CareSource

PHARMACY POLICY STATEMENT **Ohio Medicaid**	
DRUG NAME	Remicade (infliximab)
BILLING CODE	J1745 (1 unit = 10 mg or 1x100 mg vial = 10 units)
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Home/Office/Outpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include Enbrel & Humira 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. Must have a documented negative TB test (i.e. tuberculosis skin test (PPD), an interferon-release assay (IGRA), or a chest x-ray) within 6 months prior to starting therapy; AND
3. Medication must be prescribed by a rheumatologist; AND
4. Member has had back pain for 3 months or more that began before the age of 45; AND
5. Current imaging results show an inflammation of one or both of the sacroiliac joints; AND
6. Member shows at least **one** of the following signs or symptoms of Spondyloarthritis:
   a) Arthritis;
   b) Elevated serum C-reactive protein;
   c) Inflammation at the tendon, ligament or joint capsule insertions;
   d) Positive HLA-B27 test;
   e) Limited chest expansion;
   f) Morning stiffness for 1 hour or more; AND
7. Member meets at least **one** of the following scenarios:
   a) Member has Axial (spinal) disease;
   b) Member has peripheral arthritis without axial involvement and has tried and failed treatment with methotrexate or sulfasalazine. Treatment failure requires at least 3 months of therapy without an adequate response;
   c) Member has tried and failed to respond to treatment with at least **two** prescription NSAIDs taken at the maximum recommended dosages. Treatment failure requires at least 4 weeks of therapy without an adequate response; AND
8. Member has documented trial and failure of or contraindication to **both** Humira and Enbrel. Treatment failure requires at least 12 weeks of therapy without an adequate response.
9. **Dosage allowed:** 5 mg/kg at 0, 2 and 6 weeks, then every 8 weeks. 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. Must have been retested for TB with a negative result within the past 12 months; AND
2. Member must be in compliance with all other initial criteria; AND
3. Chart notes have been provided that show the member has shown 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 6-17 years of age with moderately to severely active CD as defined by Pediatric Crohn's Disease Activity Index (PCDAI) greater than 30 OR member is 18 years of age or older with moderately to severely active non-fistulizing CD as defined by Crohn's Disease Activity Index (CDAI) greater than 220 and less than 400; AND
2. Member has had a trial and inadequate response to at least one (1) of the following:
   a) 6-mercaptopurine;
   b) Azathioprine;
   c) Methotrexate;
   d) Corticosteroid(s); OR
3. Member is 18 years of age or older with fistulizing CD; AND
4. Must have a documented negative TB test (i.e. tuberculosis skin test (PPD), an interferon-release assay (IGRA), or a chest x-ray) within 6 months prior to starting therapy; AND
5. Medication must be prescribed by a gastroenterologist; AND
6. Member has documented trial and failure of or contraindication to Humira. Treatment failure requires at least 12 weeks of therapy without an adequate response.
7. **Dosage allowed:** 5 mg/kg at 0, 2, and 6 weeks, followed by 5 mg/kg every 8 weeks thereafter. If no response by week 14, consider discontinuing therapy.

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

For **reauthorization**:
1. Must have been retested for TB with a negative result within the past 12 months; AND
2. Member must be in compliance with all other initial criteria; AND
3. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease; AND
4. Documented member's PCDAI or CDAI score improvement.

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

PLAQUE PSORIASIS (PP)

For **initial** authorization:
1. Member must be 18 years of age or older; AND
2. Must have a documented negative TB test (i.e. tuberculosis skin test (PPD), an interferon-release assay (IGRA), or a chest x-ray) within 6 months prior to starting therapy; AND
3. Medication must be prescribed by a dermatologist or rheumatologist; AND
4. Member has PP for 6 months or longer; AND
5. Member is not going to receive systemic therapy or phototherapy while on Remicade; AND
6. Member's plaque psoriasis involving 10% or more of the body surface area (BSA) or 5% or more of BSA if psoriasis involves sensitive areas (hands, feet, face, or genitals); AND

7. Member's Psoriasis Area and Severity Index (PASI) greater than or equal to 12; AND
8. 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 (tanning beds emit mostly UVA light and therefore would not meet this criteria)).
   c) At least a 4 week trial with topical antipsoriatic agents (i.e. anthralin, calcipotriene, coal tar, corticosteroids, tazarotene); AND
9. Member has tried and failed to respond to treatment of an immunosuppressant (i.e. cyclosporine, methotrexate, acetretin) for at least a 12 week trial.
10. Member has documented trial and failure of or contraindication to **both** Humira and Enbrel. Treatment failure requires at least 12 weeks of therapy without an adequate response.
11. **Dosage allowed:** 5 mg/kg at 0, 2 and 6 weeks, then every 8 weeks. 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. Must have been retested for TB with a negative result within the past 12 months; AND
2. Member must be in compliance with all other initial criteria; AND
3. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease; AND
4. Documented member's PASI score improvement.

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. Must have a documented negative TB test (i.e. tuberculosis skin test (PPD), an interferon-release assay (IGRA), or a chest x-ray) within 6 months prior to starting therapy; AND
3. Medication must be prescribed by a rheumatologist or dermatologist; AND
4. Member meets at least **one** of the following scenarios:
   a) Member has predominantly axial disease (i.e. sacroiliitis or spondylitis) as indicated by radiographic evidence;
   b) Member has shown symptoms of predominantly axial disease (i.e. sacroiliitis or spondylitis) for more than 3 months (i.e. limited spinal range of motion, spinal morning stiffness for more than 30 minutes) and has tried and failed to respond to treatment with at least 2 prescription NSAIDs taken at the maximum recommended dosages. Treatment failure requires at least 4 weeks of therapy without an adequate response;
   c) Member has predominately non-axial disease and has tried and failed to respond to treatment with at least an 8 week trial of methotrexate and NSAID; AND
5. Member has documented trial and failure of or contraindication to **both** Humira and Enbrel. Treatment failure requires at least 12 weeks of therapy without an adequate response.
6. **Dosage allowed:** 5 mg/kg at 0, 2 and 6 weeks, then every 8 weeks. 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. Must have been retested for TB with a negative result within the past 12 months; AND
2. Member must be in compliance with all other initial criteria; AND
3. Chart notes have been provided that show the member has shown 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 moderate to severe active RA; AND
2. Must have a documented negative TB test (i.e. tuberculosis skin test (PPD), an interferon-release assay (IGRA), or a chest x-ray) within 6 months prior to starting therapy; AND
3. Medication must be prescribed by a rheumatologist; AND
4. Medication must be used in combination with methotrexate, or if intolerant to methotrexate, another immunosuppressant (i.e. azathioprine, hydroxychloroquine, cyclosporine, etc.); AND
5. Member must have tried and failed treatment with at least **two** non-biologic DMARDS OR must have a contraindication to all non-biologic DMARDS. Treatment trial duration with each non-biologic DMARD agent must have been at least 12 weeks (non-biologic DMARDs include: methotrexate, hydroxychloroquine, sulfasalazine, azathioprine, cyclosporine and leflunomide); AND
6. Member has documented trial and failure of or contraindication to **both** Humira and Enbrel. Treatment failure requires at least 12 weeks of therapy without an adequate response.
7. **Dosage allowed:** 3 mg/kg at 0, 2 and 6 weeks, then every 8 weeks. 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. Must have been retested for TB with a negative result within the past 12 months; AND
2. Member must be in compliance with all other initial criteria; AND
3. Chart notes have been provided that show the member has shown 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.

ULCERATIVE COLITIS (UC)

For **initial** authorization:
1. Member is 6-17 years of age with moderate to severe active UC as defined by Pediatric Ulcerative Colitis Activity Index (PUCAI) of 35 or greater OR member is 18 years of age or older with moderately to severely active UC as defined by Mayo score of 6 or greater with an endoscopy subscore of 2 or 3; AND
2. Medication must be prescribed by a gastroenterologist; AND
3. Must have a documented negative TB test (i.e. tuberculosis skin test (PPD), an interferon-release assay (IGRA), or a chest x-ray) within 6 months prior to starting therapy; AND
4. Member must have tried and failed treatment with at least with **one** or more of the following:
   a) 6-mercaptopurine;
   b) Azathioprine;
   c) Methotrexate;
   d) Oral corticosteroids;
   e) Salicylates; AND

5. Member has documented trial and failure of or contraindication to Humira (only for members 18 years of age or older). Treatment failure requires at least 12 weeks of therapy without an adequate response.
6. **Dosage allowed:** 5 mg/kg at 0, 2, and 6 weeks, followed by 5 mg/kg every 8 weeks thereafter.

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

For **reauthorization**:

1. Must have been retested for TB with a negative result within the past 12 months; AND
2. Member must be in compliance with all other initial criteria; AND
3. Chart notes have been provided that show the member has shown 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.

CareSource considers Remicade (infliximab) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Amyloid angiopathy
- Asthma
- Behcet's disease
- Birdshot retinochoroidopathy
- Bronchiolitis obliterans
- Central nervous system amyloidosis
- Chemotherapy induced enterocolitis (not due to Yervoy or Opdivo)
- Chronic immune-mediated myelitis
- Chronic obstructive pulmonary disease
- Cogan's syndrome
- Corneal ulcer
- Cranial nerve palsy
- Cystoid macular degeneration
- Disc herniation-induced sciatica
- Discoid lupus erythematosus
- Eczema
- Eosinophilic fasciitis
- Graft-versus-host-disease
- Granuloma annulare
- Granulomatous angiitis
- Granulomatous mastitis
- Hepatitis C genotype 1
- IgG4-related disease
- Infectious uveitis
- Iritis
- Juvenile idiopathic arthritis
- Kawasaki syndrome

- Localized scleroderma/morphea
- Membranous glomerulopathy
- Microscopic colitis
- Multifocal osteomyelitis (e.g., (chronic recurrent multifocal osteomyelitis (CRMO))
- Neurosarcoidosis
- Nodular scleritis
- Panniculitis
- Polyarteritis nodosa
- Polymyositis
- Prevention of post-operative recurrence of Crohn's disease
- Rejection following small bowel transplantation
- Relapsing polychondritis
- Scleroderma
- Sjogren's syndrome
- Still's disease
- Systemic lupus erythematosus
- Takayasu arteritis
- Tolosa-Hunt syndrome
- Tubulo-interstitial nephritis with uveitis (TINU) syndrome
- Wegener's granulomatosis/Wegener's peripheral neuropathy.

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: trias of Humira and Enbrel were added. For RA: non-biologic DMARDS were listed and criterion wasadded 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.

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