Pharmacy Medical Necessity Guidelines: Remicade® (infliximab)

Effective: November 14, 2017

Prior Authorization Required  √  Type of Review – Care Management
Not Covered

Type of Review – Clinical Review  √
Pharmacy (RX) or Medical (MED) Benefit  MED
Department to Review  PRECERT

This Pharmacy Medical Necessity Guideline applies to the following:

**Tufts Health Plan Commercial Plans**
- Tufts Health Plan Commercial Plans – large group plans
- Tufts Health Plan Commercial Plans – small group and individual plans

**Tufts Health Public Plans**
- Tufts Health Direct – Health Connector
- Tufts Health Together – A MassHealth Plan
- Tufts Health RITogether – A Rite Care + Rhody Health Partners Plan

**Tufts Health Freedom Plan products**
- Tufts Health Freedom Plan - large group plans
- Tufts Health Freedom Plan - small group plans

Fax Numbers:
- All plans except Tufts Health Direct – Health Connector
  PRECERT: 617.972.9409
- Tufts Health Direct – Health Connector Only
  MM: 888.415.9055

**Note:** For Tufts Health Plan Medicare Preferred Members, please refer to the Tufts Health Plan Medicare Preferred Prior Authorization Criteria. Background, applicable product and disclaimer information can be found on the last page.

**OVERVIEW**

**FOOD AND DRUG ADMINISTRATION-APPROVED INDICATIONS**

Remicade (infliximab) is a tumor necrosis factor blocker indicated for the treatment of:

- **Crohn’s Disease**
  - 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 fistulizing Crohn’s disease.

- **Adult Ulcerative Colitis**
  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**
  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**
  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**
  Reducing signs and symptoms in patients with active ankylosing spondylitis.

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

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

The plan may authorize coverage of Remicade (infliximab) for Members when **all** the following criteria are met:

**Ankylosing Spondylitis**
1. The Member has a documented diagnosis of ankylosing spondylitis
   AND
2. The prescription is written by a rheumatologist
   OR
3. The Member has tried and failed treatment with another biological agent indicated for the treatment of ankylosing spondylitis
   OR
4. The Member is new to the plan and has been stable on Remicade (infliximab) prior to enrollment

**Crohn’s Disease or Ulcerative Colitis / Pediatric Ulcerative Colitis**
1. The Member has a documented diagnosis of Crohn’s disease or ulcerative colitis by a gastroenterologist
   AND
2. The Member has demonstrated an inadequate response to an appropriate trial with two or more of the following agents:
   - Corticosteroids (i.e., prednisone, prednisolone, methylprednisolone)
   - 5-Aminosalicylates (i.e., Sulfasalazine, Azulfidine®, Apriso™, Delzicol™, Pentasa®, Rowasa®, Dipentum®, Colazal®)
   - 6-mercaptopurine (6-MP, Purinethol®) and/or azathioprine (Imuran®)
   - Methotrexate (MTX)
   OR
3. The Member has tried and failed treatment with another biological agent indicated for the treatment of Crohn’s disease or ulcerative colitis
   OR
4. The Member is new to the plan and has been stable on Remicade (infliximab) prior to enrollment

**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. The Member has failed to respond to, or has been unable to tolerate phototherapy **and ONE** of the following therapeutically-similar medications:
   - Soriatane (acitretin)
   - Methotrexate
   - Cyclosporine
   OR
4. The Member has tried and failed treatment with another biological agent indicated for the treatment of plaque psoriasis
   OR
5. The Member is new to the plan and has been stable on Remicade (infliximab) prior to enrollment

**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 has a documented inadequate response or inability to tolerate the DMARD methotrexate
   OR
4. The Member has tried and failed treatment with another biological agent indicated for the treatment of psoriatic arthritis

    OR

5. The Member is new to the plan and has been stable on Remicade (infliximab) prior to enrollment

**Rheumatoid Arthritis**

1. The Member has a documented diagnosis of rheumatoid arthritis

    AND

2. The prescription is written by a rheumatologist

    AND

3. The Member has a documented inadequate response or inability to tolerate the DMARD methotrexate

    OR

4. The Member has tried and failed treatment with another biological agent indicated for the treatment of rheumatoid arthritis

    OR

5. The Member is new to the plan and has been stable on Remicade (infliximab) prior to enrollment

**Note:** Documentation of an inadequate response to methotrexate is *NOT* necessary if the intention is to administer methotrexate and Remicade (infliximab) together. The concurrent administration of methotrexate and Remicade (infliximab) may provide a synergistic effect and promote immunologic tolerance of Remicade (infliximab) therapy.

**Note:** Coverage decisions for conditions other than those outlined above will be made on a case-by-case basis.

**LIMITATIONS**

1. For the diagnosis of plaque psoriasis, inconvenience does not qualify as a contraindication to phototherapy.

**CODES**

The following HCPCS/CPT code(s) are:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J1745</td>
<td>Injection, infliximab, excludes biosimilar, 10mg</td>
</tr>
</tbody>
</table>

**REFERENCES**


**APPROVAL HISTORY**

November, 2001: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

- December 14, 2004: Remove "Kineret" from criteria #4 under the treatment of Rheumatoid Arthritis
- June 14, 2005: Add "Psoriatic Arthritis" to Coverage Topic / Criteria
- August 9, 2005: Under Psoriatic Arthritis, delete criteria #4, "The Member is unable to self-administer or fails to respond to or tolerate Enbrel". Under Rheumatoid Arthritis, delete criteria #4, "The Member is unable to self-administer or fails to respond to or tolerate ONE of the following: Enbrel or Humira". Under Ankylosing Spondylitis, delete criteria #3, "The Member is unable to self-administer or fails to respond to or tolerate Enbrel".
- February 14, 2006: Added a new indication, "Ulcerative Colitis" to the coverage criteria
- November 14, 2006: Added note to coverage criteria: For chronic plaque psoriasis, please refer to Clinical Coverage Criteria entitled “Injectable Drugs for the Treatment of Psoriasis”
- November 13, 2007: No changes
- November 11, 2008: No changes
- November 10, 2009: No changes
- January 1, 2010: Removal of Tufts Medicare Preferred language (separate criteria have been created specifically for Tufts Medicare Preferred).
- November 9, 2010: Added Apriso to examples of 5-aminosalicylates (Crohn’s Disease, Ulcerative Colitis indications)
- October 9, 2012: No changes.
- October 15, 2013: No changes.
- October 7, 2014: No changes.
- October 6, 2015: No changes.
- January 1, 2016: Administrative change to rebranded template.
- September 13, 2016: Effective 01/01/2017: Added exception language for Members new to the plan and stable on Remicade prior to enrollment. Added trial and failure with another biological agent indicated for the same condition.
- April 11, 2017: Administrative update, Adding Tufts Health RITogether to the template.
- September 12, 2017: No changes
- November 14, 2017: Administrative update adding a limitation to clarify that for plaque psoriasis, inconvenience does not qualify as a contraindication to phototherapy.

**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 CareLinkSTM 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.