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: 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/m² 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, 20 mg, 22.5 mg and 25 mg.