



**Avsola® (infliximab-axxq)**  
**Inflectra® (infliximab-dyyb)**  
**Infliximab**  
**Remicade® (infliximab)**  
**Renflexis® (infliximab-adba)**  
**Effective 08/01/2022**

<b>Plan</b>	<input type="checkbox"/> MassHealth <input checked="" type="checkbox"/> MassHealth (PUF) <input type="checkbox"/> Commercial/Exchange	<b>Program Type</b>	<input checked="" type="checkbox"/> Prior Authorization <input checked="" type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
<b>Benefit</b>	<input checked="" type="checkbox"/> Pharmacy Benefit <input checked="" type="checkbox"/> Medical Benefit (NLX)		
<b>Specialty Limitations</b>	These medications have been designated specialty and must be filled at a contracted specialty pharmacy.		
<b>Contact Information</b>	<b>Specialty Medications</b>		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	<b>Non-Specialty Medications</b>		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	<b>Medical Specialty Medications (NLX)</b>		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
<b>Exceptions</b>	N/A		

**Overview**

**FDA approved indications:**

**Ankylosing Spondylitis:** Avsola®, Inflectra®, infliximab, Remicade®, Renflexis®  
**Crohn’s Disease, Moderate-to-severe:** Avsola®, Inflectra®, infliximab, Remicade®, Renflexis®  
**Crohn’s Disease (including fistulizing disease), Moderate-to-severe:** Avsola®, Inflectra®, infliximab, Remicade®, Renflexis®  
**Plaque Psoriasis, Moderate-to-severe:** Avsola®, Inflectra®, infliximab, Remicade®, Renflexis®  
**Psoriatic Arthritis:** Avsola®, Inflectra®, infliximab, Remicade®, Renflexis®,  
**Rheumatoid Arthritis (RA), Moderate-to-severe:** Avsola®, Inflectra®, infliximab, Remicade®, Renflexis®  
**Ulcerative colitis, Moderate-to-Severe:** Avsola®, , Inflectra®, infliximab, Remicade®, Renflexis®,

No PA	PA required
	Avsola® (infliximab-axxq)
	Inflectra® (infliximab-dyyb)
	infliximab
	Remicade® (infliximab)
	Renflexis® (infliximab-abda)

**Coverage Guidelines**



Authorizations requests will be reviewed on a case by case basis for members new to AllWays Health Partners who are currently receiving treatment with the requested medication, excluding when the product is obtained as samples or via manufacturer's patient assistance programs.

**OR**

Authorization may be granted for members when all the following criteria are met, and documentation is provided:

Moderate-to-severe Rheumatoid arthritis

Prescriber provides documentation of **ALL** of the following:

1. Appropriate diagnosis
2. Member meets **ONE** of the following:
  - a. Paid claim or provider attestation of inadequate response or adverse reaction to **ONE** traditional DMARD or contraindication to traditional DMARDs
  - b. Paid claim or provider attestation of inadequate response or adverse reaction to **ONE** biologic DMARD that is FDA-approved for the requested indication
3. Appropriate dosing<sup>†</sup>
4. Provider provides clinical rationale for use of the requested agent instead of Enbrel<sup>®</sup> and Humira<sup>®</sup>
5. If the request is for Inflectra<sup>®</sup> (infliximab-dyyb) or Renflexis<sup>®</sup> (infliximab-abda), provider provides clinical rationale for use of the requested agent instead of unbranded infliximab or Avsola<sup>®</sup> (infliximab-axxq)
6. If the request is for BRAND NAME Remicade<sup>®</sup> (infliximab), the above criteria must be met and medical records must be provided documenting an inadequate response or adverse reaction to unbranded infliximab

Psoriatic arthritis

Prescriber provides documentation of **ALL** of the following:

1. Appropriate diagnosis
2. Appropriate dosing<sup>†</sup>
3. Provider provides clinical rationale for use of the requested agent instead of Enbrel<sup>®</sup> and Humira<sup>®</sup>
4. If the request is for Inflectra<sup>®</sup> (infliximab-dyyb) or Renflexis<sup>®</sup> (infliximab-abda), provider provides clinical rationale for use of the requested agent instead of unbranded infliximab or Avsola<sup>®</sup> (infliximab-axxq)
5. If the request is for BRAND NAME Remicade<sup>®</sup> (infliximab), the above criteria must be met and medical records must be provided documenting an inadequate response or adverse reaction to unbranded infliximab

Ankylosing spondylitis

Prescriber provides documentation of **ALL** of the following:

1. Appropriate diagnosis
2. Paid claims or physician attestation of inadequate response or adverse reaction to **TWO** NSAIDs or contraindication to **ALL** NSAIDs
3. Appropriate dosing<sup>†</sup>
4. Provider provides clinical rationale for use of the requested agent instead of Enbrel<sup>®</sup> and Humira<sup>®</sup>
5. If the request is for Inflectra<sup>®</sup> (infliximab-dyyb) or Renflexis<sup>®</sup> (infliximab-abda), provider provides clinical rationale for use of the requested agent instead of unbranded infliximab or Avsola<sup>®</sup> (infliximab-axxq)



6. If the request is for BRAND NAME Remicade® (infliximab), the above criteria must be met and medical records must be provided documenting an inadequate response or adverse reaction to unbranded infliximab

#### Moderate-to-severe plaque psoriasis

Prescriber provides documentation of **ALL** of the following:

1. Appropriate diagnosis
2. Member meets **ONE** of the following:
  - a. Paid claims or physician attestation of inadequate response or adverse reaction to **ONE conventional therapy** (see appendix)
    - a. topical agent
    - b. phototherapy
    - c. systemic agent
  - b. Contraindication to **ALL conventional therapies**:
    - a. topical agents
    - b. phototherapy
    - c. systemic agents
3. Paid claims or physician attestation of inadequate response or adverse reaction to **ONE** biologic DMARD that is FDA-approved for plaque psoriasis
4. Appropriate dosing<sup>†</sup>
5. Provider provides clinical rationale for use of the requested agent instead of Enbrel® and Humira®
6. If the request is for Inflectra® (infliximab-dyyb) or Renflexis® (infliximab-abda), provider provides clinical rationale for use of the requested agent instead of unbranded infliximab or Avsola® (infliximab-axxq)
7. If the request is for BRAND NAME Remicade® (infliximab), the above criteria must be met and medical records must be provided documenting an inadequate response or adverse reaction to unbranded infliximab

#### Moderate-to-severe Crohn's disease

Prescriber provides documentation of **ALL** of the following:

1. Appropriate diagnosis
2. Appropriate dosing<sup>†</sup>
3. Provider provides clinical rationale for use of the requested agent instead of Humira®
4. If the request is for Inflectra® (infliximab-dyyb) or Renflexis® (infliximab-abda), provider provides clinical rationale for use of the requested agent instead of unbranded infliximab or Avsola® (infliximab-axxq)
5. If the request is for BRAND NAME Remicade® (infliximab), the above criteria must be met and medical records must be provided documenting an inadequate response or adverse reaction to unbranded infliximab

#### Fistulizing Crohn's disease

Prescriber provides documentation of **ALL** of the following:

1. Appropriate diagnosis
2. Appropriate dosing<sup>†</sup>
3. If the request is for Inflectra® (infliximab-dyyb) or Renflexis® (infliximab-abda), provider provides clinical rationale for use of the requested agent instead of unbranded infliximab or Avsola® (infliximab-axxq)



4. If the request is for BRAND NAME Remicade® (infliximab), the above criteria must be met and medical records must be provided documenting an inadequate response or adverse reaction to unbranded infliximab

Moderate-to-severe Ulcerative colitis

Prescriber provides documentation of **ALL** of the following:

1. Appropriate diagnosis
2. Appropriate dosing<sup>†</sup>
3. Provider provides clinical rationale for use of the requested agent instead of Humira®
4. If the request is for Inflectra® (infliximab-dyyb) or Renflexis® (infliximab-abda), provider provides clinical rationale for use of the requested agent instead of unbranded infliximab or Avsola® (infliximab-axxq)
5. If the request is for BRAND NAME Remicade® (infliximab), the above criteria must be met and medical records must be provided documenting an inadequate response or adverse reaction to unbranded infliximab

<sup>†</sup> Requests for more frequent or higher doses - see Appendix

**Continuation of Therapy**

Resubmission by prescriber will infer a positive response to therapy and request can be recertified if dosing is appropriate.

**Limitations**

1. Initial authorizations will be granted for:
  - a. For the diagnosis of Ankylosing spondylitis, Crohn’s disease, psoriatic arthritis, rheumatoid arthritis, ulcerative colitis: 6 months
  - b. For the diagnosis of Plaque psoriasis and Off Label indications (referenced in appendices): 3 months
2. Reauthorizations for all diagnoses will be granted for 12 months

**Appendices**

**Appendix A: Examples of Traditional DMARDs**

Traditional DMARDs*	
azathioprine	methotrexate*
cyclosporine	sulfasalazine*
hydroxychloroquine*	thalidomide
leflunomide	
If a member has a contraindication to <b>ALL</b> of the most commonly used traditional DMARDs* (methotrexate, sulfasalazine, and hydroxychloroquine), a trial with a traditional DMARD may be bypassed.	

**Appendix B: Conventional Therapies for Plaque Psoriasis**

Conventional Treatment Lines	Agents Used
Topical Agents	emollients, keratolytics, corticosteroids, coal tar, anthralin, calcipotriene, tazarotene, calcitriol, calcineurin inhibitors
Systemic Agents	Traditional DMARDs: methotrexate, apremilast, acitretin,
Phototherapy	ultraviolet A and topical psoralens (topical PUVA), ultraviolet A and oral psoralens (systemic PUVA), narrow band UV-B (NUVB)

### Appendix C: More frequent/Higher doses

Requests more frequent or higher doses of injectable biologics, may be approved if ALL of the following is provided:

1. Documentation of severe disease
2. **ONE** of the following:
  - a. Inadequate response or adverse reaction to **ONE** other injectable biologic which is FDA-approved for the requested indication\*
  - b. Contraindication to **ALL** other injectable biologics which are FDA-approved for the requested indication
3. Documented partial response to FDA-approved dosing of current biologic therapy
4. Documentation of specialist consult for the requested indication

\*A trial with another injectable biologic may be bypassed if:

- The requested regimen is Avsola<sup>®</sup> (infliximab-axxq), Inflectra<sup>®</sup> (infliximab-dyyb), infliximab, Remicade<sup>®</sup> (infliximab), or Renflexis<sup>®</sup> (infliximab-abda) for Crohn's disease or ulcerative colitis and the request documents low drug levels and no/low antibodies. The recommended trough level for infliximab is greater than or equal to 5 mcg/mL in patients with inflammatory bowel disease.

### Appendix D: Off Label Indications

#### Hidradenitis Suppurativa

Prescriber provides documentation of **ALL** of the following:

1. Diagnosis of moderate to severe hidradenitis suppurativa (Hurley Stage II and Hurley Stage III disease)
2. Paid claims or physician attestation of inadequate response or adverse reaction to ONE oral antibiotic or contraindication to ALL oral antibiotics (e.g. rifampin, clindamycin, tetracycline, doxycycline, minocycline)
3. Paid claims or physician attestation of inadequate response, adverse reaction or contraindication to Humira<sup>®</sup> (adalimumab)
4. For Inflectra<sup>®</sup> (infliximab-dyyb) or Renflexis<sup>®</sup> (infliximab-abda), provider provides clinical rationale for use of the requested agent instead of unbranded infliximab or Avsola<sup>®</sup> (infliximab-axxq)
5. For BRAND NAME Remicade<sup>®</sup> (infliximab), the above criteria must be met and medical records must be provided documenting an inadequate response or adverse reaction to unbranded infliximab
6. Appropriate dosing: Avsola<sup>®</sup> (infliximab-axxq), Inflectra<sup>®</sup> (infliximab-dyyb), Remicade<sup>®</sup> (infliximab), or Renflexis<sup>®</sup> (infliximab-abda): 5 mg/kg on week 0, 2 and 6 then every 8 weeks,

#### Uveitis

Prescriber provides documentation of **ALL** of the following:

1. Paid claims or physician attestation of inadequate response, adverse reaction or contraindication to **ALL** of the following:
  - a. Ophthalmic (topical) or oral glucocorticoids
  - b. Oral or injectable immunosuppressive therapy (e.g., azathioprine, mycophenolate, methotrexate, cyclosporine, tacrolimus and cyclophosphamide)
  - c. **ONE** of the following:
    - i. Paid claims or physician attestation of Inadequate response, adverse reaction or contraindication to Humira<sup>®</sup> (adalimumab)

- ii. Clinical rationale for use of Avsola<sup>®</sup> (infliximab-axxq), Remicade<sup>®</sup> (infliximab) Inflectra<sup>®</sup> (infliximab-dyyb), or Renflexis<sup>®</sup> (infliximab-abda) instead of Humira<sup>®</sup> (adalimumab)
- d. For Inflectra<sup>®</sup> (infliximab-dyyb) or Renflexis<sup>®</sup> (infliximab-abda), clinical rationale for use of the requested agent instead of unbranded infliximab or Avsola<sup>®</sup> (infliximab-axxq)
- e. For BRAND NAME Remicade<sup>®</sup> (infliximab), the above criteria must be met and medical records must be provided documenting an inadequate response or adverse reaction to unbranded infliximab

### **Scleritis**

Prescriber provides documentation of **ALL** of the following:

- 1. Paid claims or physician attestation of inadequate response, adverse reaction or contraindication to **ALL** of the following:
  - a. Ophthalmic (topical) or oral glucocorticoids
  - b. Oral or injectable immunosuppressive therapy (e.g., azathioprine, mycophenolate, methotrexate, cyclosporine, tacrolimus and cyclophosphamide)
  - c. For Inflectra<sup>®</sup> (infliximab-dyyb) or Renflexis<sup>®</sup> (infliximab-abda), clinical rationale for use of the requested agent instead of unbranded infliximab or Avsola<sup>®</sup> (infliximab-axxq)
  - d. For BRAND NAME Remicade<sup>®</sup> (infliximab), the above criteria must be met and medical records must be provided documenting an inadequate response or adverse reaction to unbranded infliximab

### **Pulmonary Sarcoidosis**

Prescriber provides documentation of **ALL** of the following:

- 1. Member has an appropriate diagnosis of sarcoidosis with pulmonary involvement
- 2. Paid claims or physician attestation of inadequate response, adverse reaction or contraindication to **ALL** of the following:
  - a. Systemic glucocorticoids
  - b. **ONE** traditional DMARD (methotrexate, azathioprine, leflunomide, or mycophenolate)
  - c. **ONE** of the following:
    - i. Paid claims or physician attestation of inadequate response, adverse reaction or contraindication to Humira<sup>®</sup> (adalimumab)
    - ii. Clinical rationale for use of Avsola<sup>®</sup> (infliximab-axxq), Remicade<sup>®</sup> (infliximab) Inflectra<sup>®</sup> (infliximab-dyyb), or Renflexis<sup>®</sup> (infliximab-abda) instead of Humira<sup>®</sup> (adalimumab)
  - d. For Inflectra<sup>®</sup> (infliximab-dyyb) or Renflexis<sup>®</sup> (infliximab-abda), clinical rationale for use of the requested agent instead of unbranded infliximab or Avsola<sup>®</sup> (infliximab-axxq)
  - e. 5. For BRAND NAME Remicade<sup>®</sup> (infliximab), the above criteria must be met and medical records must be provided documenting an inadequate response or adverse reaction to unbranded infliximab

### **Takayasu Arteritis (TAK)**

Prescriber provides documentation of **ALL** of the following:

- 1. Paid claims or physician attestation of inadequate response, adverse reaction or contraindication to **ALL** of the following:
  - a. Systemic glucocorticoids
  - b. **ONE** traditional DMARD (methotrexate, azathioprine, leflunomide, or mycophenolate)
  - c. **ONE** of the following:

- i. Paid claims or physician attestation of inadequate response, adverse reaction or contraindication to Humira<sup>®</sup> (adalimumab) and Enbrel<sup>®</sup> (etanercept)
- ii. Clinical rationale for use of Avsola<sup>®</sup> (infliximab-axxq), Remicade<sup>®</sup> (infliximab) Inflectra<sup>®</sup> (infliximab-dyyb), or Renflexis<sup>®</sup> (infliximab-abda) instead of Humira<sup>®</sup> (adalimumab) and Enbrel<sup>®</sup> (etanercept)
- d. For Inflectra<sup>®</sup> (infliximab-dyyb) or Renflexis<sup>®</sup> (infliximab-abda), clinical rationale for use of the requested agent instead of unbranded infliximab or Avsola<sup>®</sup> (infliximab-axxq)
- e. For BRAND NAME Remicade<sup>®</sup> (infliximab), the above criteria must be met and medical records must be provided documenting an inadequate response or adverse reaction to unbranded infliximab

### Neurologic Sarcoidosis

Prescriber provides documentation of **ALL** of the following:

1. Appropriate diagnosis
2. Paid claims or physician attestation of an inadequate response or adverse reaction to **ONE** systemic corticosteroid or contraindication to **ALL** systemic corticosteroids
3. Paid claims or physician attestation of an inadequate response or adverse reaction to **TWO** or a contraindication to **ALL** of the following:
  - a. Azathioprine
  - b. Cyclophosphamide
  - c. Leflunomide
  - d. Methotrexate
  - e. Mycophenolate mofetil

### References

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2. Renflexis (infliximab) [prescribing information]. Whitehouse Station, NJ: Merck Sharp & Dohme; November 2017.
3. Inflectra (infliximab dyyb) [prescribing information]. New York, NY: Pfizer; November 2017
4. Yoo DH, Racewicz A, Brzezicki J, et al. A phase III randomized study to evaluate the efficacy and safety of CT-P13 compared with reference infliximab in patients with active rheumatoid arthritis: 54-week results from the PLANETRA study. *Arthritis Res Ther.* 2016;18:82.[PubMed 27038608]
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18. Mooij JE, van Rappard DC, Mekkes JR. Six patients with pyoderma gangrenosum successfully treated with infliximab. *Int J Dermatol* 2013; 52:1418
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## Review History

11/17/2021 – Created and Reviewed Nov P&T; switched from CVS SGM to Custom criteria; matched with MH UPPL. Effective 01/01/2022

05/18/2022 – Updated and Reviewed for May P&T; Matched MH UPPL. Avsola and unbranded infliximab as preferred formulations of infliximab. A trial with other infliximab agents would require a step through one of these formulations. As unbranded infliximab is an authorized biosimilar to Remicade, a request for the latter agent would require a trial with unbranded infliximab. UC criteria: Requirement of provider specialty was removed, required trial with one anti-TNF agent and Entyvio was removed, and “Member is not currently receiving concomitant therapy with immunomodulators or biologic agents” was removed. Appendix C: Off label indications was updated. Renamed Appendix B to “Conventional Therapies for Plaque Psoriasis”. Effective 07/01/2022.

06/22/2022 - Reviewed and updated for June P&T; matched MH UPPL. Added off label indication of neurologic sarcoidosis to Appendix section. Effective 08/01/2022.

## Disclaimer





AllWays Health Partners complies with applicable federal civil rights laws and does not discriminate or exclude people on the basis of race, color, national origin, age, disability, or sex.