNs for Simlandi (56047, 56048) to Humira (Adalimumab) and Biosimilar Agents to Drugs Requiring PA table and supporting tables • Added GCNs for Steqeyma (56753, 56754), Yesintek (56599, 56607, 56603), and ustekinumab-ttwe (55956, 55957) to Stelara (Ustekinumab) and Biosimilar Agents Drugs Requiring PA table and supporting tables • Added GCNs for Tremfya (56228, 56229) to Tremfya (Guselkumab) Drugs • Requiring PA table and supporting tables
03/10/2025	• Added GCNs for Selarsdi (55583, 55584) and Otulfi (56286, 56287) to Stelara (Ustekinumab) and Biosimilar Agents Drugs Requiring PA table and supporting tables

Publication Date	Notes
	• Added GCNs for Omvoh (57113, 57114, 57115, 57116) to Omvoh (Mirikizumab-mrkz) Drugs Requiring PA table
04/04/2025	• Added GCN for Simlandi (57361) to Adalimumab Biosimilars Drugs Requiring PA table and supporting tables • Added GCN for Tremfya (57417) to Tremfya Drugs Requiring PA table and supporting tables
04/25/2025	• Added new indication of HS for Bimzelx as approved by the DUR Board • Added new indication for polyarticular juvenile idiopathic arthritis for ages 2-17 years for Kevzara as approved by the DUR Board • Added new indication of Crohn's disease and updated maximum dosage of 900 mg IV on weeks 0, 4, and 8 for Omvoh as approved by the DUR Board • Added new indication for ulcerative colitis in adults for Skyrizi as approved by the DUR Board