

**SOUTH DAKOTA MEDICAID
PRIOR AUTHORIZATION CRITERIA**

Physician Administered Drugs, Vaccines, and Immunizations

Biosimilar Agents – Preferred Drug List

- **Initial Therapy (must meet all):**
 - Individual meets **one** of the following regarding previous therapy trials:
 - Member has failed a ≥90 day trial for a preferred medication
 - Clinical justification is provided why the member cannot utilize a preferred product
 - Approval duration: 1 year
- **Continuation of Therapy (must meet all):**
 - Requested drug remains the preferred product with SD Medicaid
 - Reason for initial approval is still present
 - Approval duration: 1 year

**** If biosimilar product varies in FDA approved age and indication compared to the parent product, exceptions may be made.**

Tocilizumab

PA effective 5/15/26

PREFERRED AGENT (NO PA REQUIRED)	NON-PREFERRED AGENT (PA REQUIRED)
TYENNE (tocilizumab-aazg)	AVTOZMA (tocilizumab-anoh)
	ACTEMRA (tocilizumab)
	TOFIDENCE (tocilizumab-bavi)

IV Formulation

Therapy Indication	TYENNE	AVTOZMA	ACTEMRA	TOFIDENCE
Covid-19	18+	18+	2+	18+
Cytokine release syndrome	2+	2+	2+	Not indicated
Giant cell arteritis	18+	18+	18+	18+
Polyarticular Juvenile Idiopathic Arthritis	2+	2+	2+	2+
Rheumatoid arthritis	18+	18+	18+	18+
Systemic Juvenile Idiopathic Arthritis	2+	2+	2+	2+

SQ Formulation

Therapy Indication	TYENNE	AVTOZMA	ACTEMRA	TOFIDENCE
Giant cell arteritis	18+	Not available	18+	Not available
Interstitial lung disease, systemic sclerosis associated	Not indicated	Not available	18+	Not available
Polyarticular Juvenile Idiopathic Arthritis	2+	Not available	2+	Not available
Rheumatoid arthritis	18+	Not available	18+	Not available
Systemic Juvenile Idiopathic Arthritis	2+	Not available	2+	Not available

**SOUTH DAKOTA MEDICAID
PRIOR AUTHORIZATION CRITERIA**

Physician Administered Drugs, Vaccines, and Immunizations

Infliximab

PA effective 6/15/26

PREFERRED AGENT (NO PA REQUIRED)	NON-PREFERRED AGENT (PA REQUIRED)
INFLIXIMAB	AVSOLA (infliximab-axxq)
	INFLECTRA (infliximab-dyyb)
	REMICADE (infliximab)
	RENFLEXIS (infliximab-abda)

IV Formulation

Therapy Indication	INFLIXIMAB	AVSOLA	INFLECTRA	REMICADE	RENFLEXIS
Ankylosing Spondylitis	18+	18+	18+	18+	18+
Colitis, immune checkpoint inhibitor induced	18+	18+	18+	18+	18+
Chrohn disease, moderate to severe, induction and maintenance of remission	6+	6+	6+	6+	6+
Plaque psoriasis	18+	18+	18+	18+	18+
Psoriatic arthritis	18+	18+	18+	18+	18+
Rheumatoid arthritis	18+	18+	18+	18+	18+
Ulcerative colitis	6+	6+	6+	6+	6+

Pegfilgrastim

PA effective 7/15/26

PREFERRED AGENT (NO PA REQUIRED)	NON-PREFERRED AGENT (PA REQUIRED)
FULPHILIA (pegfilgrastim-jmdb)	NEULASTA (pegfilgrastim)
	UDENYCA (pegfilgrastim-cbqv)
	ZIEXTNEZO (pegfilgrastim-bmez)
	FYLNETRA (pegfilgrastim-pbbk)
	NYVEPRIA (pegfilgrastim-apgf)
	STIMUFEND (pegfilgrastim-fpgk)

SQ Formulation

Therapy Indication	FULPHILIA	NEULASTA	UDENYCA	ZIEXTENZO	FLYNETRA	NYVEPRIA	STIMUFEND
Chemotherapy-induced neutropenia, prevention	All ages	All ages	All ages	All ages	All ages	All ages	All ages
Hematopoietic radiation injury syndrome, acute	Not indicated	All ages	All ages	All ages	Not indicated	Not indicated	All ages