Drug Therapy Guidelines

Infliximab (Remicade®, Inflectra®/infliximab-dyyb, Renflexis™/infliximab-abda)

**Medical Benefit**

- **Effective:** 2/15/19

**Pharmacy-Formulary 1**

- **Next Review:** 12/19

**Pharmacy-Formulary 2**

- **Date of Origin:** 4/1/05

**Pharmacy-Formulary 3/Exclusive**

- **Review Dates:** 4/1/05, 2/1/06, 10/15/06, 11/5/07, 12/15/08, 12/09, 6/10, 1/11, 12/12, 12/13, 12/14, 12/15, 12/16, 6/17, 12/17, 12/18

### I. Medication Description

Remicade® (infliximab) is a chimeric monoclonal antibody that neutralizes the biological activity of tumor necrosis factor-α (TNF-α) by binding with high affinity to the soluble and transmembrane forms of TNF-α, which subsequently inhibits binding of TNF-α with its receptors. Biological activities attributed to TNF-α include the following: induction of proinflammatory cytokines such as interleukins 1 and 6; enhancement of leukocyte migration by increasing endothelial layer permeability and expression of adhesion molecules by endothelial cells and leukocytes; activation of neutrophil and eosinophil functional activity; and induction of acute phase reactants and other liver proteins, as well as tissue-degrading enzymes produced by synoviocytes and/or chondrocytes. The clinical result of inhibiting TNF-α activity includes reduction in inflammatory processes associated with specific autoimmune disorders.

Inflectra® (infliximab-dyyb) and Renflexis™ are biosimilar to infliximab. Biosimilar medications are approved and treated as therapeutically equivalent to the reference biologic medicine, including having identical contraindications, precautions, adverse reactions, drug interactions, and administration instructions.

### II. Position Statement

Coverage is determined through a prior authorization process with supporting clinical documentation for every request.

### III. Policy

- **Coverage is provided for the following conditions when the listed criteria are met:**
  - **Ankylosing spondylitis (active disease):**
    - Prescribed by a rheumatologist **AND**
    - The member has had inadequate results with at least two NSAIDs (unless NSAIDs are contraindicated)
  - **Crohn’s disease (moderate to severe):**
    - Prescribed by a gastroenterologist **AND**
    - At least ONE of the following criteria is met:
      - The member has had an inadequate response to or not tolerated immune modulators (ex. azathioprine, 6-MP, methotrexate) **OR**
      - The member has not responded to steroids or is steroid refractory **OR**
      - The member has fistulizing disease
  - **Plaque psoriasis (moderate to severe disease):**
    - Prescribed by a rheumatologist or dermatologist **AND**
- At least 10% of BSA affected or less than 10% BSA affected but with palmar, plantar, head/neck, or genitalia involvement **AND**
- Member has had an inadequate response to PUVA or UVB therapy unless contraindicated **AND**
- Member has had an inadequate response to non-biologic systemic therapy (i.e. methotrexate, cyclosporine, acitretin) unless contraindicated

  o **Psoriatic arthritis (active disease):**
    - Prescribed by a rheumatologist or dermatologist **AND**
    - One of the following:
      - Member has tried therapy with at least one non-biologic DMARD with either treatment failure after 12 weeks or intolerable side effects (unless DMARDs are contraindicated) **OR**
      - If predominantly axial disease is documented, the member has experienced treatment failure with at least two oral NSAIDs (unless NSAIDs are contraindicated)

  o **Rheumatoid arthritis (moderate to severe disease):**
    - Prescribed by a rheumatologist **AND**
    - Medication is used in combination with methotrexate (unless contraindicated) **AND**
    - Member has tried therapy with at least one non-biologic DMARD with either treatment failure after 12 weeks or intolerable side effects (unless DMARDs are contraindicated)

  o **Ulcerative colitis (moderate to severe disease):**
    - Prescribed by a gastroenterologist **AND**
    - Member has had an inadequate response or intolerance to any TWO of the following:
      - Sulfasalazine or 5-Aminosalicylic acid (5-ASA)
      - Immune modulators (ex. azathioprine, 6-MP)
      - Oral or intravenous (IV) steroids (steroid refractory)

**AND**
- Coverage of the non-preferred medications (Inflectra and Renflexis) can be considered if the member has first attempted therapy with one diagnosis-appropriate plan-preferred medication (Remicade or Simponi Aria) **OR** if the following criteria have been met:
  - When requesting coverage of a brand medication for which an A/B rated generic is available, there is sufficient evidence that the use of the A/B rated generic equivalent has resulted in inadequate results **AND**
  - At least one of the following is met:
    - The plan-preferred medications are contraindicated or will likely cause an adverse reaction by or physical or mental harm to the member.
    - The plan-preferred medications are expected to be ineffective based on the known clinical history and conditions of the member and the member’s prescription drug regimen.
    - The member has tried the plan-preferred medications or another prescription drug in the same pharmacologic class or with the same mechanism of action and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
    - The member is stable on the medication selected by their healthcare professional for the medical condition under consideration (where “stable” is defined as receiving the...
medication for an adequate period of time, have achieved optimal response, and continued favorable outcomes are expected UNLESS the medication was initially selected due to the availability of a drug sample or a coupon card and the member does not otherwise meet the definition of “stable”).

- The plan-preferred medication is not in the best interest of the member because it will likely cause a significant barrier to the member’s adherence or to compliance with the member’s plan of care, will likely worsen a comorbid condition of the member, or will likely decrease the member’s ability to achieve or maintain reasonable functional ability in performing daily activities.

IV. Quantity Limits

- For Rheumatoid Arthritis
  - Month 1 (induction dosing): no more than 100 billable units (1,000mg)
  - Month 2 (induction dosing): no more than 60 billable units (600mg)
  - Month 3 and after (maintenance dosing): no more than 100 billable units every 4 weeks
- For Crohn’s Disease
  - Month 1 (induction dosing): no more than 100 billable units (1,000mg)
  - Month 2 (induction dosing): no more than 60 billable units (600mg)
  - Month 3 and after (maintenance dosing): no more than 100 billable units every 8 weeks
- For Ankylosing Spondylitis
  - Month 1 (induction dosing): no more than 100 billable units (1,000mg)
  - Month 2 (induction dosing): no more than 60 billable units (600mg)
  - Month 3 and after (maintenance dosing): no more than 60 billable units every 6 weeks
- For all other indications:
  - Month 1 (induction dosing): no more than 100 billable units (1,000mg)
  - Month 2 (induction dosing): no more than 60 billable units (600mg)
  - Month 3 and after (maintenance dosing): no more than 60 billable units every 8 weeks

V. Coverage Duration

Coverage is available for 1 year and may be renewed.

VI. Coverage Renewal Criteria

Coverage can be renewed based upon the following criteria:
- Clinical response or remission of disease is maintained with continued use AND
- Absence of unacceptable toxicity from the drug

VII. Billing/Coding Information

- Remicade (infliximab) J1745 – 1 billable unit is 10mg
### Drug Therapy Guidelines

| Infliximab (Remicade®, Inflectra®, infliximab-dyyb, Renflexis™/infliximab-abda) | Last Review Date: 12/2018 |
| --- |

- Inflectra (infliximab-dyyb) Q5103 – 1 billable unit is 10 mg
- Renflexis (infliximab-abda) Q5104 – 1 billable unit is 10 mg
- Pertinent Indications:
  - Rheumatoid Arthritis – M06.9, M05.00, M05.30, M05.60, M06.1, M06.4, M08.00, M12.00
  - Ankylosing Spondylitis – M45.9
  - Crohn’s Disease – K50.00, K50.10, K50.80, K50.90
  - Plaque psoriasis – L40.0-L40.4, L40.8
  - Psoriatic arthritis – L40.54, L40.59
  - Ulcerative Colitis – K51.00, K51.20, K51.30, K51.50, K51.80, K51.90

### VIII. Summary of Policy Changes

- 4/1/11: Clarification of prior DMARD use requirements
- 6/15/12:
  - Addition of pediatric Crohn’s diagnosis
  - Revision of DMARD and steroid requirements for Crohn’s and Ulcerative Colitis
  - Addition of opportunistic infections to Black Box (Listeria, Legionella)
  - Revision of systemic or phototherapy requirements for Plaque Psoriasis
- 3/15/13: no policy changes
- 3/15/14: no policy changes
- 3/15/15: no policy changes
- 7/1/15: formulary distinctions made, removal of need for Tb testing on members not at high risk
- 3/15/16: updated quantity limits to including induction dosing
- 1/1/17: addition of Inflectra (infliximab-dyyb) to the policy as a non-preferred medication
- 5/1/17: step therapy criteria added
- 7/1/17: addition of Renflexis (infliximab-abda) to the policy as a non-preferred medication
- 1/1/18: updated billing/coding information; clarified criteria for use in RA; updated step criteria
- 4/1/18: updated billing/coding information
- 2/15/19: added steroid trials to CD and UC coverage criteria

### IX. References

1. Up-to-date Online, retrieved November 2018
3. Facts and Comparisons Online, retrieved November 2016
5. Rutgeerts P; Sandborn WJ; Feagan BG; Reinisch W; Olson A; Johanss J; Travers S; Rachmilewitz D; Hanauer SB; Lichtenstein GR; de Villiers WJ; Present D; Sands BE; Colombel JF. Infliximab for induction and maintenance therapy for ulcerative colitis. N Engl J Med. 2005 Dec 8; 353(23):2462-76.
<table>
<thead>
<tr>
<th>Drug Therapy Guidelines</th>
<th>Infliximab (Remicade®, Inflectra®/infliximab-dyyb, Renflexis™/infliximab-abda)</th>
<th>Last Review Date: 12/2018</th>
</tr>
</thead>
</table>


*These guidelines are not applicable to benefits covered under Medicare Advantage. Medicare Advantage benefit coverage requests are reviewed in accordance with the guidance set forth in Chapter 15 Section 50 of the Centers for Medicare & Medicaid Services Medicare Benefit Policy Manual.

The Plan fully expects that only appropriate and medically necessary services will be rendered. The Plan reserves the right to conduct pre-payment and post-payment reviews to assess the medical appropriateness of the above-referenced therapies.

The preceding policy is a guideline to allow for coverage of the pertinent medication/product, and is not meant to serve as a clinical practice guideline.