Pharmacy Medical Necessity Guidelines:
Infliximab products (Inflectra™, Remicade®, and Renflexis™)

Effective: April 16, 2018

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<th>Type of Review – Care Management</th>
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Fax Numbers:

MM: 888.415.9055

OVERVIEW

FOOD AND DRUG ADMINISTRATION-APPROVED INDICATIONS

Inflectra (infliximab-dyyb), Remicade (infliximab), and Renflexis (infliximab-abda) are tumor necrosis factor blockers indicated for the treatment of:

- **Crohn’s Disease (Inflectra, Remicade, Renflexis)**
  - Reducing signs and symptoms and inducing and maintaining clinical remission in adult and pediatric patients 6 years of age and older with moderately to severely active disease who have had an inadequate response to conventional therapy.
  - Reducing the number of draining enterocutaneous and rectovaginal fistulas and maintaining fistula closure in adult patients with fistulating Crohn’s disease.

- **Adult Ulcerative Colitis (Inflectra, Remicade, Renflexis)**
  - Reducing signs and symptoms, inducing and maintaining clinical remission and mucosal healing, and eliminating corticosteroid use in patients with moderately to severely active ulcerative colitis who have had an inadequate response to conventional therapy.

- **Pediatric Ulcerative Colitis (Remicade)**
  - Reducing signs and symptoms and inducing and maintaining clinical remission in pediatric patients 6 years of age and older with moderately to severely active ulcerative colitis who have had an inadequate response to conventional therapy.

- **Rheumatoid Arthritis (Inflectra, Remicade, Renflexis)**
  - In combination with methotrexate, for reducing signs and symptoms, inhibiting the progression of structural damage, and improving physical function in patients with moderately to severely active rheumatoid arthritis.

- **Ankylosing Spondylitis (Inflectra, Remicade, Renflexis)**
  - Reducing signs and symptoms in patients with active ankylosing spondylitis.

- **Psoriatic Arthritis (Inflectra, Remicade, Renflexis)**
  - Reducing signs and symptoms of active arthritis, inhibiting the progression of structural damage, and improving physical function in patients with psoriatic arthritis.

- **Plaque Psoriasis (Inflectra, Remicade, Renflexis)**
  - Adult patients with chronic severe (i.e., extensive and/or disabbling) plaque psoriasis who are candidates for systemic therapy and when other systemic therapies are medically less appropriate. Treatment should only be administered to patients who will be closely monitored and have regular follow-up visits with a physician.

**COVERAGE GUIDELINES**

Renflexis (infliximab-abda)
The plan may authorize coverage of Renflexis (infliximab-abda) for Members when all the following criteria for a particular regimen are met:

**Ankylosing Spondylitis**
1. The Member has a documented diagnosis of ankylosing spondylitis
2. The prescription is written by a rheumatologist
   AND
3. The Member is 18 years of age or older
   AND
4. Documentation of the following:
   a. The Member is new to the plan and has been stable on the requested medication prior to enrollment
   b. Documentation the Member has been previously hospitalized for rheumatoid arthritis
   OR
5. The Member has tried and failed treatment with, or the Member has a contraindication to at least one NSAID
   AND
6. The Member has tried and failed treatment with, or the provider has indicated clinical inappropriateness of Humira and Enbrel

**Crohn’s Disease (except fistulizing Crohn’s Disease)**
1. The Member has a documented diagnosis of Crohn’s disease by a gastroenterologist
   AND
2. The Member is at least 6 years of age or older
   AND
3. Documentation of the following:
   a. The Member is new to the plan and has been stable on the requested medication prior to enrollment
   b. Documentation from the provider that switching to Humira may be associated with worse clinical outcomes
   OR
4. The Member has demonstrated an inadequate response to, or the Member has a contraindication to an appropriate trial with two or more of the following agents:
   a. Corticosteroids (i.e., prednisone, prednisolone, methylprednisolone)
   b. 5-Aminosalicylates (i.e., Sulfasalazine, Azulfidine, Apriso, Delzicol, Pentasa, Rowasa, Dipentum, Colazal)
   c. 6-mercaptopurine (6-MP, Purinethol), azathioprine (Imuran), and/or cyclosporine (Gengraf, Neoral, Sandimmune)
   d. Methotrexate (MTX)
   AND
5. The Member has tried and failed treatment with, or the provider has indicated clinical inappropriateness of Humira

**Ulcerative Colitis**
1. The Member has a documented diagnosis of ulcerative colitis by a gastroenterologist
   AND
2. The Member is at least 6 years of age or older
   AND
3. Documentation of the following:
   a. The Member is new to the plan and has been stable on the requested medication prior to enrollment
   b. Documentation the Member has been previously hospitalized for ulcerative colitis
   OR
4. The Member has demonstrated an inadequate response to, or the Member has a contraindication to an appropriate trial with two or more of the following agents:
   a. Corticosteroids (i.e., prednisone, prednisolone, methylprednisolone)
   b. 5-Aminosalicylates (i.e., Sulfasalazine, Azulfidine, Apriso, Delzicol, Pentasa, Rowasa, Dipentum, Colazal)
   c. 6-mercaptopurine (6-MP, Purinethol), azathioprine (Imuran), and/or cyclosporine (Gengraf, Neoral, Sandimmune)
   d. Methotrexate (MTX)
   AND
5. The Member has tried and failed treatment with, or the provider has indicated clinical inappropriateness of Humira
**Fistulizing Crohn’s Disease**
1. The Member has a documented diagnosis of fistulizing Crohn’s disease by a gastroenterologist
   AND
2. The Member is at least 6 years of age or older
   AND
3. Documentation of the following:
   a. The Member is new to the plan and has been stable on the requested medication prior to enrollment
   b. Documentation the Member has been previously hospitalized for fistulizing Crohn’s disease
   OR
4. The Member has demonstrated an inadequate response to, or the Member has a contraindication to an appropriate trial with two or more of the following agents:
   a. Corticosteroids (i.e., prednisone, prednisolone, methylprednisolone)
   b. 5-Aminosalicylates (i.e., Sulfasalazine, Azulfidine, Apriso, Delzicol, Pentasa, Rowasa, Dipentum, Colazal)
   c. 6-mercaptopurine (6-MP, Purinethol), azathioprine (Imuran), and/or cyclosporine (Gengraf, Neoral, Sandimmune)
   d. Methotrexate (MTX)

**Plaque Psoriasis**
1. The Member has a documented definitive diagnosis from a dermatologist of severe chronic plaque psoriasis
   AND
2. The Member is 18 years of age or older
   AND
3. Documentation of the following:
   a. The Member is new to the plan and has been stable on the requested medication prior to enrollment
   b. Documentation the Member has been previously hospitalized for plaque psoriasis
   OR
4. The Member has tried and failed treatment with, or the Member has a contraindication to, at least 2 of the preferred therapies, such as PUVA or UVB phototherapy, acitretin, cyclosporine or methotrexate
   AND
5. The Member has tried and failed treatment with, or the provider has indicated clinical inappropriateness of Humira and Enbrel

**Psoriatic Arthritis**
1. The Member has a documented diagnosis of psoriatic arthritis
   AND
2. The prescription is written by a rheumatologist
   AND
3. The Member is 18 years of age or older
   AND
4. Documentation of the following:
   a. The Member is new to the plan and has been stable on the requested medication prior to enrollment
   b. Documentation the Member has been previously hospitalized for psoriatic arthritis
   OR
5. The Member tried and failed treatment with, or has a contraindication to methotrexate and one other DMARD (Disease Modifying Anti-rheumatic Drug), such as azathioprine, gold therapy, hydroxychloroquine, penicillamine, sulfasalazine, cyclosporine or leflunomide
   AND
6. The Member has tried and failed treatment with, or the provider has indicated clinical inappropriateness of Humira and Enbrel

**Rheumatoid Arthritis**
1. The Member has a documented diagnosis of rheumatoid arthritis
   AND
2. The prescription is written by a rheumatologist
3. The Member is 18 years of age or older

4. Documentation of the following:
   a. The Member is new to the plan and has been stable on the requested medication prior to enrollment
   b. Documentation the Member has been previously hospitalized for rheumatoid arthritis

5. The Member is currently taking methotrexate or has a contraindication to methotrexate and one other DMARD (Disease Modifying Anti-rheumatic Drug), such as azathioprine, gold therapy, hydroxychloroquine, penicillamine, sulfasalazine, cyclosporine or leflunomide

6. The Member has tried and failed treatment with, or the provider has indicated clinical inappropriateness of Humira and Enbrel

**Inflectra (infliximab-dyyb) and Remicade (infliximab)**

In addition to the criteria above, the plan may authorize coverage of **Inflectra (infliximab-dyyb) and Remicade (infliximab)** for Members when the following criteria is met:

1. The Member tried and failed treatment with, has a contraindication to, or there is documentation of clinical inappropriateness of treatment with Renflexis (infliximab-abda)

2. The Member is new to the plan and has been stable on the requested medication prior to enrollment

**LIMITATIONS**

1. For the diagnosis of plaque psoriasis, inconvenience does not qualify as a contraindication to phototherapy.
2. Documentation of a Member being a social drinker does not qualify as a medically acceptable contraindication or clinically inappropriate to methotrexate therapy.
3. Members new to the plan and stable on the requested medication are not required to provide documentation of prerequisite trials with conventional (i.e., non-biologic) therapies (e.g., hydroxychloroquine, methotrexate, sulfasalazine).

**CODES**

The following HCPCS/CPT code(s) are:

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<th>Description</th>
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<td>Q5103</td>
<td>Injection, infliximab-dyyb, biosimilar, (Inflectra), 10 mg</td>
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<td>Q5104</td>
<td>Injection, infliximab-abda, biosimilar, (Renflexis), 10 mg</td>
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**REFERENCES**


APPROVAL HISTORY

March 11, 2004: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:
- October 7, 2014: No changes
- June 9, 2015: Added pharmacy coverage guidelines for fistulizing Crohn’s Disease.
- October 6, 2015: No changes
- January 1, 2016: Administrative change to rebranded template.
- September 13, 2016: Administrative update: added HCPCS code Q5102.
- January 10, 2017: Added Inflectra to MNG and changed name of MNG to “Infliximab Products”. Changed department to review to Medical Management.
- April 11, 2017: Administrative update, Adding Tufts Health RITogether to the template
- September 12, 2017: Effective 9/18/17, added Renflexis (infliximab-abda) to the Medical Necessity Guideline. Effective 1/1/18, Renflexis (infliximab-abda) is the preferred infliximab product and use will be required prior to approval of Inflectra (infliximab-dyyb) or Remicade (infliximab).
- November 14, 2017: Administrative update adding a limitation to clarify that for plaque psoriasis, inconvenience does not qualify as a contraindication to phototherapy.
- December 12, 2017: Effective January 1, 2018 updated the criteria for Crohn’s disease allowing members new to the plan stable on the requested product to also require documentation that switching to Humira may be associated with worse clinical outcomes based on new state requirements. For all other indications, updated criteria allowing members new to the plan stable on the requested product to also require documentation of previous hospitalization for the requested indication due to new state requirements. Added the following limitation: Members new to the plan and stable on the requested product are not required to provide documentation of prerequisite trials with conventional (i.e., non-biologic) therapies (e.g., hydroxychloroquine, methotrexate, sulfasalazine).
- April 1, 2018: Administrative update: Removed Q Code Q5102; Added new Q Code Q5103 & Q5104 to Medical Necessity Guideline.
- April 10, 2018: Added the Limitation that documentation of a Member being a social drinker does not qualify as a medically acceptable contraindication or clinically inappropriateness to methotrexate therapy.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They are used in conjunction with a Member’s benefit document and in coordination with the Member’s physician(s). The plan makes coverage decisions on a case-by-case basis considering the individual Member’s health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

This Pharmacy Medical Necessity Guideline does not apply to Uniformed Services Family Health Plan Members or to certain delegated service arrangements. Unless otherwise noted in the Member’s benefit document or applicable Pharmacy Medical Necessity Guideline, Pharmacy Medical Necessity Guidelines do not apply to CareLinkSM Members. For self-insured plans, drug coverage may vary depending on the
terms of the benefit document. If a discrepancy exists between a coverage guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates will take precedence.

For Tufts Health Plan Medicare Preferred, please refer to Tufts Health Plan Medicare Preferred Prior Authorization Criteria.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to Member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.