Division: Pharmacy Policy	Subject: Prior Authorization Criteria
Original Development Date: Original Effective Date: Revision Date:	July 27, 2016

OTREXUP® (methotrexate auto-injector)

LENGTH OF AUTHORIZATION: UP TO ONE YEAR

REVIEW CRITERIA:

Rheumatoid Arthritis (severe):

- Patient is 18 years or older with active rheumatoid arthritis **AND**
- Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) to NSAIDs **AND**
- Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) to methotrexate tablets **AND**
- Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) to methotrexate intramuscularly

Psoriasis (Severe) Recalcitrant, disabling

- Patient is 18 years or older with a diagnosis of severe, recalcitrant disabling psoriasis
- Patient did not respond adequately (or is not a candidate) to a 3 month minimum trial of phototherapy (e.g., Psoralens with UVA light (PUVA) OR UVB with coal tar or dithranol **AND**
- Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) to methotrexate tablets **AND**
- Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) to methotrexate intramuscularly

Juvenile Idiopathic Arthritis:

- Patient is 2 years old or older with the diagnosis of Juvenile Idiopathic Arthritis **AND**
- Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) to NSAIDs **AND**
- Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) to methotrexate tablets **AND**
- Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) to methotrexate intramuscularly

Division: Pharmacy Policy	Subject: State of Florida's Agency for Health Care Administration's Prior Authorization Criteria
Original Development Date: Original Effective Date: Revision Date:	July 27, 2016

DOSING AND STRENGTHS:

Rheumatoid Arthritis

- 7.5 mg once weekly

Psoriasis (Severe), Recalcitrant, disabling

- 10mg to 25 mg subcutaneously once weekly

Juvenile Idiopathic Arthritis:

- 10 mg/m^2 subcutaneously once weekly

Single-dose auto-injector delivering 0.4 mL of methotrexate in the following dosage strengths:

- 7.5 mg, 10 mg, 12.5 mg, 15 mg, 17.5 mg, 20mg, 22.5 mg and 25 mg.