Harvard Pilgrim Health Care | TUFTS Health Plan

Pharmacy Medical Necessity Guidelines: **Adalimumab Products**

Effective: July 1, 2026

Guideline Type	☒ Prior Authorization ☒ Non-Formulary ☐ Step-Therapy ☐ Administrative

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; Fax: 617-673-0988

☒ Tufts Health Plan Commercial products; Fax: 617-673-0988

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 617-673-0988

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Food and Drug Administration – Approved Indications

Adalimumab is a tumor necrosis factor (TNF) blocker indicated for:

Disease State	
Ankylosing Spondylitis	X
Crohn's Disease	X
Hidradenitis Suppurativa	X
Plaque Psoriasis	X
Polyarticular Juvenile Idiopathic Arthritis	X
Psoriatic Arthritis	X
Rheumatic Arthritis	X
Ulcerative Colitis	X
Uveitis	X

Adalimumab products in this Medical Necessity Guideline include: Adalimumab-aacf, Adalimumab-aaty, Adalimumab-adaz, Adalimumab-adbm, Adalimumab-fkjp, Adalimumab-ryvk, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Humira, Hyrimoz, Idacio, Yuflyma, and Yusimry.

Simlandi is the preferred Adalimumab product and requires prior authorization. See Simlandi Medical Necessity Guideline.

Clinical Guideline Coverage Criteria

The plan may authorize coverage of Adalimumab Products for Members when all of the following criteria are met:

Ankylosing Spondylitis

Initial Authorization Criteria

1. Documented diagnosis of active ankylosing spondylitis

AND

2. Patient is at least 18 years of age or older

AND

3. Prescribed by a rheumatologist

AND

4. Documentation of history of failure to **one (1)** prescription strength non-steroidal anti-inflammatory drug (e.g., celecoxib, diclofenac, ibuprofen, naproxen, meloxicam), unless contraindicated or clinically significant adverse effects are experienced *(Note: document drug, date and duration of trial)*

AND

5. Documentation of history of failure to **two (2)** of the listed medications from each of the following therapeutic categories (only one medication is required if only one is available for a listed therapeutic category) (*Note: Document drugs, dates and durations of trials):*
    a. *Interleukin* Antagonists: Bimzelx, Tatlz
    b. *Janus* Kinase Inhibitors: Rinvoq, Xeljanz
    c. Tumor Necrosis Factor: Cimzia, Enbrel, Simponi

AND

6. Documentation of history of failure to a minimum three (3) month supply of Simlandi, unless contraindicated (*Note: document date and duration of trial)*

AND

7. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Reauthorization Criteria

1. Documentation the patient has been established on the requested medication for at least 12 months

AND

2. Documented diagnosis of active ankylosing spondylitis

AND

3. Patient is at least 18 years of age or older

AND

4. Prescribed by a rheumatologist

AND

5. Documentation of clinically significant improvement or stabilization in clinical signs and symptoms of disease as determined by the prescriber

AND

6. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Crohn's Disease

Initial Authorization Criteria

1. Documented diagnosis of Crohn's disease

AND

2. Patient is at least 6 years of age or older

AND

3. Prescribed by a gastroenterologist

AND

4. Documentation of history of failure to **one (1)** of the following, unless contraindicated or clinically significant adverse effects are experienced *(Note: document drug, date, and duration of trial):*
    a. Corticosteroid
    b. 5-aminosalycylate
    c. 6-mercaptopurine
    d. Methotrexate

AND

5. Documentation of history of failure to **two (2)** of the listed medications from each of the following therapeutic categories (only one medication is required if only one is available for a listed therapeutic category) (*Note: Document drugs, dates and durations of trials):*
    a. Interleukin Antagonists: Omvoh, Skyrizi, Tremfya, or Yesintek or Starjemza
    b. Janus Kinase Inhibitors: Rinvoq
    c. Tumor Necrosis Factors: Cimzia

AND

6. Documentation of history of failure to a minimum three (3) month supply of Simlandi, unless contraindicated (*Note: document date and duration of trial)*

AND

7. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Reauthorization Criteria

1. Documentation the patient has been established on the requested medication for at least 12 months

AND

2. Documented diagnosis of moderately to severely active Crohn's disease

AND

3. Patient is at least 6 years of age or older

AND

4. Prescribed by a gastroenterologist

AND

5. Documentation of clinically significant improvement or stabilization in clinical signs and symptoms of disease as determined by the prescriber

AND

6. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Hidradenitis Suppurativa

Initial Authorization Criteria

1. Documented diagnosis of moderate to severe hidradenitis suppurativa

AND

2. Documentation of Hurley Stage II or III disease

AND

3. Patient is at least 12 years of age or older

AND

4. Prescribed by a dermatologist

AND

5. Documentation of history of failure to **three (3)** of the following conventional treatments, unless contraindicated or clinically significant adverse effects are experienced *(Note: document treatments, dates, and duration of trials):*
    a. Local hygiene and ordinary hygiene
    b. Weight reduction in patients who are obese
    c. Use of ordinary soaps and antiseptic and antiperspirant agents (e.g., aluminum chloride hexahydrate) iv.
    d. Application of warm compresses with sodium chloride solution or Burow's solution
    e. Laser hair removal
    f. Cessation of cigarette smoking
    g. Medical anti-inflammatory or antiandrogen therapy such as oral or topical antibiotics, intralesional triamcinolone, spironolactone, or finasteride

AND

6. Documentation of history of failure to a minimum three (3) month supply of Simlandi, unless contraindicated (*Note: document date and duration of trial*)

AND

7. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Reauthorization Criteria

1. Documentation the patient has been receiving the requested medication for at least six (6) months

AND

2. Documented diagnosis of moderate to severe hidradenitis suppurativa

AND

3. Patient is at least 12 years of age or older

AND

4. Prescribed by a dermatologist

AND

5. Submission of medical charts documenting the patient experienced a beneficial clinical response defined as an improvement from baseline in at least **one (1)** objective measure (e.g., Hurley staging, Sartorius score, Physician Global Assessment, Hidradenitis Suppurativa Severity Index)

AND

6. Submission of medical charts documenting that compared to baseline, the patient has experienced an improvement in at least one symptom of hidradenitis suppurativa such as decreased pain or drainage of lesions, nodules, or cysts

AND

7. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Plaque Psoriasis

1. Documented diagnosis of moderate to severe chronic plaque psoriasis

AND

2. Documentation of **one (1)** of the following:
    a. Greater than or equal to 3% body surface area involvement
    b. Severe scalp psoriasis
    c. Palmoplantar, facial, or genital involvement

AND

3. Patient is at least 18 years of age or older

AND

4. Prescribed by a dermatologist

AND

5. Documentation of failure to a minimum three (3) month supply of at least **one (1)** of the following traditional systemic agents, unless contraindicated or clinically significant adverse effects are experienced: methotrexate, cyclosporine, acitretin, or phototherapy (*Note: document drug, date and duration of trial*)

AND

6. Documentation of history of failure to **two (2)** of the listed medications from each of the following therapeutic categories (only one medication is required if only one is available for a listed therapeutic category) (*Note: Document drugs, dates and durations of trials):*
    a. Interleukin Antagonists: Bimzelx, Skyrizi, Taltz, Tremfya, or Yesintek or Starjemza
    b. Phosphodiesterase 4 inhibitors: Otezla
    c. Tumor Necrosis Factors: Cimzia, Enbrel

AND

7. Documentation of history of failure to a minimum three (3) month supply of Simlandi, unless contraindicated (*Note: document date and duration of trial)*

AND

8. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Reauthorization Criteria

1. Documentation the patient has been receiving the requested medication for at least six (6) months

AND

2. Documented diagnosis of moderately to severe plaque psoriasis

AND

3. Patient is at least 18 years of age or older

AND

4. Prescribed by a dermatologist

AND

5. Submission of medical charts documenting the patient experienced a beneficial clinical response defined as reduction in body surface area affected by plaque psoriasis from baseline

AND

6. Submission of medical charts documenting that compared to baseline, the patient has experienced an improvement in at least one symptom of plaque psoriasis such as itching, redness, flaking, scaling, burning, cracking, or pain

AND

7. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Polyarticular Juvenile Idiopathic Arthritis

Initial Authorization Criteria

1. Documented diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis

AND

2. Patient is at least 2 years of age or older

AND

3. Prescribed by a rheumatologist

AND

4. Documentation of history of failure to **one (1)** traditional disease modifying antirheumatic drug (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine), unless contraindicated or clinically significant adverse effects are experienced *(Note: document drug, date, and duration of trial)*

AND

5. Documentation of history of failure to **two (2)** of the listed medications from each of the following therapeutic categories (only one medication is required if only one is available for a listed therapeutic category) (*Note: Document drugs, dates and durations of trials):*
    a. Interleukin Antagonists: Actemra
    b. Janus Kinase Inhibitor: Rinvoq, Xeljanz
    c. Selective T Cell Costimulation: Orencia
    d. Tumor Necrosis Factors: Cimzia, Enbrel

AND

6. Documentation of history of failure to a minimum three (3) month supply of Simlandi, unless contraindicated (*Note: document date and duration of trial)*

AND

7. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Reauthorization Criteria

1. Documentation the patient has been established on the requested medication for at least 12 months

AND

2. Documented diagnosis of active moderately to severely active polyarticular juvenile idiopathic arthritis

AND

3. Patient is at least 2 years of age or older

AND

4. Prescribed by a rheumatologist

AND

5. Documentation of clinically significant improvement or stabilization in clinical signs and symptoms of disease as determined by the prescriber

AND

6. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Psoriatic Arthritis

Initial Authorization Criteria

1. Documented diagnosis of active psoriatic arthritis

AND

2. Documentation of **one (1)** of the following:
    a. Actively inflamed joints
    b. Dactylitis
    c. Enthesitis
    d. Axial disease
    e. Active skin and/or nail involvement

AND

3. Patient is at least 18 years of age or older

AND

4. Prescribed by a rheumatologist or dermatologist

AND

5. Documentation of failure to a minimum three (3) month supply of at least **one (1)** disease-modifying anti-rheumatic drug (e.g., methotrexate, sulfasalazine, cyclosporine), unless contraindicated or clinically significant adverse effects are experienced (*Note: document drug, date and duration of trial*)

AND

6. Documentation of history of failure to **two (2)** of the listed medications from each of the following therapeutic categories (only one medication is required if only one is available for a listed therapeutic category) (*Note: Document drugs, dates and durations of trials):*

a. Interleukin Antagonists: Bimzelx, Skyrizi, Taltz, Tremfya, or Yesintek or Starjemza
b. Janus Kinase Inhibitors: Rinvoq, Xeljanz
c. Phosphodiesterase 4 inhibitors: Otezla
d. Selective T Cell Stimulators: Orencia
e. Tumor Necrosis Factors: Cimzia, Enbrel, Simponi

AND

7. Documentation of history of failure to a minimum three (3) month supply of Simlandi, unless contraindicated (*Note: document date and duration of trial)*

AND

8. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Reauthorization Criteria

1. Documentation the patient has been receiving the requested medication for at least six (6) months

AND

2. Documented diagnosis of active psoriatic arthritis

AND

3. Patient is at least 18 years of age or older

AND

4. Prescribed by a rheumatologist or dermatologist

AND

5. Submission of medical charts documenting the patient experienced a beneficial clinical response defined improvement from baseline in at least **one (1)** of the following:
   a. Body surface area affected by psoriatic arthritis
   b. Total active (swollen and tender) joint count

AND

6. Submission of medical charts documenting that compared to baseline, the patient has experienced an improvement in at least one symptom of psoriatic arthritis such as joint pain, morning stiffness, fatigue, joint or tendon sheath swelling

AND

7. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Rheumatoid Arthritis

Initial Authorization Criteria

1. Documented diagnosis of moderately to severely active rheumatoid arthritis

AND

2. Patient is at least 18 years of age or older

AND

3. Prescribed by a rheumatologist

AND

4. Documentation of history of failure to **one (1)** traditional disease modifying antirheumatic drug (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine), unless contraindicated or clinically significant adverse effects are experienced *(Note: document drug, date, and duration of trial)*

AND

5. Documentation of history of failure to **two (2)** of the listed medications from each of the following therapeutic categories (only one medication is required if only one is available for a listed therapeutic category) (*Note: Document drugs, dates and durations of trials):*
   a. Interleukin Antagonists: Actemra
   b. Janus Kinase Inhibitors: Olumiant, Rinvoq, Xeljanz
   c. Selective T Cell Stimulators: Orencia
   d. Tumor Necrosis Factors: Cimzia, Enbrel, Simponi

AND

6. Documentation of history of failure to a minimum three (3) month supply of Simlandi, unless contraindicated (*Note: document date and duration of trial)*

AND

7. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Reauthorization Criteria

1. Documentation the Member has been established on the requested medication for at least 12 months

AND

2. Documented diagnosis of moderately to severely active rheumatoid arthritis

AND

3. Patient is at least 18 years of age or older

AND

4. Prescribed by a rheumatologist

AND

5. Documentation of clinically significant improvement or stabilization in clinical signs and symptoms of disease as determined by the prescriber

AND

6. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Ulcerative Colitis

Initial Authorization Criteria

1. Documented diagnosis of moderately to severely active ulcerative colitis

AND

2. Patient is at least 5 years of age or older

AND

3. Prescribed by a gastroenterologist

AND

4. Documentation of history of failure to **one (1)** of the following, unless contraindicated or clinically significant adverse effects are experienced *(Note: document drug, date, and duration of trial):*
    a. Corticosteroid
    b. *5*-aminosalycyclate
    c. 6-mercaptopurine
    d. Methotrexate

AND

5. Documentation of history of failure to **two (2)** of the listed medications from each of the following therapeutic categories (only one medication is required if only one is available for a listed therapeutic category) (*Note: Document drugs, dates and durations of trials):*
    a. Interleukin Antagonists: Omvoh, Skyrizi, Tremfya, or Yesintek or Starjemza
    b. Janus Kinase Inhibitors: Rinvoq, Xeljanz
    c. Sphingosine 1-phosphate receptor modulator: Zeposia
    d. Tumor Necrosis Factors: Simponi

AND

6. Documentation of history of failure to a minimum three (3) month supply of Simlandi, unless contraindicated (*Note: document date and duration of trial)*

AND

7. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Reauthorization Criteria

1. Documentation the patient has been established on the requested medication for at least 12 months

AND

2. Documented diagnosis of moderately to severely active ulcerative colitis

AND

3. Patient is at least 5 years of age or older

AND

4. Prescribed by a gastroenterologist

AND

5. Documentation of clinically significant improvement or stabilization in clinical signs and symptoms of disease as determined by the prescriber

AND

6. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Uveitis

Initial Authorization Criteria

1. Documented diagnosis of uveitis (non-infectious intermediate, posterior or panuveitis)

AND

2. Patient is at least 2 years of age or older

AND

3. Prescribed by an ophthalmologist, ocular immunologist, or rheumatologist

AND

4. Documentation of history of failure to conventional therapy (e.g., periocular, intraocular, or systemic corticosteroids; immunosuppressants), unless contraindicated or clinically significant adverse effects are experienced *(Note: document drug, date, and duration of trial)*

AND

5. Documentation of history of failure to a minimum three (3) month supply of Simlandi, unless contraindicated (*Note: document date and duration of trial*

AND

6. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule

Reauthorization Criteria

1. Documentation the patient has been established on the requested medication for at least 12 months

AND

2. Documented diagnosis of uveitis (non-infectious intermediate, posterior or panuveitis)

AND

3. Patient is at least 2 years of age or older

AND

4. Prescribed by an ophthalmologist, ocular immunologist, or rheumatologist

AND

5. Documentation of clinically significant improvement or stabilization in clinical signs and symptoms of disease as determined by the prescriber

AND

6. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Humira (adalimumab)

In addition to the coverage criteria above for the requested indication

1. Documentation of history of failure to Adalimumab-aacf, Adalimumab-aaty, Adalimumab-adaz, Adalimumab-adbm, Adalimumab-fkjp, Adalimumab-ryvk, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Yuflyma, and Yusimry, unless contraindicated *(Note: document drugs, dates and duration of trials)*

Limitations

1. Members who have already initiated the requested medication using samples, free goods, similar offerings, or self-paying for the medication directly do not qualify for an established clinical response and should be reviewed against initial approval criteria.
2. Documentation of a Member being a social drinker does not qualify as a medically acceptable contraindication or clinical inappropriateness to methotrexate therapy.
3. For ankylosing spondylitis, Crohn's disease, polyarticular juvenile idiopathic arthritis, rheumatoid arthritis, ulcerative colitis and uveitis, authorizations will be provided in 12-month intervals. A patient who has received less than 12 months of therapy or who is restarting therapy with the requested drug is reviewed under Initial Authorization Criteria.
4. For hidradenitis suppurativa, plaque psoriasis and psoriatic arthritis, initial approval will be authorized for six (6) months. Reauthorization will be provided in 12-month intervals. A Member who has received less than six (6) months of therapy or who is restarting therapy with the requested drug is reviewed under Initial Authorization Criteria
5. Members new to the plan stable on the requested medication should be reviewed against Initial Authorization Criteria.

Codes

None

References

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Approval And Revision History

June 10, 2025: Reviewed by the Pharmacy & Therapeutics Committee (eff 9/1/25).

- October 14, 2024: Provider requirements no longer allow with in consultation with the specialist. Added coverage criteria to prevent duplicative targeted immunomodulator therapy. For hidradenitis suppurativa, plaque psoriasis and psoriatic arthritis, initial approvals limited to 6 months with annual reauthorization coverage criteria added, added disease severity requirements, added nonbiologic prerequisite requirements, updated Initial Authorization Criteria biologic prerequisite language (no change in prerequisites) and removed previous treatment with a biologic agent indicated for the requested use and Humira stability language. For ankylosing spondylitis, Crohn's disease, polyarticular juvenile idiopathic arthritis, rheumatoid arthritis, ulcerative colitis and uveitis, approvals limited to 12 months with reauthorization coverage criteria added, added nonbiologic prerequisites, updated Initial Authorization Criteria biologic prerequisite language (no change in prerequisites), and removed previous treatment with a biologic agent indicated for the requested use and Humira stability language. (eff 1/1/26).
- December 9, 2025: Simlandi moved from non-preferred to preferred status. Humira moved from preferred to non-preferred status (eff 3/1/26).
- June 9, 2026: Added Starjemza as a prerequisite for Crohn’s disease, plaque psoriasis, psoriatic arthritis, and ulcerative colitis to support the updated ustekinumab strategy – Yesintek and Starjemza are the preferred ustekinumab products. Administrative update to the limitation statement to include members initiated on the requested medication by self-paying for the medication directly do not qualify for established clinical response and should be reviewed against initial approval criteria. Administrative update to remove CareLink from Medical Necessity Guideline template. (eff 7/1/26).

Background, Product and Disclaimer Information

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed

revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.