CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Georgia Medicaid

DRUG NAME	Adalimumab (Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Yuflyma, Yusimry)
BENEFIT TYPE	Pharmacy
STATUS	Prior Authorization Required

Humira, a tumor necrosis factor (TNF) blocker was originally approved in 2002 for the treatment of rheumatoid arthritis. Since then, the FDA has granted approval for a variety of indications. Multiple biosimilars have been approved for Humira including Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Yuflyma and Yusimry. They are indicated for some, but not all, of the same indications as Humira.

Adalimumab is a monoclonal antibody produced by recombinant DNA technology. It specifically binds to TNF-alpha and blocks its interaction with TNF receptors. TNF is a naturally occurring cytokine that is involved in normal inflammatory and immune responses. Adalimumab is administered by subcutaneous injection.

Adalimumab (Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Yuflyma, Yusimry) will be considered for coverage when the following criteria are met:

Ankylosing Spondylitis (AS)

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a rheumatologist; AND
3. Member has a documented diagnosis of active AS; AND
4. Member shows **ONE** of the following signs or symptoms of inflammation:
   a) Elevated serum C-reactive protein (CRP);
   b) Sacroiliitis on magnetic resonance imaging (MRI); AND
5. Member has had a trial and failure of **TWO** NSAIDs for 14 days each, taken at the maximum recommended dosages; AND
6. Member has tried and failed **TWO** preferred biologic DMARDs for at least 3 months. If the request is for a non-preferred adalimumab product, member has had a trial of all preferred biosimilars, where applicable, or acceptable clinical reason must be provided as to why biosimilar cannot be used; AND
7. Member has had a negative tuberculosis test within the past 12 months.
8. **Dosage allowed/Quantity limit:** 40 mg subcutaneously every other week. Quantity limit: 2 syringes/pens per 28 days.

If all the above requirements are met, the medication will be approved for 12 months.

For **reauthorization**:

1. If the request is for a non-preferred adalimumab product, member has had a trial of all preferred biosimilars, where applicable, or acceptable clinical reason must be provided as to why biosimilar cannot be used; AND

2. Chart notes have been provided showing improvement of signs and symptoms of disease such as decreased morning stiffness, tenderness or inflammatory back pain, improved quality of life, etc.

If all the above requirements are met, the medication will be approved for an additional 12 months.

Crohn's Disease (CD)

For **initial** authorization:

1. Member is 6 years of age or older; OR
2. Medication must be prescribed by or in consultation with a gastroenterologist; AND
3. Member has a diagnosis of moderately to severely active CD; AND
4. Member has had a documented trial and inadequate response, or intolerance to **ONE** of the following conventional therapies:
   a) Corticosteroid;
   b) 6-mercaptopurine, azathioprine, or methotrexate; OR
5. Provider attests member has severe disease that requires immediate use of an advanced therapy (biologic, JAK inhibitor, etc.) agent such as penetrating or fistulizing disease, multiple resections, etc.; AND
6. If the request is for a non-preferred adalimumab product, member has had a trial of all preferred biosimilars, where applicable, or acceptable clinical reason must be provided as to why biosimilar cannot be used; AND
7. Member has had a negative tuberculosis test within the past 12 months.
8. **Dosage allowed/Quantity limit:**
   a) Adults: 160 mg subcutaneously on day one, then 80 mg 2 week later (day 15), then 40 mg every other week beginning on day 29;
   b) Pediatrics:
      i. 17 kg (37 lbs) to < 40 kg (88 lbs): Induction: 80 mg on day 1 and 40 mg two weeks later (day 15); maintenance: 20 mg every other week;
      ii. ≥ 40 kg (88 lbs.): Induction: 160 mg on day 1 and 80 mg two weeks later (day 15); maintenance: 40 mg every other week.

If all the above requirements are met, the medication will be approved for 12 months.

For **reauthorization**:

1. If the request is for a non-preferred adalimumab product, member has had a trial of all preferred biosimilars, where applicable, or acceptable clinical reason must be provided as to why biosimilar cannot be used; AND
2. Chart notes have been provided showing improvement in signs and symptoms of CD such as mucosal healing, fewer flare-ups of symptoms, improved quality of life, etc.

If all the above requirements are met, the medication will be approved for an additional 12 months.

Hidradenitis Suppurativa (HS) (Humira, Abrilada, Amjevita, Adalimumab-adbm (Cyltezo), Adalimumab-bwwd (Hadlima), Adalimumab-fkjp (Hulio), Adalimumab-ada (Hyrimoz), Yusimry Only)

For **initial** authorization:

1. If the request is for Humira, member is 12 years of age or older; OR
2. If the request is for Abrilada, Amjevita, adalimumab-adbm (Cyltezo), adalimumab-bwwd (Hadlima), adalimumab-adaz (Hyrimoz), adalimumab-fkjp (Hulio), or Yusimry member is 18 years of age or older; AND

3. Medication must be prescribed by or in consultation with a dermatologist; AND
4. Member has a documented diagnosis of moderate to severe HS with Hurley stage II or III disease; AND
5. Member has been counseled on weight loss if they are overweight or obese; AND
6. Member is a non-smoker or has been counseled on smoking cessation and advised to quit; AND
7. Member has tried and failed **ONE** of the following:
   a) Topical clindamycin x 12 weeks and an oral tetracycline x 12 weeks (sequential or concomitant)
   b) Oral clindamycin plus rifampicin x 8-12 weeks; AND
8. If the request is for a non-preferred adalimumab product, member has had a trial of all preferred biosimilars, where applicable, or acceptable clinical reason must be provided as to why biosimilar cannot be used; AND
9. Member has had a negative tuberculosis test within the past 12 months.
10. **Dosage allowed/Quantity limit:**
    Adults: 160 mg initial dose, then 80 mg 2 weeks later (day 15), then 40 mg every week or 80 mg every other week beginning on day 29.
    Adolescents (Humira only):

Body Weight of Adolescent Patients (12 years of age and older)	Recommended Dosage
30 kg (66 lbs) to less than 60 kg (132 lbs)	• Day 1: 80 mg • Day 8 and subsequent doses: 40 mg every other week
60 kg (132 lbs) and greater	• Day 1: 160 mg (given in one day or split over two consecutive days); • Day 15: 80 mg • Day 29 and subsequent doses: 40 mg every week or 80 mg every other week

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:
1. If the request is for a non-preferred adalimumab product, member has had a trial of all preferred biosimilars, where applicable, or acceptable clinical reason must be provided as to why biosimilar cannot be used; AND
2. Chart notes must include documentation of a positive clinical response such as reduced count of total abscesses and inflammatory nodules or reduction of skin pain.

If all the above requirements are met, the medication will be approved for an additional 12 months.

Polyarticular Juvenile Idiopathic Arthritis (pJIA)

For **initial** authorization:
1. Member must be 2 years of age or older; AND
2. Medication must be prescribed by or in consultation with a rheumatologist; AND
3. Member has a diagnosis of moderately to severely active pJIA; AND
4. Member has had an adequate trial and failure of **ONE** conventional DMARD (e.g., methotrexate, leflunomide, etc.) for 8 weeks, unless not tolerated or contraindicated; AND
5. Member must have tried and failed treatment with Actemra. Treatment failure requires at least 12 weeks of therapy; AND
6. If the request is for a non-preferred adalimumab product, member has had a trial of all preferred biosimilars, where applicable, or acceptable clinical reason must be provided as to why biosimilar cannot be used; AND
7. Member has had a negative tuberculosis test within the past 12 months.

8. **Dosage allowed/Quantity limit:**
   a) 10 kg (22 lbs) to < 15 kg (33 lbs): 10 mg subcutaneously every other week;
   b) 15 kg (33 lbs) to < 30 kg (66 lbs): 20 mg subcutaneously every other week;
   c) ≥ 30 kg (66 lbs): 40 mg subcutaneously every other week

If all the above requirements are met, the medication will be approved for 12 months.

For **reauthorization**:
1. If the request is for a non-preferred adalimumab product, member has had a trial of all preferred biosimilars, where applicable, or acceptable clinical reason must be provided as to why biosimilar cannot be used; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease such as decreased joint swelling and pain and improved quality of life.

If all the above requirements are met, the medication will be approved for an additional 12 months.

Plaque Psoriasis (PsO)

For **initial** authorization:
1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a dermatologist; AND
3. Member has clinical documentation of moderate to severe plaque psoriasis characterized by 3% or more of body surface area (BSA) or disease affecting sensitive areas (e.g., hands, feet, face, genitals, etc.); AND
4. Member has tried and failed to respond to treatment with **ONE** of the following:
   a) At least 12 weeks of photochemotherapy (i.e., psoralen plus ultraviolet A therapy);
   b) At least 12 weeks of phototherapy (i.e., UVB light therapy, Excimer laser treatments);
   c) At least a 4-week trial with topical antipsoriatic agents (i.e., anthralin, calcipotriene, coal tar, corticosteroids, tazarotene, tacrolimus, pimecrolimus); AND
5. Member has tried and failed, or unable to tolerate **ONE** systemic conventional DMARD (i.e., cyclosporine, methotrexate, acitretin) for at least 12 weeks; AND
6. Member has tried and failed **TWO** preferred biologic DMARDs for at least 3 months. If the request is for a non-preferred adalimumab product, member has had a trial of all preferred biosimilars, where applicable, or acceptable clinical reason must be provided as to why biosimilar cannot be used; AND
7. Member has had a negative tuberculosis test within the past 12 months.
8. **Dosage allowed/Quantity limit:** 80 mg initial dose, then 40 mg every other week starting 1 week after the initial dose.

If all the above requirements are met, the medication will be approved for 12 months.

For **reauthorization**:
1. If the request is for a non-preferred adalimumab product, member has had a trial of all preferred biosimilars, where applicable, or acceptable clinical reason must be provided as to why biosimilar cannot be used; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease such as documented member's BSA improvement, etc.

If all the above requirements are met, the medication will be approved for an additional 12 months.

Psoriatic Arthritis (PsA)

For **initial** authorization:
1. Member must be 18 years of age or older; AND

2. Medication must be prescribed by or in consultation with a rheumatologist or a dermatologist; AND
3. Member has a documented diagnosis of active PsA; AND
4. Member has met a 4-week trial of an NSAID taken at maximally tolerated dose **AND** a 3-month trial of a conventional DMARD agent (e.g., methotrexate, sulfasalazine, cyclosporine, etc.) unless **ONE** of the following situations is met:
   a) Conventional DMARD is **NOT** required for:
      i) Concomitant axial disease (i.e., involving sacroiliac joint and spine) or enthesitis; OR
   b) NSAID and conventional DMARD are **NOT** required for:
      i) Severe PsA (defined as having **ONE** of the following: erosive disease, active PsA at many sites including dactylitis or enthesitis, elevated levels of ESR or CRP, joint deformities, or major impairment in quality of life); AND
5. Member has tried and failed **TWO** preferred biologic DMARDs for 3 months. If the request is for a non-preferred adalimumab product, member has had a trial of all preferred biosimilars, where applicable, or acceptable clinical reason must be provided as to why biosimilar cannot be used; AND
6. Member has had a negative tuberculosis test within the past 12 months.
7. **Dosage allowed/Quantity limit:** 40 mg subcutaneously every other week. Quantity limit: 2 syringes/pens per 28 days.

If all the above requirements are met, the medication will be approved for 12 months.

For **reauthorization**:
1. If the request is for a non-preferred adalimumab product, member has had a trial of all preferred biosimilars, where applicable, or acceptable clinical reason must be provided as to why biosimilar cannot be used; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease such as decreased joint swelling and pain, improved skin appearance, improved quality of life, etc.

If all the above requirements are met, the medication will be approved for an additional 12 months.

Rheumatoid Arthritis (RA)

For **initial** authorization:
1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a rheumatologist; AND
3. Member has a documented diagnosis of moderately to severely active RA; AND
4. Member must have a trial and failure of, or intolerance to methotrexate for 3 months;
   Note: If methotrexate is contraindicated, one of the following conventional DMARDs must be trialed instead: leflunomide, sulfasalazine, or hydroxychloroquine; AND
5. Member has tried and failed **TWO** preferred biologic DMARDs for 3 months. If the request is for a non-preferred adalimumab product, member has had a trial of all preferred biosimilars, where applicable, or acceptable clinical reason must be provided as to why biosimilar cannot be used; AND
6. Member has had a negative tuberculosis test within the past 12 months.
7. **Dosage allowed/Quantity limit:** 40 mg subcutaneously every other week. Quantity limit: 2 syringes/pens per 28 days.
   If remain uncontrolled, and if not also on methotrexate, may increase to 40 mg every week or 80 mg every other week.

If all the above requirements are met, the medication will be approved for 12 months.

For **reauthorization**:
1. If the request is for a non-preferred adalimumab product, member has had a trial of all preferred biosimilars, where applicable, or acceptable clinical reason must be provided as to why biosimilar cannot be used; AND
2. Chart notes demonstrate improvement of RA signs and symptoms such as fewer number of painful and swollen joints, achievement of remission, slowed progression of joint damage, etc.

If all the above requirements are met, the medication will be approved for an additional 12 months.

Ulcerative Colitis (UC)

For **initial** authorization:
1. If the request is for Humira, member is 5 years of age or older; OR
2. If the request is for adalimumab-adbm (Cyltezo), adalimumab-bwwd (Hadlima), adalimumab-adaz (Hyrimoz), adalimumab-fkjp (Hulio), Abrilada, Amjevita, Idacio, Yuflyma, or Yusimry member is 18 years of age or older; AND
3. Medication must be prescribed by or in consultation with a gastroenterologist; AND
4. Member has a diagnosis of moderately to severely active UC; AND
5. Member must have a documented trial and inadequate response with **ONE** of the following:
   a) 6-mercaptopurine or azathioprine;
   b) Corticosteroid (e.g., budesonide, prednisone, methylprednisolone, etc.);
   c) 5-aminosalicylate (e.g., Asacol HD, Lialda, Pentasa, Delzicol, mesalamine, etc.); AND
6. If the request is for a non-preferred adalimumab product, member has had a trial of all preferred biosimilars, where applicable, or acceptable clinical reason must be provided as to why biosimilar cannot be used; AND
7. Member has had a negative tuberculosis test within the past 12 months.
8. **Dosage allowed/Quantity limit:**
   a) Adults: 160 mg subcutaneously on day 1, then 80 mg 2 weeks later (day 15), then 40 mg every other week beginning on day 29.
   b) Pediatric 20 kg (44 lbs) to less than 40 kg (88 lbs) (Humira Only): 80 mg subcutaneously on day 1, 40 mg on day 8, 40 mg on day 15. Starting on day 29, give 40 mg every other week or 20 mg every week.
   c) Pediatric 40 kg (88 lbs) and greater (Humira Only): 160 mg subcutaneously on day 1, 80 mg on day 8, 80 mg on day 15. Starting on day 29, give 80 mg every other week or 40 mg every week.

If all the above requirements are met, the medication will be approved for 12 months.

For **reauthorization**:
1. If the request is for a non-preferred adalimumab product, member has had a trial of all preferred biosimilars, where applicable, or acceptable clinical reason must be provided as to why biosimilar cannot be used; AND
2. Chart notes have been provided showing improvement in signs and symptoms of UC such as clinical remission, decrease in rectal bleeding, decreased corticosteroid use, etc..

If all the above requirements are met, the medication will be approved for an additional 12 months.

Uveitis (Humira, Abrilada, Amjevita, Adalimumab-adbm (Cyltezo), adalimumab-bwwd (Hadlima), adalimumab-fkjp (Hulio), Adalimumab-adaz (Hyrimoz), Yuflyma, Yusimry Only)

For **initial** authorization:
1. If the request is for Humira, member is 2 years of age or older; OR

2. If the request is for Abrilada, Amjevita, adalimumab-adbm (Cyltezo), adalimumab-bwwd (Hadlima), adalimumab-fkjp (Hulio), adalimumab-adaz (Hyrimoz), Yuflyma, or Yusimry, member is 18 years of age or older; AND
3. Medication must be prescribed by or in consultation with an ophthalmologist or rheumatologist; AND
4. Member has a documented diagnosis of non-infectious intermediate, posterior, or panuveitis; AND
5. Member has had a trial and failure of **BOTH** of the following (unless contraindicated or intolerable):
   a) Corticosteroid (e.g. prednisone, methylprednisolone);
   b) Systemic immunosuppressant (e.g. mycophenolate mofetil, methotrexate, etc.); AND
6. If the request is for a non-preferred adalimumab product, member has had a trial of all preferred biosimilars, where applicable, or acceptable clinical reason must be provided as to why biosimilar cannot be used; AND
7. Member has had a negative tuberculosis test within the past 12 months.
8. **Dosage allowed/Quantity limit:**
   Adults: 80 mg as a single subcutaneous dose, then 40 mg every other week beginning 1 week after the initial dose.
   Pediatrics (Humira Only):

Pediatric Weight (2 Years of Age and older)	Recommended Dosage
10 kg (22 lbs) to less than 15 kg (33 lbs)	10 mg every other week
15 kg (33 lbs) to less than 30 kg (66 lbs)	20 mg every other week
30 kg (66 lbs) and greater	40 mg every other week

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:
1. If the request is for a non-preferred adalimumab product, member has had a trial of all preferred biosimilars, where applicable, or acceptable clinical reason must be provided as to why biosimilar cannot be used; AND
2. Chart notes must document positive clinical response such as fewer flares, decreased or discontinued corticosteroid use, improved or stabilized visual acuity, or improved vitreous haze grade.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Adalimumab (Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Yuflyma, Yusimry) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
05/08/2017	New policy for Humira created. Policies SRx-0041, SRx-0042, and SRx-0043 archived. For diagnosis of CD: Remicade was removed from criteria requirements. For HS diagnosis: prescribed by a dermatologist requirement was added. For diagnosis of PP: immunosuppressive drug criterion was separated from phototherapies and topical agents' trials; Psoriasis Area and Severity Index (PASI) score requirement was added. For diagnosis of RA: non-biologic DMARDS were listed and criterion was added to use drug in combination with methotrexate, or if intolerant to methotrexate, use

	another immunosuppressant. List of diagnoses considered not medically necessary was added.
02/26/2019	Medication status changed to non-preferred. Actemra, Cimzia, Cosentyx, Enbrel, Kevzara, Olumiant, Otezla, Siliq and Xeljanz added to trial agents list. TB test allowed to be done within 12 months prior to initiation of therapy; chest x-ray option removed. References added. Symptoms of back pain for AS extended till before age of 50. Other drugs options allowed for PsA if there is an intolerance or contraindication to methotrexate.
11/13/2019	Age coverage for diagnosis of HS expanded; it's now approved for 12 years old and older.
11/22/2020	Replaced list of excluded diagnoses with the generic statement. Updated references. For all diagnoses: Removed repeat TB in reauth for all diagnoses. AS: Removed list of symptoms of spondyloarthritis because imaging result should be sufficient. Removed peripheral arthritis requirement – not relevant for this diagnosis. CD: Specified length of trials for conventional therapies, previously not specified. For severe disease, removed esophageal/gastroduodenal disease, specified that history of colonic resection must also be high risk for recurrence. JIA: Changed trials to require one non-biologic DMARD. Specified name to be pJIA. PsA: Added requirement of diagnosis of PsA. Changed the trial section to be 4 weeks of an NSAID AND 3 months of a DMARD unless other circumstances apply (e.g., concomitant axial disease, severe PsA, etc.). PsO: Removed rheumatologist from prescriber. Changed BSA to 3% or sensitive area involvement. Removed PASI score requirement. RA: Changed the trials to require methotrexate as one of the non-biologic DMARD trials; only one trial is needed if member has poor prognostic factors. Removed concurrent use with methotrexate. UC: Specified the length of trials for conventional therapies (previously not specified).
05/04/2021	For Ulcerative Colitis (UC), age limit expanded to 5 years of age or older (previously 18 or older). Dosage allowed section updated.
12/20/2021	Transferred to new template. Uveitis: Added references. Added age limit. Added pediatric dosing. Added diagnosis specifying type of uveitis. Added rheumatology as a specialist (FOCUS guideline). Changed the immunosuppressant examples to the most common ones with greatest evidence. Removed "loss of visual acuity or has evidence of retinal involvement." Changed trial of one to trial of both (Rosenbaum et al), removed trial duration. Created specific renewal criteria. Reduced initial auth duration from 12 months to 6 months. HS: Added references. Corrected adult dosing, added pediatric dosing. Removed PGA from diagnosis. Changed "negative urine nicotine test" to non-smoker status or smoking cessation education/counseling. Changed trial drug options to one or the other rather than both. Simplified the statement regarding weight loss. Changed the trial durations, 4 weeks was incorrect. Created specific renewal criteria. Reduced initial auth duration from 12 months to 6 months. RA: Removed Xeljanz, Olumiant from try first options per recent JAK inhibitor label changes; also changed from other specific drug names to say 2 preferred biologics one of which is a TNF inhibitor. Added additional reference. Edited the terminology "non-biologic" DMARD to "conventional" DMARD (JAK inhibitors are non-biologic DMARDs). Changed from requiring 2 csDMARD to just 1. Added complete dosing options per label.
03/31/2023	Changed name of policy to adalimumab and added Amjevita. Added Amjevita trial to applicable diagnoses.

09/27/2023	Changed policy name to Adalimumab (Humira, Hadlima, Hyrimoz and Hulio); replaced trial of Amjevita with trial of Hadlima, Hyrimoz and Hulio; removed Amjevita from the policy and added Hadlima, Hyrimoz and Hulio; added references.
01/24/2024	Changed policy name to Adalimumab (Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Yuflyma, Yusimry); added package insert references.
08/19/2024	RA: added quantity limit Uveitis: added in consultation with for prescriber specialty AS: changed trial of each NSAID from 4 weeks to 2 weeks for a total of 4 weeks of treatment per EULAR 22 guidelines; removed criteria requiring back pain for 3 or more months before the age of 50; added that member must have elevated CRP per EULAR 22 guidelines pJIA: added examples in reauthorization criteria;
10/31/2024	Added adalimumab-adbm as preferred agent. Added preferred vs non-preferred chart. PJIA: Updated age to 2 years or older for all products. CD: Updated age to 6 years or older for all products. HS: Added Hyrimoz and Yusimry
11/14/2024	Removed adalimumab-fkjp as preferred product
08/19/2025	Updated references. UC: removed duration from trials CD: replaced “biologics” with “advanced therapies (biologic, JAK inhibitor, etc.)”, added provider attestation to severe disease that requires immediate use of advanced therapy and replaced requirements with examples of severe disease PsA, pJIA, PsO: replaced “non-biologic" with “conventional”

Preferred	Non-Preferred
• Adalimumab-adaz • Adalimumab-adbm • Hadlima	• Abrilada (adalimumab-afzb) • Amjevita (adalimumab-atto) • Cyltezo • Hulio (adalimumab-fkjp) • Hyrimoz • Idacio (adalimumab-aacf) • Yuflyma (adalimumab-aaty) • Yusimry (adalimumab-aqvh) • Adalimumab-bwwd • Humira (adalimumab)

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1. Humira [prescribing information]. North Chicago, IL; AbbVie Inc.: 2025.
2. Abrilada [prescribing information]. New York, NY; Pfizer Inc.: 2024.
3. Amjevita [prescribing information]. Thousand Oaks, Ca; Amgen Inc.: 2024.
4. Cyltezo [prescribing information]. Ridgefield, CT; Boehringer Ingelheim Pharmaceuticals, Inc.: 2024.
5. Hadlima [prescribing information]. Jersey City, NJ; Organon & Co.: 2024.
6. Hyrimoz [prescribing information]. Princeton, NJ; Sandoz: 2025.
7. Hulio [prescribing information]. Morgantown, WV; Mylan Pharmaceuticals Inc.: 2025.
8. Idacio [prescribing information]. Lake Zurich, IL; Fresenius Kabi: 2024.
9. Yuflyma [prescribing information]. Jersey City, NJ; Celltrion, Inc.; 2025.
10. Yusimry [prescribing information]. Redwood City, CA; Coherus Biosciences, Inc.: 2023.
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