RX.PA.016.MPC Infliximab Products (Remicade®, Infliximab, Avsola®, Renflexis®, Inflectra®, Zymfentra™

The purpose of this policy is to define the prior authorization process for Remicade® (infliximab), Infliximab, Avsola® (infliximab-axxq), Renflexis® (infliximab-abda), Inflectra® (infliximab-dyyb), and Zymfentra™ (infliximab-dyyb).

Site of Service
Medication(s) included in this criteria are subject to review under policy RX.PA.070.MPC: Site of Service – Outpatient Infusion/Injection Services

Remicade® (infliximab), Infliximab, Avsola® (infliximab-axxq), Renflexis® (infliximab- abda) and Inflectra® (infliximab-dyyb) are indicated for the following:

- Reducing signs and symptoms, inhibiting the progression of structural damage, and improving physical function in patients with moderately to severely active rheumatoid arthritis. Remicade® (infliximab) is indicated only in combination with methotrexate.
- Reducing signs and symptoms of active arthritis, inhibiting the progression of structural damage, and improving physical function in patients with psoriatic arthritis.
- Reducing signs and symptoms in patients with active ankylosing spondylitis
- Treatment of 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 are closely monitored and have regular follow-up visits with a physician.
- Reducing signs and symptoms and inducing and maintaining a clinical remission in adult and pediatric patients 6 years of age and older with moderately to severely active Crohn's disease who have had an inadequate response to conventional therapy AND for reducing the number of draining enterocutaneous and rectovaginal fistulas and maintaining fistula closure in adult patients with fistulizing Crohn's disease.
- Reducing signs and symptoms, inducing and maintaining clinical remission and mucosal healing, and eliminating corticosteroid use in adult patients with moderately to severely active ulcerative colitis who have had an inadequate response to conventional therapy

Zymfentra™ (infliximab-dyyb) is indicated for the following:

- Reducing signs and symptoms and inducing and maintaining clinical remission in adults with moderately to severely active Crohn's disease who have had an inadequate response to conventional therapy AND for reducing the number of draining enterocutaneous and rectovaginal fistulas and maintaining fistula closure in adult patients with fistulizing Crohn's disease.
- Reducing signs and symptoms, inducing and maintaining clinical remission and mucosal healing, and eliminating corticosteroid use in adult patients with moderately to severely active ulcerative colitis who have had an inadequate response to conventional therapy.

PROCEDURE

A. Initial Authorization Criteria:

Must meet all of the criteria listed under the respective diagnosis:

For All Diagnoses:

- Requests for Remicade® (infliximab), Infliximab, Avsola® (infliximab-axxq), Renflexis® (infliximab-abda), Inflectra® (infliximab-dyyb), Zymfentra® (infliximab-dyyb) are subject to the preferred medical medication list.

	Products
Preferred	• **Renflexis® (infliximab-abda)** • **Inflectra® (infliximab-dyyb)** • **Infliximab** • **Avsola® (infliximab-axxq)**
Non-preferred	• **Remicade® (infliximab)** • **Zymfentra™ (infliximab-dyyb)**

- Requests for non-preferred products must have documented trial and failure or intolerance or contraindication to ALL preferred products
- Must have a negative tuberculosis skin test [such as Tuberculin PPD (purified protein derivative) test] or Interferon-Gamma Release Assay (IGRA) whole-blood test [such as QuantiFERON®-TB Gold In-Tube test (QFT-GIT) or T-SPOT®.*TB* test (T-Spot)]
- Must currently not be using a tumor necrosis factor (TNF)-blocking agent or other biologic agents in combination with Remicade
- Must have no evidence of infection

1. Rheumatoid Arthritis:

- Must be prescribed by a rheumatologist

- Must be age 18 years or older
- Must have a diagnosis of moderate to severely active rheumatoid arthritis
- Must have an adequate trial (of at least 3 months) of methotrexate with an inadequate response or significant side effects/toxicity or have a contraindication to this therapy
    - Members with significant side effects/toxicity or who have a contraindication to methotrexate must have an adequate trial (of at least 3 months) of leflunomide, hydroxychloroquine, or sulfasalazine with an inadequate response, significant side effect/toxicity, or have a contraindication to these therapies
- Must have adequate trial (of at least 3 months) and failure of Enbrel and a preferred adalimumab product

2. Psoriatic Arthritis:

- Must be prescribed by a rheumatologist or dermatologist
- Must be age 18 years or older
- Must have a diagnosis of active psoriatic arthritis
- For peripheral disease and dactylitis:
    - Must have an adequate trial (of at least 4 weeks) with a non-steroidal anti- inflammatory drugs (NSAIDs) at an anti-inflammatory target dose, with an inadequate response, significant side effects/toxicity, or have a contraindication to these therapies
    - Must have an adequate trial (of at least 3 months) of a conventional systemic therapy (methotrexate, sulfasalazine, or leflunomide) with an inadequate response, significant side effects /toxicity, or have a contraindication to these therapies
- For axial disease and enthesitis:
    - Must have an adequate trial (of at least 4 weeks each) with TWO NSAIDs at anti-inflammatory doses with an inadequate response or significant side effects/toxicity or have a contraindication to this therapy
- For skin or nail psoriatic arthritis:
    - Must have an adequate trial of topical treatments, phototherapy, or photochemotherapy with an inadequate response or significant side effects/toxicity or have a contraindication to these therapies
    - Must have an adequate trial (of at least 3 months) of a conventional systemic therapy (methotrexate, cyclosporine, or acitretin) with an inadequate response or significant side effects/toxicity or have a contraindication to these therapies
- Must have adequate trial (of at least 3 months) and failure of Enbrel and a preferred adalimumab product

3. Ankylosing Spondylitis:

- Must be prescribed by a rheumatologist
- Must be age 18 years or older
- Must have a diagnosis of ankylosing spondylitis
- Must have an adequate trial (of at least 4 weeks) with TWO NSAIDs at anti-inflammatory

dose, with an inadequate response, significant side effects/toxicity, or have a contraindication to these therapies
- Must have adequate trial (of at least 3 months) and failure of Enbrel and a preferred adalimumab product

4. Plaque Psoriasis:
- Must be prescribed by a dermatologist
- Must be age 18 years or older
- Must have a diagnosis of severe chronic plaque psoriasis
- Must have a minimum body surface area involvement of > 5% (Members with plaque psoriasis of palms, soles, head and neck, or genitalia are not required to have a minimum body surface area involvement)
- Must have an adequate trial of topical treatments, phototherapy, or photochemotherapy with an inadequate response or significant side effects/toxicity or have a contraindication to these therapies
- Must have an adequate trial (of at least 3 months) of a conventional systemic therapy (methotrexate, cyclosporine, or acitretin) with an inadequate response or significant side effects/toxicity or have a contraindication to these therapies
- Must have adequate trial (of at least 3 months) of Enbrel and a preferred adalimumab product

5. Crohn's Disease:
- Must be prescribed by a gastroenterologist
- Must be age 6 years or older
- Must have a diagnosis of moderate to severely active Crohn's disease or fistulizing Crohn's disease
- Must have an adequate trial of conventional therapy including corticosteroids **OR** at least 3 months of immunosuppressants (e.g., azathioprine, 6-mercaptopurine) with an inadequate response or significant side effects/toxicity or have a contraindication to these therapies
- Must have adequate trial (of at least 3 months) and failure of a preferred adalimumab product for members 18 years old and older
- Documentation to confirm that the patient has had a treatment failure with a preferred Ustekinumab product (Yesintek, Pyzchiva, Steqeyma), for at least 3 months or the patient is intolerant or contraindicated
- Request for Zymfentra (infliximab-dyyb) only:
    - Coverage for subcutaneous formulations is not preferred.
    - Prescriber must supply clinical documentation to support why the subcutaneous formulation is medically necessary over ALL the preferred IV formulations.
    - Prescriber must provide documentation of contraindication to all preferred infliximab products

6. Ulcerative Colitis:

- Must be prescribed by a gastroenterologist
- Must be age 6 years or older
- Must have a diagnosis of moderate to severely active ulcerative colitis
- Must have an adequate trial of conventional therapy including corticosteroids, at least 3 months of 5-ASA agents (e.g., sulfasalazine, mesalamine), **OR** at least 3 months of immunosuppressants (azathioprine, 6-mercaptopurine) with an inadequate response or significant side effects/toxicity or have a contraindication to these therapies
- Must have adequate trial (of at least 3 months) and failure of a preferred adalimumab product and a preferred Ustekinumab product for members 18 years old and older
    - Previous trial of an Adalimumab product and Ustekinumab product is not required in the following patients:
        - Moderate to severe symptoms:
            - Mayo endoscopy sub-score of 2 or higher
            - >6 bowel movements per day
            - ≥4 bloody stools per day
            - Hemoglobin (Hgb) < 75% of normal (male patients < 10 g/dL, female patients < 9 g/dL)

        OR

        - Mildly active symptoms with poor prognosis factors for disease severity:
            - Severe endoscopic disease: Mayo sub-score of 3
            - Extensive colitis
            - Corticosteroid dependence
            - Elevated CRP: ≥ 10 mg/dL
            - Low serum album: <3.4 gm/dL
- Request for Zymfentra (infliximab-dyyb) only:
    - Coverage for subcutaneous formulations is not preferred.
    - Prescriber must supply clinical documentation to support why the subcutaneous formulation is medically necessary over ALL the preferred IV formulations.
    - Prescriber must provide documentation of contraindication to all preferred infliximab products

B. Must be prescribed at a dose within the manufacturer's dosing guidelines (based on diagnosis, weight, etc) listed in the FDA approved labeling or within compendia supported dosing guidelines.

C. Infliximab products will be considered investigational or experimental for any other use and coverage may be provided if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia (AHFS-DI, DrugDex, Lexi-Drug, etc…) or at least two published peer-reviewed randomized controlled trials for the treatment of the diagnosis(es) for which it is prescribed. Abstracts (including meeting abstracts) are excluded from review

consideration. These requests will be reviewed on a case by case basis to determine medical necessity.

D. Reauthorization Criteria:

	Products
Preferred	• **Renflexis® (infliximab-abda)** • **Inflectra® (infliximab-dyyb)** • **Infliximab** • **Avsola® (infliximab-axxq)**
Non-preferred	• **Remicade® (infliximab)** • **Zymfentra™ (infliximab-dyyb)**

- Requests for non-preferred products must have documented trial and failure or intolerance or contraindication to ALL preferred products

All prior authorization renewals are reviewed on an annual basis to determine the Medical Necessity for continuation of therapy. Authorization may be extended at 1-year intervals based upon:

MPC Renewal:

- Chart documentation from the prescriber that the member's condition has improved based upon the prescriber's assessment while on therapy.

Renewal from Previous Insurer:

- Members who have received prior approval (from insurer other than MPC), or have been receiving medication samples, should be considered under criterion A (Initial Authorization Criteria)
- Provider has documented positive clinical response to therapy for the member

Limitations:

Length of Authorization (if above criteria met)	
Initial Authorization	Up to 1 year
Reauthorization	Same as initial

Codes:

Code	Description
J1745	Injection, infliximab, excludes biosimilar, 10 mg
Q5103	Injection, infliximab-dyyb, biosimilar, (inflectra), 10 mg
Q5104	Injection, infliximab-abda, biosimilar, (renflexis), 10 mg

Code	Description
Q5121	Injection, infliximab-axxq, biosimilar, (Avsola), 10 mg

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REVIEW HISTORY

DESCRIPTION OF REVIEW / REVISION	DATE APPROVED
Update to include preferred vs non-preferred products under the continuation of therapy pathway	*09/2026*
Update to ulcerative colitis indication to clarify requirement of adalimumab for patients with moderate-severe disease process	*06/2026*
Annual review	*02/2026*
Selected review Addition of trial and failure, contraindication to, or intolerance to a Ustekinumab product for Crohn's and ulcerative colitis indications	*07/2025*
Annual review	*02/2025*
Selected review Addition of site of service policy requirements *Addition of clinical documentation for subcutaneous formulation requests*	*03/2024*
Annual review *Addition of renewal criteria for MPC vs renewal from previous insurer*	*02/2024*
Updated approved dosing verbiage to include compendia supported dosing regimens	*09/2023*
Annual review	*02/2023*
Update to preferred medication list to include Avsola	*08/2022*
Update to off-label restrictions	*04/2022*
Annual review and addition of Infliximab	*02/2022*
Addition of dosing requirements, off-label restrictions and treatment failure requirement with either Humira and Enbrel	*12/2021*
Addition of preferred/non-preferred requirements in review criteria	*09/2021*
Removal of pharmacy benefit requirements in review criteria	*04/2021*
P&T Review	*11/2020*