



AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name: Enbrel

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Effective Date: 2/1/2024

Last Review Date: 11/2023

Applies to:	<input type="checkbox"/> Illinois	<input type="checkbox"/> Florida	<input type="checkbox"/> Florida Kids
	<input checked="" type="checkbox"/> New Jersey	<input type="checkbox"/> Maryland	<input type="checkbox"/> Michigan
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Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Enbrel under the patient's prescription drug benefit.

Description:

A. FDA-Approved Indications

1. Moderately to severely active rheumatoid arthritis (RA)
2. Moderately to severely active polyarticular juvenile idiopathic arthritis (pJIA) in patients aged 2 years and older
3. Active psoriatic arthritis (PsA)
4. Active ankylosing spondylitis (AS)
5. Chronic moderate to severe plaque psoriasis (PsO) in patients aged 4 years or older who are candidates for systemic therapy or phototherapy. (Reference the Biological Response Modifiers (BRMs) in the Treatment of Plaque Psoriasis NJ Protocol)
6. Juvenile psoriatic arthritis in patients aged 2 years and older (JPsA)

B. Compendial Uses

1. Non-radiographic axial spondyloarthritis
2. Oligoarticular juvenile idiopathic arthritis
3. Reactive arthritis
4. Hidradenitis suppurativa, severe, refractory
5. Behcet's disease
6. Graft versus host disease
7. Immune checkpoint inhibitor toxicity

All other indications are considered experimental/investigational and not medically necessary.

Applicable Drug List:

Preferred: Enbrel

Policy/Guideline:

Documentation:

A. **Rheumatoid arthritis (RA)**

1. For initial requests:
 - i. Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.



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- ii. Laboratory results, chart notes, or medical record documentation of biomarker testing (i.e., rheumatoid factor [RF], anti-cyclic citrullinated peptide [anti-CCP], and C-reactive protein [CRP] and/or erythrocyte sedimentation rate [ESR]) (if applicable).
2. For continuation requests: Chart notes or medical record documentation supporting positive clinical response.

B. Articular juvenile idiopathic arthritis (JIA)

1. Initial requests: Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy.
2. Continuation requests: Chart notes or medical record documentation supporting positive clinical response.

C. Psoriatic arthritis (PsA), ankylosing spondylitis (AS), non-radiographic axial spondyloarthritis (nr-axSpA), reactive arthritis, and hidradenitis suppurativa

1. Initial requests: Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.
2. Continuation requests: Chart notes or medical record documentation supporting positive clinical response.

D. Graft versus host disease and immunotherapy-related inflammatory arthritis (initial requests only): Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.

E. Behcet's disease (initial requests only): Chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy (if applicable).

Prescriber Specialty:

This medication must be prescribed by or in consultation with one of the following:

- A. Rheumatoid arthritis, articular juvenile idiopathic arthritis, ankylosing spondylitis, non-radiographic axial spondyloarthritis, reactive arthritis, and Behcet's disease: rheumatologist
- B. Psoriatic arthritis and hidradenitis suppurativa: rheumatologist or dermatologist
- C. Graft versus host disease: oncologist or hematologist



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- D. Stevens-Johnson syndrome or toxic epidermal necrolysis: oncologist, hematologist, or dermatologist
- E. Immunotherapy-related inflammatory arthritis: oncologist, hematologist, or rheumatologist

Criteria for Initial Approval:

A. Rheumatoid arthritis (RA)

1. Authorization of 12 months may be granted for adult members who have previously received a biologic or targeted synthetic drug (e.g., Rinvoq, Xeljanz) indicated for moderately to severely active rheumatoid arthritis.
2. Authorization of 12 months may be granted for adult members for treatment of moderately to severely active RA when all of the following criteria are met:
 - i. Member meets either of the following criteria:
 - a. Member has been tested for either of the following biomarkers and the test was positive:
 1. Rheumatoid factor (RF)
 2. Anti-cyclic citrullinated peptide (anti-CCP)
 - b. Member has been tested for ALL of the following biomarkers:
 1. RF
 2. Anti-CCP
 3. C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR)
 - ii. Member meets either of the following criteria:
 - a. Member has experienced an inadequate response to at least a 3-month trial of methotrexate despite adequate dosing (i.e., titrated to at least 15 mg/week).
 - b. Member has an intolerance or contraindication to methotrexate (see Appendix A).

B. Articular juvenile idiopathic arthritis (JIA)

1. Authorization of 12 months may be granted for members 2 years of age and older who have previously received a biologic or targeted synthetic drug (e.g., Xeljanz) indicated for moderately to severely active articular juvenile idiopathic arthritis.
2. Authorization of 12 months may be granted for members 2 years of age and older for the treatment of moderately to severely active articular juvenile idiopathic arthritis when any of the following criteria is met:
 - i. Member has had an inadequate response to methotrexate or another conventional synthetic drug (e.g., leflunomide, sulfasalazine, hydroxychloroquine) administered at an adequate dose and duration.



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- ii. Member has had an inadequate response to a trial of scheduled non-steroidal anti-inflammatory drugs (NSAIDs) and/or intra-articular glucocorticoids (e.g., triamcinolone hexacetonide) and one of the following risk factors for poor outcome:
 - a. Involvement of ankle, wrist, hip, sacroiliac joint, and/or temporomandibular joint (TMJ)
 - b. Presence of erosive disease or enthesitis
 - c. Delay in diagnosis
 - d. Elevated levels of inflammation markers
 - e. Symmetric disease
- iii. Member has risk factors for disease severity and potentially a more refractory disease course (see Appendix B) and member also meets one of the following:
 - a. High-risk joints are involved (e.g., cervical spine, wrist, or hip).
 - b. High disease activity.
 - c. Is judged to be at high risk for disabling joint disease.

C. Psoriatic arthritis (PsA)

- 1. Authorization of 12 months may be granted for members 2 years of age or older who have previously received a biologic or targeted synthetic drug (e.g., Rinvoq, Otezla) indicated for active psoriatic arthritis.
- 2. Authorization of 12 months may be granted for members 2 years of age or older for treatment of active psoriatic arthritis when either of the following criteria is met:
 - i. Member has mild to moderate disease and meets one of the following criteria:
 - a. Member has had an inadequate response to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine) administered at an adequate dose and duration.
 - b. Member has an intolerance or contraindication to methotrexate or leflunomide (see Appendix A), or another conventional synthetic drug (e.g., sulfasalazine).
 - c. Member has enthesitis or predominantly axial disease.
 - ii. Member has severe disease.

D. Ankylosing spondylitis (AS) and non-radiographic axial spondyloarthritis (nr-axSpA)

- 1. Authorization of 12 months may be granted for adult members who have previously received a biologic or targeted synthetic drug (e.g., Rinvoq, Xeljanz) indicated for active ankylosing spondylitis or active non-radiographic axial spondyloarthritis.



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2. Authorization of 12 months may be granted for adult members for treatment of active ankylosing spondylitis or active non-radiographic axial spondyloarthritis when any of the following criteria is met:
 - i. Member has experienced an inadequate response to at least two non-steroidal anti-inflammatory drugs (NSAIDs).
 - ii. Member has an intolerance or contraindication to two or more NSAIDs.

E. Reactive arthritis

1. Authorization of 12 months may be granted for members who have previously received a biologic indicated for reactive arthritis.
2. Authorization of 12 months may be granted for treatment of reactive arthritis when any of the following criteria is met:
 - i. Member has experienced an inadequate response to at least a 3-month trial of one of the following despite adequate dosing or maximally tolerated dose:
 - a. Sulfasalazine (i.e., titrated to 1000 mg twice daily)
 - b. Methotrexate (i.e., titrated to at least 15 mg/week)
 - ii. Member has an intolerance or contraindication to methotrexate (see Appendix A) and sulfasalazine (e.g., porphyria, intestinal or urinary obstruction).

F. Hidradenitis suppurativa

1. Authorization of 12 months may be granted for members who have previously received a biologic indicated for the treatment of severe, refractory hidradenitis suppurativa.
2. Authorization of 12 months may be granted for treatment of severe, refractory hidradenitis suppurativa when either of the following is met:
 - i. Member has experienced an inadequate response to an oral antibiotic for at least 90 days.
 - ii. Member has an intolerance or contraindication to oral antibiotics.

G. Graft versus host disease

Authorization of 12 months may be granted for treatment of graft versus host disease when either of the following criteria is met:

1. Member has experienced an inadequate response to systemic corticosteroids.
2. Member has an intolerance or contraindication to corticosteroids.

I. Behcet's disease



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1. Authorization of 12 months may be granted for members who have previously received Otezla or a biologic indicated for the treatment of Behcet's disease.
2. Authorization of 12 months may be granted for the treatment of Behcet's disease when the member has had an inadequate response to at least one nonbiologic medication for Behcet's disease (e.g., apremilast, colchicine, systemic glucocorticoids, azathioprine).

J. Immune checkpoint inhibitor toxicity

1. Authorization of 1 month may be granted for treatment of immune checkpoint inhibitor toxicity when the member has Stevens-Johnson syndrome or toxic epidermal necrolysis.
2. Authorization of 12 months may be granted for treatment of immune checkpoint inhibitor toxicity when the member has severe immunotherapy-related inflammatory arthritis and has experienced an inadequate response, intolerance, or contraindication to corticosteroids.

Continuation of Therapy:

A. Rheumatoid arthritis (RA)

Authorization of 12 months may be granted for all adult members (including new members) who are using the requested medication for moderately to severely active rheumatoid arthritis and who achieve or maintain a positive clinical response as evidenced by disease activity improvement of at least 20% from baseline in tender joint count, swollen joint count, pain, or disability.

B. Articular juvenile idiopathic arthritis (JIA)

Authorization of 12 months may be granted for all members 2 years of age and older (including new members) who are using the requested medication for moderately to severely active articular juvenile idiopathic arthritis and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:

1. Number of joints with active arthritis (e.g., swelling, pain, limitation of motion)
2. Number of joints with limitation of movement
3. Functional ability



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C. Psoriatic arthritis (PsA)

Authorization of 12 months may be granted for all members 2 years of age or older (including new members) who are using the requested medication for psoriatic arthritis and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:

1. Number of swollen joints
2. Number of tender joints
3. Dactylitis
4. Enthesitis
5. Axial disease
6. Skin and/or nail involvement

D. Ankylosing spondylitis (AS) and non-radiographic axial spondylarthritis (nr-axSpA)

Authorization of 12 months may be granted for all adult members (including new members) who are using the requested medication for active ankylosing spondylitis or active non-radiographic axial spondyloarthritis and who achieve or maintain a positive clinical response with the requested medication as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:

1. Functional status
2. Total spinal pain
3. Inflammation (e.g., morning stiffness)

E. Reactive arthritis

Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for reactive arthritis and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition (e.g., tender joint count, swollen joint count, or pain).

F. Hidradenitis suppurativa

Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for severe, refractory hidradenitis suppurativa and who achieve or maintain a positive clinical response as evidenced by low disease



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activity or improvement in signs and symptoms of the condition when any of the following is met:

1. Reduction in abscess and inflammatory nodule count from baseline
2. Reduced formation of new sinus tracts and scarring
3. Decrease in frequency of inflammatory lesions from baseline
4. Reduction in pain from baseline
5. Reduction in suppuration from baseline
6. Improvement in frequency of relapses from baseline
7. Improvement in quality of life from baseline
8. Improvement on a disease severity assessment tool from baseline

G. Graft versus host disease and immune checkpoint inhibitor toxicity

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

H. All other indications

Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for an indication outlined in criteria for initial approval and who achieve or maintain positive clinical response with the requested medication as evidenced by low disease activity or improvement in signs and symptoms of the condition.

Other Criteria:

Member has had a documented negative tuberculosis (TB) test (which can include a tuberculosis skin test [PPD], an interferon-release assay [IGRA], or a chest x-ray)* within 6 months of initiating therapy for persons who are naïve to biologic drugs or targeted synthetic drugs associated with an increased risk of TB.

*If the screening testing for TB is positive, there must be further testing to confirm there is no active disease. Do not administer the requested medication to members with active TB infection. If there is latent disease, TB treatment must be started before initiation of the requested medication.

Member cannot use the requested medication concomitantly with any other biologic drug or targeted synthetic drug.



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Appendix A: Examples of Contraindications to Methotrexate or Leflunomide

1. Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease
2. Breastfeeding
3. Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
4. Elevated liver transaminases
5. History of intolerance or adverse event
6. Hypersensitivity
7. Interstitial pneumonitis or clinically significant pulmonary fibrosis
8. Myelodysplasia
9. Pregnancy or currently planning pregnancy
10. Renal impairment
11. Significant drug interaction

Appendix B: Risk factors for articular juvenile idiopathic arthritis

1. Positive rheumatoid factor
2. Positive anti-cyclic citrullinated peptide antibodies
3. Pre-existing joint damage

Appendix C: Examples of Clinical Reasons to Avoid Pharmacologic Treatment with Methotrexate, Cyclosporine, or Acitretin

1. Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease
2. Breastfeeding
3. Drug interaction
4. Cannot be used due to risk of treatment-related toxicity
5. Pregnancy or currently planning pregnancy
6. Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension)

Approval Duration and Quantity Restrictions:

Approval:

Initial Approval: immune checkpoint inhibitor toxicity when the member has Stevens-Johnson syndrome or toxic epidermal necrolysis = 1 month; all others = 12 months

Renewal Approval: 12 months

Quantity Level Limit:



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Medication	Standard Limit	Exception Limit*
Enbrel (etanercept) 25 mg per 0.5 mL prefilled syringe	8 syringes per 28 days	None
Enbrel (etanercept) 25 mg /0.5 mL single-dose vial	8 vials per 28 days	16 vials per 28 days
Enbrel (etanercept) 50 mg per 1 mL prefilled syringe/cartridge	4 syringes per 28 days	8 syringes per 28 days
Enbrel (etanercept) 50 mg per mL SureClick Autoinjector	4 cartridges per 28 days	8 cartridges per 28 days

*Exception limits apply to loading doses.

References:

1. Enbrel [package insert]. Thousand Oaks, CA: Immunex Corporation; October 2023.
2. van der Heijde D, Ramiro S, Landewe R, et al. 2016 Update of the international ASAS-EULAR management recommendations for axial spondyloarthritis. *Ann Rheum Dis.* 2017;0:1-14.
3. Flagg SD, Meador R, Hsia E, et al. Decreased pain and synovial inflammation after etanercept therapy in patients with reactive and undifferentiated arthritis: an open-label trial. *Arthritis Rheum.* 2005;53(4):613-617.
4. IBM Micromedex® DRUGDEX® System (electronic version). IBM Watson Health, Greenwood Village, Colorado, USA. Available at: <https://www.micromedexsolutions.com/> (cited: 08/08/2022).
5. Smolen JS, Landewé RBM, Bijlsma JWJ, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2019 update. *Ann Rheum Dis.* 2020;79(6):685-699. doi:10.1136/annrheumdis-2019-216655.
6. [Singh JA](#), [Saag KG](#), [Bridges SL Jr](#), et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Rheumatol.* 2016;68(1)1-26.
7. Saag KG, Teng GG, Patkar NM, et al. American College of Rheumatology 2008 recommendations for the use of nonbiologic and biologic disease-modifying antirheumatic drugs in rheumatoid arthritis. *Arthritis Rheum.* 2008;59(6):762-784.
8. Ringold S, Angeles-Han ST, Beukelman T, et al. 2019 American College of Rheumatology/Arthritis Foundation Guideline for the Treatment of Juvenile Idiopathic



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Arthritis: Therapeutic Approaches for Non-Systemic Polyarthritis, Sacroiliitis, and Enthesitis. *Arthritis Care Res.* 2019;71(6):717-734. doi:10.1002/acr.23870.

9. Menter A, Gottlieb A, Feldman SR, et al. Guidelines for the management of psoriasis and psoriatic arthritis. Section 1: Overview of psoriasis and guidelines of care for the treatment of psoriasis with biologics. *J Am Acad Dermatol.* 2008;58(5):826-850.
10. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Section 6: Guidelines of care for the treatment of psoriasis and psoriatic arthritis: case-based presentations and evidence-based conclusions. *J Am Acad Dermatol.* 2011;65(1):137-174.
11. Gossec L, Smolen JS, Ramiro S, et al. European League Against Rheumatism (EULAR) recommendations for the management of psoriatic arthritis with pharmacological therapies; 2015 update. *Ann Rheum Dis.* 2016;75(3):499-510.
12. Gladman DD, Antoni C, P Mease, et al. Psoriatic arthritis: epidemiology, clinical features, course, and outcome. *Ann Rheum Dis.* 2005;64(Suppl II):ii14-ii17.
13. Coates LC, Soriano ER, Corp N, et al. Group for Research and Assessment of Psoriasis and Psoriatic Arthritis (GRAPPA): updated treatment recommendations for psoriatic arthritis 2021. *Nat Rev Rheumatol.* 2022;18(8):465-479.
14. Braun J, van den Berg R, Baraliakos X, et al. 2010 update of the ASAS/EULAR recommendations for the management of ankylosing spondylitis. *Ann Rheum Dis* 2011;70:896-904.
15. Ward MM, Deodhar A, Gensler LS, et al. 2019 Update of the American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network Recommendations for the Treatment of Ankylosing Spondylitis and Nonradiographic Axial Spondyloarthritis. *Arthritis Rheumatol.* 2019;71(10):1599-1613. doi:10.1002/art.41042.
16. Martin PJ, Rizzo JD, Wingard JR, et al. First and second line systemic treatment of acute graft versus host disease: Recommendations of the American Society of Blood and Marrow Transplantation. *Biol Blood Marrow Transplant.* 2012;18(8):1150-1163.
17. Hatemi G, Christensen R, Bang D, et al. 2018 update of the EULAR recommendations for the management of Behcet's syndrome. *Ann Rheum Dis.* 2018;77:808-818.
18. Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. *J Am Acad Dermatol.* 2019;80(4):1029-1072.
19. Testing for TB Infection. Centers for Disease Control and Prevention. Retrieved on August 9, 2022 from: <https://www.cdc.gov/tb/topic/testing/tbtesttypes.htm>.
20. Singh JA, Guyatt G, Ogdie A, et al. 2018 American College of Rheumatology/National Psoriasis Foundation Guideline for the Treatment of Psoriatic Arthritis. *Arthritis Rheumatol.* 2019;71(1):5-32. doi:10.1002/art.40726.
21. Flores D, Marquez J, Garza M, Espinoza LR. Reactive arthritis: newer developments. *Rheum Dis Clin North Am.* 2003;29(1):37-vi.
22. The NCCN Drugs & Biologics Compendium 2022 National Comprehensive Cancer Network, Inc. Available at: <http://www.nccn.org>. Accessed August 9, 2022.



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23. Lexicomp [database online]. Hudson, OH: Lexi-Comp, Inc.; <https://online.lexi.com/lco/action/home> [available with subscription]. Accessed August 8, 2022.
24. Menter, A, Cordero, KM, Davis, DM, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis in pediatric patients. *J Am Acad Dermatol.* 2020;82(1):161-201.
25. Menter, A, Gelfand, JM, Connor, C, et al. Joint AAD-NPF guidelines of care for the management of psoriasis with systemic nonbiologic therapies. *J Am Acad Dermatol.* 2020;82(6):1445-86.
26. Onel KB, Horton DB, Lovell DJ, et al. 2021 American College of Rheumatology guideline for the treatment of juvenile idiopathic arthritis: therapeutic approaches for oligoarthritis, temporomandibular joint arthritis, and systemic juvenile idiopathic arthritis. *Arthritis Rheumatol.* 2022;74(4):553-569.
27. Elmets C, Korman N, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with topical therapy and alternative medicine modalities for psoriasis severity measures. *J Am Acad Dermatol.* 2021; 84(2):432-470.
28. Alikhan A, Sayed C, Alavi A, et al. North American clinical management guidelines for hidradenitis suppurativa: A publication from the United States and Canadian Hidradenitis Suppurativa Foundations Part I: Diagnosis, evaluation, and the use of complementary and procedural management. *J Am Acad Dermatol.* 2019;81(1):76-90.
29. Alikhan A, Sayed C, Alavi A, et al. North American clinical management guidelines for hidradenitis suppurativa: A publication from the United States and Canadian Hidradenitis Suppurativa Foundations Part II: Topical, intralesional, and systemic medical management. *J Am Acad Dermatol.* 2019;81(1):91-101.
30. Smolen JS, Aletaha D. Assessment of rheumatoid arthritis activity in clinical trials and clinical practice. In: UpToDate, Post TW (Ed), UpToDate, Waltham, MA. Available with subscription. URL: www.uptodate.com. Accessed March 19, 2021.
31. Fraenkel L, Bathon JM, England BR, et al. 2021 American College of Rheumatology guideline for the treatment of rheumatoid arthritis. *Arthrit Care Res.* 2021;0:1-16.
32. Azulfidine [package insert]. New York, NY: Pfizer; August 2021.