| Division: Pharmacy Policy | Subject: Prior Authorization Criteria |
|---|---|
| Original Development Date:<br>Original Effective Date:<br>Revision Date: | July 27, 2016 |

# RASUVO® (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 non-steroidal anti-inflammatory drugs 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 |
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**DOSING AND STRENGTHS:**

Rheumatoid Arthritis

- 7.5mg subcutaneously once weekly

Psoriasis (Severe), Recalcitrant, disabling

- 10 to 25 mg subcutaneously once weekly

Juvenile Idiopathic Arthritis:

- 10 mg/$m^2$ subcutaneously once weekly

Single-dose manually-triggered auto-injector delivering methotrexate in the following dosage strengths:

- 7.5 mg, 10 mg, 12.5 mg, 15mg, 17.5 mg, 20 mg, 22.5 mg, 25 mg, 27.5 mg, and 30 mg