

PHARMACY POLICY STATEMENT

Indiana Medicaid

DRUG NAME	Remicade (infliximab)
BILLING CODE	J1745 (1 unit = 10 mg or 1 x 100 mg vial = 10 units)
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include Actemra, Cimzia, Cosentyx, Enbrel, Kevzara, Olumiant, Otezla, Siliq and Xeljanz QUANTITY LIMIT—1200 mg (120 units per dose)
LIST OF DIAGNOSES CONSIDERED NOT MEDICALLY NECESSARY	Click Here

Remicade (infliximab) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

ANKYLOSING SPONDYLITIS (AS)

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a rheumatologist; AND
3. Member has a documented diagnosis of active ankylosing spondylitis (AS); AND
4. Member must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has had back pain for 3 months or more that began before the age of 50; AND
6. Current imaging results show an inflammation of one or both of the sacroiliac joints (sacroiliitis); AND
7. Member has tried and failed to respond to treatment with at least **two** NSAIDs taken at the maximum recommended dosages. Treatment failure requires at least 4 weeks of therapy with each NSAID without an adequate response; AND
8. Member must have tried and failed treatment with at least **two** of the following: Enbrel, Cimzia and Cosentyx. Treatment failure requires at least for 12 weeks of therapy with each drug.
9. **Dosage allowed:** 5 mg/kg at 0, 2 and 6 weeks, then every 6 weeks thereafter.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CROHN'S DISEASE (CD)

For **initial** authorization:

1. Member is 6 years of age or older with moderately to severely active CD; AND
2. Medication must be prescribed by or in consultation with a gastroenterologist; AND
3. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
4. Member has had a documented trial and inadequate response, or intolerance to at least **one** of the following conventional therapies: a 4-week trial of a corticosteroid OR a 12-week trial of 6-mercaptopurine, azathioprine, or methotrexate; OR
5. Member has severe disease that requires immediate use of a biologic agent, as indicated by **one** of the following:
 - a) Extensive small bowel disease involving more than 100 cm;
 - b) History of bowel or colon resection and is at high risk for CD recurrence (e.g., smoker, <30 years old, 2 or more resections, penetrating/fistulizing disease, etc.);
 - c) Fistulizing disease.
6. **Dosage allowed:** 5mg/kg at 0, 2, and 6 weeks, then every 8 weeks thereafter. Prior to any dosages or dosing frequencies greater than listed, medical necessity documentation must be supplied to justify coverage.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Chart notes have been provided showing improvement in signs and symptoms of CD (defined as mucosal healing, fewer flare-ups of symptoms, improved quality of life, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

PLAQUE PSORIASIS (PsO)

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a dermatologist; AND
3. Member has clinical documentation of moderate to severe plaque psoriasis characterized by 3% or more of body surface area (BSA) or disease affecting sensitive areas (e.g., hands, feet, face, genitals, etc.); AND
4. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has tried and failed to respond to treatment with at least **one** of the following:
 - a) At least 12 weeks of photochemotherapy (i.e., psoralen plus ultraviolet A therapy);
 - b) At least 12 weeks of phototherapy (i.e., UVB light therapy, Excimer laser treatments);
 - c) At least a 4-week trial with topical antipsoriatic agents (i.e., anthralin, calcipotriene, coal tar, corticosteroids, tazarotene, tacrolimus, pimecrolimus); AND
6. Member has tried and failed, or unable to tolerate a systemic non-biologic DMARD (i.e., cyclosporine, methotrexate, acitretin) for at least 12 weeks; AND
7. Member has tried and failed treatment with at least **two** of the following: Cimzia, Cosentyx, Enbrel, Otezla and Siliq. Treatment failure requires at least 12 weeks of therapy with each drug.
8. **Dosage allowed:** 5 mg/kg at 0, 2 and 6 weeks, then every 8 weeks thereafter.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease (e.g., documented member's BSA improvement, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

PSORIATIC ARTHRITIS (PsA)

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a rheumatologist or a dermatologist; AND
3. Member has a documented diagnosis of active psoriatic arthritis (PsA); AND
4. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has met a 4-week trial of an NSAID taken at maximally tolerated doses AND a 3-month trial of a non-biologic DMARD agent (e.g., methotrexate, sulfasalazine, cyclosporine, etc.) **unless one** of the following situations is met:
 - a) Non-biologic DMARD is not required for:
 - i) Concomitant axial disease (i.e., involving sacroiliac joint and spine) or enthesitis; OR
 - b) NSAID and non-biologic DMARD are not required for:
 - i) Severe PsA (defined as having at least one of the following: erosive disease, active PsA at many sites including dactylitis or enthesitis, elevated levels of ESR or CRP, joint deformities, or major impairment in quality of life); AND
6. Member must have tried and failed treatment with at least **two** of the following: Enbrel, Cimzia, Cosentyx, Otezla and Xeljanz. Treatment failure requires at least 12 weeks of therapy with each drug.
7. **Dosage allowed:** 5 mg/kg at 0, 2 and 6 weeks, then every 8 weeks thereafter.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

RHEUMATOID ARTHRITIS (RA)

For **initial** authorization:

1. Member must be 18 years of age or older with moderately to severely active RA; AND
2. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
3. Medication must be prescribed by or in consultation with a rheumatologist; AND
4. Member must have a trial and failure of, or intolerance to methotrexate and **one** other non-biologic DMARD (i.e., hydroxychloroquine, sulfasalazine, and leflunomide) for 3 months per trial, either together or separately; AND
Note: only one non-biologic DMARD is required if member has a poor prognostic factor such as high swollen joint count, presence of early joint erosions, presence of autoantibodies (RF and/or ACPA).
5. Medication is being given in combination with methotrexate or with another non-biologic DMARD if unable to tolerate methotrexate; AND

6. Member has tried and failed treatment with at least **two** of the following: Actemra, Cimzia, Enbrel, Kevzara, Olumiant and Xeljanz. Treatment failure requires at least 12 weeks of therapy with each drug.
7. **Dosage allowed:** 3 mg/kg at 0, 2 and 6 weeks, then every 8 weeks thereafter. Prior to any dosages or dosing frequencies greater than listed, medical necessity documentation must be supplied to justify coverage.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes demonstrate improvement of RA signs and symptoms (e.g. fewer number of painful and swollen joints, achievement of remission, slowed progression of joint damage, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

ULCERATIVE COLITIS (UC)

For **initial** authorization:

1. Member is 6 years of age or older with moderately to severely active UC; AND
2. Medication must be prescribed by or in consultation with a gastroenterologist; AND
3. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
4. Member must have a documented trial and inadequate response with **one** of the following:
 - a) 3 months of 6-mercaptopurine or azathioprine;
 - b) 30 days of corticosteroid (e.g., budesonide, prednisone, methylprednisolone, etc.);
 - c) 3 months of 5-aminosalicylate (e.g., Asacol HD, Lialda, Pentasa, Delzicol, mesalamine, etc.).
5. **Dosage allowed:** 5 mg/kg at 0, 2, and 6 weeks, followed by 5 mg/kg every 8 weeks thereafter. Prior to any dosages or dosing frequencies greater than listed, medical necessity documentation must be supplied to justify coverage.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Chart notes have been provided showing improvement in signs and symptoms of UC (defined as clinical remission, decrease in rectal bleeding, decreased corticosteroid use, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Remicade (infliximab) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
05/10/2017	New policy for Remicade created. Polices SRx-0041, SRx-0042, and SRx-0043 archived. For diagnosis of AS: trial of Humira and Enbrel requirement was added. For CD: Pediatric Crohn's Disease Activity Index (PCDAI) and Crohn's Disease Activity Index (CDAI) were requirements added; trial of Humira was added. For diagnosis of PP: immunosuppressive drug criterion was separated from phototherapies and topical agents' trials; Psoriasis Area and Severity Index (PASI) score requirement was added; trials of Humira and Enbrel were added. For PsA: trials of Humira and Enbrel were added. For RA: non-biologic DMARDS were listed and criterion was added to use drug in combination with methotrexate, or if intolerant to methotrexate, use another immunosuppressant; trials of Humira and Enbrel

	were added. For UC: requirement for moderate to severe UC was revised, Pediatric Ulcerative Colitis Activity Index (PUCAI) was added. Trial of Humira required for member ≥ 18 y.o. List of diagnoses considered not medically necessary was added.
02/26/2019	Humira removed from trial criteria. Actemra, Cimzia, Cosentyx, Enbrel, Kevzara, Olumiant, Otezla, Siliq and Xeljanz added to trial agents list. TB test allowed to be done within 12 months prior to initiation of therapy; chest x-ray option removed. Symptoms of back pain for AS extended till before age of 50. Other drugs options allowed for PsA if there is an intolerance or contraindication to methotrexate.
11/22/2020	Replaced list of excluded diagnoses with the generic statement. Updated references. For all diagnoses: Removed repeat TB in reauth for all diagnoses. <u>AS</u> : Removed list of symptoms of spondyloarthritis because imaging result should be sufficient. Removed peripheral arthritis requirement – not relevant for this diagnosis. Updated maintenance dosing to 6 weeks. <u>CD</u> : Removed PCDAI and CDAI score requirements. Specified length of trials for conventional therapies, previously not specified. Those with severe disease can skip the drug trial. Changed initial approval to 6 months to observe efficacy. <u>PsA</u> : Added requirement of diagnosis of PsA. Changed the trial section to be 4 weeks of an NSAID AND 3 months of a DMARD unless other circumstances apply (e.g., concomitant axial disease, severe PsA, etc.). <u>PsO</u> : Removed rheumatologist from prescriber. Changed BSA to 3% or sensitive area involvement. Removed PASI score requirement. <u>RA</u> : Changed the trials to require methotrexate as one of the non-biologic DMARD trials; only one trial is needed if member has poor prognostic factors. <u>UC</u> : Removed PUCAI and Mayo score requirements. Specified the length of trials for conventional therapies (previously not specified).

References:

1. Remicade [prescribing information]. Horsham, PA; Janssen Biotech, Inc.: May, 2020.
2. Callhoff J, et al. Efficacy of TNFa blockers in patients with ankylosing spondylitis and non-radiographic axial spondyloarthritis: a meta-analysis. *Ann Rheum Dis*. 2015; 74:1241.
3. Ward MM, Deodhar A, Gensler LS, et al. 2019 Update of the American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network Recommendations for the Treatment of Ankylosing Spondylitis and Nonradiographic Axial Spondyloarthritis. *Arthritis Rheumatol*. 2019 Oct;71(10):1599-1613. doi: 10.1002/art.41042. Epub 2019 Aug 22.
4. Akgul O, Ozgocmen S. Classification criteria for spondyloarthropathies. *World J Orthop*. 2011;2(12):107-115. doi:10.5312/wjo.v2.i12.07.
5. Yu DT, Tubergen AV. Treatment of axial spondyloarthritis (ankylosing spondylitis and nonradiographic axial spondyloarthritis) in adults. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc.
6. Sulz MC, Burri E, Michetti P, et al. Treatment Algorithms for Crohn's Disease. *Digestion*. 2020;101 Suppl 1:43-57.
7. Lichtenstein GR, Loftus EV, Isaacs KL, Regueiro MD, Gerson LB, Sands BE. ACG Clinical Guideline: Management of Crohn's Disease in Adults. *Am J Gastroenterol*. 2018;113(4):481-517.
8. Torres J, Bonovas S, Doherty G, et al. ECCO Guidelines on Therapeutics in Crohn's Disease: Medical Treatment. *J Crohns Colitis*. 2020;14(1):4-22.
9. Pimentel AM, Rocha R, Santana GO. Crohn's disease of esophagus, stomach and duodenum. *World J Gastrointest Pharmacol Ther*. 2019;10(2):35-49.
10. Terdiman JP, Gruss CB, Heidelbaugh JJ, Sultan S, Falck-Ytter YT; AGA Institute Clinical Practice and Quality Management Committee. American Gastroenterological Association Institute guideline on the use of thiopurines, methotrexate, and anti-TNF-α biologic drugs for the induction and maintenance of remission in inflammatory Crohn's disease. *Gastroenterology*. 2013;145(6):1459-1463.
11. Regueiro M, Velayos F, Greer JB, et al. American Gastroenterological Association Institute Technical Review on the Management of Crohn's Disease After Surgical Resection. *Gastroenterology*. 2017;152(1):277-295.e3.
12. Lofberg R. Treatment of fistulas in Crohn's disease with infliximab. *Gut*. 1999;45(5):642-643.

13. Ricart E, Sandborn WJ. Infliximab for the treatment of fistulas in patients with Crohn's disease. *Gastroenterology*. 1999;117(5):1247-1248.
14. Sands BE, Anderson FH, Bernstein CN et al. A randomized controlled trial of infliximab maintenance therapy for fistulizing Crohn's disease (ACCENT II). *N Engl J Med*. 2004;350:876-885.
15. Mease PJ, et al. Adalimumab for the treatment of patients with moderately to severely active psoriatic arthritis: results of a double-blind, randomized, placebo-controlled trial. *Arthritis Rheum*. 2005; 52:3279.
16. Gladman DD, Ritchlin C. Clinical manifestations and diagnosis of psoriatic arthritis. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc. Accessed September 23, 2020.
17. Gladman DD, Ritchlin C. Treatment of psoriatic arthritis. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc. Accessed September 23, 2020.
18. Coates LC, Kavanaugh A, Mease PJ, et al. Group for Research and Assessment of Psoriasis and Psoriatic Arthritis 2015 Treatment Recommendations for Psoriatic Arthritis. *Arthritis Rheumatol*. 2016 May;68(5):1060-71.
19. Elmets CA, Korman NJ, Prater EF, et al. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis with topical therapy and alternative medicine modalities for psoriasis severity measures [published online ahead of print, 2020 Jul 30]. *J Am Acad Dermatol*. 2020;S0190-9622(20)32288-X.
20. Menter A, Gelfand JM, Connor C, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management of psoriasis with systemic nonbiologic therapies. *J Am Acad Dermatol*. 2020;82(6):1445-1486.
21. Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. *J Am Acad Dermatol*. 2019;80(4):1029-1072.
22. Elmets CA, Lim HW, Stoff B, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management and treatment of psoriasis with phototherapy [published correction appears in *J Am Acad Dermatol*. 2020 Mar;82(3):780]. *J Am Acad Dermatol*. 2019;81(3):775-804.
23. Menter A, Cordoro KM, Davis DM, et al. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis in pediatric patients. *J Am Acad Dermatol* 2020;82:161-201.
24. Singh JA, Saag KG, Bridges SL Jr, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Rheumatol*. 2016;68(1):1-26.
25. Smolen JS, Landewé RBM, Bijlsma JWJ, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2019 update. *Ann Rheum Dis*. 2020;79(6):685-699.
26. Rubin DT, Ananthakrishnan AN, Siegel CA, Sauer BG, Long MD. ACG Clinical Guideline: Ulcerative Colitis in Adults. *Am J Gastroenterol*. 2019;114(3):384-413.
27. Feuerstein JD, Isaacs KL, Schneider Y, et al. AGA Clinical Practice Guidelines on the Management of Moderate to Severe Ulcerative Colitis. *Gastroenterology*. 2020;158(5):1450-1461.

Effective date: 04/01/2021

Revised date: 11/22/2020