

Policy: MBP 5.0

Section: Medical Benefit Pharmaceutical Policy

Subject: Remicade (infliximab), Inflectra (infliximab-dyyb), Renflexis (infliximab-abda), Avsola (infliximab-axxq)

I. Policy:

Remicade (infliximab), Inflectra (infliximab-dyyb), Renflexis (infliximab-abda), or Avsola (infliximab-axxq)

II. Purpose/Objective:

To provide a policy of coverage regarding Remicade (infliximab), Inflectra (infliximab-dyyb), Renflexis (infliximab-abda), or Avsola (infliximab-axxq)

III. Responsibility:

- A. Medical Directors
- B. Medical Management
- C. Pharmacy Department

IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

- a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
- b. provided for the diagnosis and the direct care and treatment of the Member's condition, illness disease or injury;
- c. in accordance with current standards good medical treatment practiced by the general medical community;
- d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
- e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient

Medicaid Business Segment

Medically Necessary — A service, item, procedure, or level of care compensable under the Medical Assistance program that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- i. Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- ii. Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- iii. Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

DESCRIPTION:

Infliximab is a therapeutic agent that inhibits activity of tumor necrosis factor alpha (TNF-alpha), a biological response mediator of inflammation. TNF-alpha is a key inflammatory mediator in rheumatoid arthritis, Crohn's disease and other autoimmune disorders. In these chronic conditions, overproduction of TNF-alpha leads to inflammation. Infliximab reduces inflammation by binding to and neutralizing TNF- alpha on the cell membrane and in the blood. Infliximab-dyyb, infliximab-abda, and infliximab-axxq are biosimilar agents of Infliximab.

CRITERIA FOR USE: Requires Prior Authorization by Medical Director or Designee

Remicade (infliximab), Inflectra (infliximab-dyyb), Renflexis (infliximab-abda), or Avsola (infliximab-axxq) will be considered medically necessary for the commercial, exchange, and CHIP lines of business when all of the following criteria are met based on indication:

For Treatment of Rheumatoid Arthritis:

- Must be 18 years of age or greater **AND**
- Requesting provider must be a rheumatologist **AND**
- Diagnosis of moderate to severe rheumatoid arthritis according the American College of Rheumatology Criteria for the Classification and Diagnosis of Rheumatoid Arthritis **AND**
- Medical record documentation that the infliximab product is not being used concurrently with a TNF blocker or other biologic agent **AND**
- Medical record documentation of an intolerance to, contraindication to, or therapeutic failure on a minimum 3 month trial of Humira*, Rinvoq*, OR Xeljanz* **AND**
- Continuation of effective dose of methotrexate during infliximab therapy **AND**
- One of the following:
 - For infliximab biosimilar requests other than Avsola (e.g. Renflexis, Inflectra), medical record documentation of a therapeutic failure on, intolerance to, or contraindication to infliximab-axxq (Avsola) **OR**
 - For infliximab reference product requests (i.e. Remicade), medical record documentation of a therapeutic failure on, intolerance to, or contraindication to infliximab-axxq (Avsola) **AND** infliximab-abda (Renflexis), **AND** infliximab-dyyb (Inflectra).

Recommended guidelines for use in the treatment of rheumatoid arthritis

- *3 mg/kg given as an intravenous infusion followed with additional similar doses at 2 and 6 weeks after the first infusion then every 8 weeks thereafter. Infliximab should be given in combination with methotrexate.*
- *For patients who have an incomplete response, consideration may be given to adjusting the dose up to 10 mg/kg or treating as often as every 4 weeks.*

For Treatment of Crohn's Disease, Pediatric Crohn's Disease, and/or Fistulizing Crohn's Disease:

- Must be 6 years of age or older; **AND**
- Prescription is written by a gastroenterologist **AND**
- Medical record documentation of a diagnosis of moderate to severe Crohn's disease **AND**
- Medical record documentation that the infliximab product is not being used concurrently with a TNF blocker or other biologic agent **AND**
- One of the following:
 - Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to Humira* **OR**
 - Physician documentation of Crohn's disease with actively draining fistulas.
- AND**
- One of the following:
 - For infliximab biosimilar requests other than Avsola (e.g. Renflexis, Inflectra), medical record documentation of a therapeutic failure on, intolerance to, or contraindication to infliximab-axxq (Avsola) **OR**
 - For infliximab reference product requests (i.e. Remicade), medical record documentation of a therapeutic failure on, intolerance to, or contraindication to infliximab-axxq (Avsola) **AND** infliximab-abda (Renflexis), **AND** infliximab-dyyb (Inflectra).

Recommended guidelines for use in the treatment of crohn's disease or fistulizing crohn's disease:

- *5 mg/kg given intravenously as an induction regimen at 0, 2, and 6 weeks followed by a maintenance regimen of 5 mg/kg every 8 weeks thereafter*
- *For adult members who respond and then lose response, consideration may be given to treatment with 10 mg/kg.*

For Treatment of Ulcerative Colitis:

- Must be at least 6 years of age; **AND**
- Must be prescribed by a gastroenterologist; **AND**
- Physician provided documentation of a diagnosis of moderate to severe ulcerative colitis **AND**
- Physician provided documentation of failure on, intolerance to, or contraindication to an adequate trial to at least one conventional therapy: corticosteroids, aminosalicylates, or immunomodulators (eg, 6-mercaptopurine or azathioprine) **AND**
- Medical record documentation that the infliximab product is not being used concurrently with a TNF blocker or other biologic agent

AND

- Medical record documentation of one of the following:
 - Therapeutic failure on, intolerance to, or contraindication to at least a 12 week trial of Humira* **OR**
 - Medical record documentation that infliximab is being prescribed to induce disease remission

AND

- One of the following:
 - For infliximab biosimilar requests other than Avsola (e.g. Renflexis, Inflectra), medical record documentation of a therapeutic failure on, intolerance to, or contraindication to infliximab-axxq (Avsola) **OR**
 - For infliximab reference product requests (i.e. Remicade), medical record documentation of a therapeutic failure on, intolerance to, or contraindication to infliximab-axxq (Avsola) **AND** infliximab-abda (Renflexis), **AND** infliximab-dyyb (Inflectra).

Recommended guidelines for the use in the treatment of ulcerative colitis

- *5 mg/kg as an intravenous infusion followed with additional similar doses at 2 and 6 weeks after the first infusion, then every 8 weeks thereafter.*

For Treatment of Ankylosing Spondylitis:

- Physician documentation of a diagnosis of ankylosing spondylitis **AND**
- Prescribing physician must be a rheumatologist **AND**
- Must be at least 18 years of age **AND**
- Medical record documentation that the infliximab product is not being used concurrently with a TNF blocker or other biologic agent **AND**
- Medical record documentation of an intolerance to, contraindication to, or therapeutic failure on a minimum 3 month trial of Humira* **AND** Cosentyx* **AND**
- One of the following:
 - For infliximab biosimilar requests other than Avsola (e.g. Renflexis, Inflectra), medical record documentation of a therapeutic failure on, intolerance to, or contraindication to infliximab-axxq (Avsola) **OR**
 - For infliximab reference product requests (i.e. Remicade), medical record documentation of a therapeutic failure on, intolerance to, or contraindication to infliximab-axxq (Avsola) **AND** infliximab-abda (Renflexis), **AND** infliximab-dyyb (Inflectra).

Recommended guidelines for use in ankylosing spondylitis

- *5mg/kg at 0, 2 and 6 weeks, then every 6 weeks thereafter*

For the treatment of Plaque Psoriasis:

- Prescribed by a dermatologist **AND**
- Insured individual must be at least 18 years of age **AND**
- Physician provided documentation of a diagnosis of moderate to severe plaque psoriasis characterized by greater than or equal to 5% body surface area involved or disease affecting crucial body areas such as the hands, feet, face, or genitals **AND**
- Medical record documentation that the infliximab product is not being used concurrently with a TNF blocker or other biologic agent **AND**
- Medical record documentation of an inadequate response to, contraindication to, or failure on at least 3 months of Humira* **AND** Cosentyx* **AND**
- One of the following:
 - For infliximab biosimilar requests other than Avsola (e.g. Renflexis, Inflectra), medical record documentation of a therapeutic failure on, intolerance to, or contraindication to infliximab-axxq (Avsola) **OR**

- For infliximab reference product requests (i.e. Remicade), medical record documentation of a therapeutic failure on, intolerance to, or contraindication to infliximab-axxq (Avsola) AND infliximab-abda (Renflexis), AND infliximab-dyyb (Inflectra).

Recommended guidelines for the use in the treatment of plaque psoriasis

- 5 mg/kg as an intravenous infusion followed with additional similar doses at 2 and 6 weeks after the first infusion, then every 8 weeks thereafter.

For the treatment of Psoriatic Arthritis:

- Physician provided documentation of a diagnosis of moderately to severely active psoriatic arthritis which must include the following:
 - Documentation of either active psoriatic lesions or a documented history of psoriasis
- AND**
- Must be prescribed by a rheumatologist or dermatologist **AND**
- Must be at least 18 years of age **AND**
- Medical record documentation that the infliximab product is not being used concurrently with a TNF blocker or other biologic agent **AND**
- Medical record documentation of an inadequate response to, contraindication to, or failure on 12 weeks of Humira* and Cosentyx* **AND**
- One of the following:
 - For infliximab biosimilar requests other than Avsola (e.g. Renflexis, Inflectra), medical record documentation of a therapeutic failure on, intolerance to, or contraindication to infliximab-axxq (Avsola) **OR**
 - For infliximab reference product requests (i.e. Remicade), medical record documentation of a therapeutic failure on, intolerance to, or contraindication to infliximab-axxq (Avsola) AND infliximab-abda (Renflexis), AND infliximab-dyyb (Inflectra).

Recommended guidelines for the use in the treatment of psoriatic arthritis

- 5 mg/kg as an intravenous infusion followed with additional similar doses at 2 and 6 weeks after the first infusion, then every 8 weeks thereafter.

AUTHORIZATION DURATION: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 12 months or less if the reviewing provider feels it is medically appropriate and all requests will require:

- Medical record documentation of continued or sustained improvement in the signs and symptoms of the treated indication while on infliximab therapy **AND**
- One of the following:
 - For infliximab biosimilar requests other than Avsola (e.g. Renflexis, Inflectra), medical record documentation of a therapeutic failure on, intolerance to, or contraindication to infliximab-axxq (Avsola) **OR**
 - For infliximab reference product requests (i.e. Remicade), medical record documentation of a therapeutic failure on, intolerance to, or contraindication to infliximab-axxq (Avsola) AND infliximab-abda (Renflexis), AND infliximab-dyyb (Inflectra).

Remicade (infliximab), Inflectra (infliximab-dyyb), Renflexis (infliximab-abda), or Avsola (infliximab-axxq) will be considered medically necessary for the Medicare line of business when all of the following criteria are met based on indication:

For Treatment of Rheumatoid Arthritis:

- Must be 18 years of age or greater **AND**
- Requesting provider must be a rheumatologist **AND**
- Diagnosis of moderate to severe rheumatoid arthritis according the American College of Rheumatology Criteria for the Classification and Diagnosis of Rheumatoid Arthritis **AND**
- Medical record documentation that the infliximab product is not being used concurrently with a TNF blocker or other biologic agent **AND**
- Continuation of effective dose of methotrexate during infliximab therapy **AND**
- For infliximab-abda (Renflexis) requests, medical record documentation of a therapeutic failure on, intolerance to, or contraindication to two of the following: infliximab-dyyb (Inflectra), infliximab (unbranded infliximab or Remicade), and/or infliximab-axxq (Avsola).

Recommended guidelines for use in the treatment of rheumatoid arthritis

- 3 mg/kg given as an intravenous infusion followed with additional similar doses at 2 and 6 weeks after the first infusion then every 8 weeks thereafter. Infliximab should be given in combination with methotrexate.
- For patients who have an incomplete response, consideration may be given to adjusting the dose up to 10 mg/kg or treating as often as every 4 weeks.

For Treatment of Crohn's Disease, Pediatric Crohn's Disease, and/or Fistulizing Crohn's Disease:

- Must be 6 years of age or older; **AND**
- Prescription is written by a gastroenterologist **AND**
- Medical record documentation of a diagnosis of moderate to severe Crohn's disease **AND**
- Medical record documentation that the infliximab product is not being used concurrently with a TNF blocker or other biologic agent **AND**
- For infliximab-abda (Renflexis) requests, medical record documentation of a therapeutic failure on, intolerance to, or contraindication to two of the following: infliximab-dyyb (Inflectra), infliximab (unbranded infliximab or Remicade), and/or infliximab-axxq (Avsola).

Recommended guidelines for use in the treatment of crohn's disease or fistulizing crohn's disease:

- 5 mg/kg given intravenously as an induction regimen at 0, 2, and 6 weeks followed by a maintenance regimen of 5 mg/kg every 8 weeks thereafter
- For adult members who respond and then lose response, consideration may be given to treatment with 10 mg/kg.

For Treatment of Ulcerative Colitis:

- Must be at least 6 years of age; **AND**
- Must be prescribed by a gastroenterologist; **AND**
- Physician provided documentation of a diagnosis of moderate to severe ulcerative colitis **AND**
- Medical record documentation that the infliximab product is not being used concurrently with a TNF blocker or other biologic agent **AND**
- For infliximab-abda (Renflexis) requests, medical record documentation of a therapeutic failure on, intolerance to, or contraindication to two of the following: infliximab-dyyb (Inflectra), infliximab (unbranded infliximab or Remicade), and/or infliximab-axxq (Avsola).

Recommended guidelines for the use in the treatment of ulcerative colitis

- 5 mg/kg as an intravenous infusion followed with additional similar doses at 2 and 6 weeks after the first infusion, then every 8 weeks thereafter.

For Treatment of Ankylosing Spondylitis:

- Physician documentation of a diagnosis of ankylosing spondylitis **AND**
- Prescribing physician must be a rheumatologist **AND**
- Must be at least 18 years of age **AND**
- Medical record documentation that the infliximab product is not being used concurrently with a TNF blocker or other biologic agent **AND**
- For infliximab-abda (Renflexis) requests, medical record documentation of a therapeutic failure on, intolerance to, or contraindication to two of the following: infliximab-dyyb (Inflectra), infliximab (unbranded

infliximab or Remicade), and/or infliximab-axxq (Avsola).

Recommended guidelines for use in ankylosing spondylitis

- 5mg/kg at 0, 2 and 6 weeks, then every 6 weeks thereafter

For the treatment of Plaque Psoriasis:

- Prescribed by a dermatologist **AND**
- Insured individual must be at least 18 years of age **AND**
- Physician provided documentation of a diagnosis of moderate to severe plaque psoriasis characterized by greater than or equal to 5% body surface area involved or disease affecting crucial body areas such as the hands, feet, face, or genitals **AND**
- Medical record documentation that the infliximab product is not being used concurrently with a TNF blocker or other biologic agent **AND**
- For infliximab-abda (Renflexis) requests, medical record documentation of a therapeutic failure on, intolerance to, or contraindication to two of the following: infliximab-dyyb (Inflectra), infliximab (unbranded infliximab or Remicade), and/or infliximab-axxq (Avsola).

Recommended guidelines for the use in the treatment of plaque psoriasis

- 5 mg/kg as an intravenous infusion followed with additional similar doses at 2 and 6 weeks after the first infusion, then every 8 weeks thereafter.

For the treatment of Psoriatic Arthritis:

- Physician provided documentation of a diagnosis of moderately to severely active psoriatic arthritis which must include the following:
 - Documentation of either active psoriatic lesions or a documented history of psoriasis**AND**
- Must be prescribed by a rheumatologist or dermatologist **AND**
- Must be at least 18 years of age **AND**
- Medical record documentation that the infliximab product is not being used concurrently with a TNF blocker or other biologic agent **AND**
- For infliximab-abda (Renflexis) requests, medical record documentation of a therapeutic failure on, intolerance to, or contraindication to two of the following: infliximab-dyyb (Inflectra), infliximab (unbranded infliximab or Remicade), and/or infliximab-axxq (Avsola).

Recommended guidelines for the use in the treatment of psoriatic arthritis

- 5 mg/kg as an intravenous infusion followed with additional similar doses at 2 and 6 weeks after the first infusion, then every 8 weeks thereafter.

AUTHORIZATION DURATION: Approval will be given for an initial duration of six (6) months. For continuation of coverage, medical record documentation of clinical improvement or lack of progression in the signs and symptoms of the treated indication at six (6) months of infliximab therapy is required.

After the initial six (6) month approval, subsequent approvals for coverage will be for a duration of one (1) year. Reevaluation of coverage will be every one (1) year requiring medical record documentation of continued or sustained improvement in the signs and symptoms of the treated indication while on infliximab therapy.

LINE OF BUSINESS:

Eligibility and contract specific benefit limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy.

This policy will be revised as necessary and reviewed no less than annually.

Devised: 10/01 (pharmacy policy 21.0)

Revised: 03/01, 01/02 (Medical Benefit Pharmaceutical Policy 5.0), 08/02 CMS Indication addition, 07/03 clarification of additional CMS mandated indications indication, 11/03 addition of pediatric criteria; 03/04(update coverage criteria); 05/05 Update indications; 08/05 update indications; 07/07 update RA criteria for coverage, 11/07 (criteria updates), 02/09 (indications); 05/10 (criteria edit); 10/11 (added pediatric ulcerative colitis); 1/13, 09/16/14 (P&T), 11/18/14 (P&T), 12/31/14 (formulary alternatives for all indications except UC updated), 03/15, 09/15/15 (removed joint counts), 3/21/17 (Inflectra added), 1/16/18 (Renflexis added), 3/20/18 (form alt, duplicate therapy), 4/24/18 (per DHS grandfather), 9/18/18 (RA form alt), 1/21/20 (RA form alt, and ped UC age), 6/18/21 (Avsola added, grandfathering removed, Avsola failure), 7/20/21 (update UC 'conventional therapy' and Humira failure language), 7/19/22 (auth duration), 7/12/23 (LOB carve out, Medicaid business segment)

Reviewed: 02/14, 09/16/14, 11/18/14, 9/13/16, 8/30/19, 1/19/21