Mass General Brigham
Health Plan

Avsola® (infliximab-axxq)
Inflectra ® (infliximab-dyyb)
Infliximab
Remicade ® (infliximab)
Renflexis ® (infliximab-adba)
Effective 06/05/2023

Plan	☒ MassHealth UPPL ☐Commercial/Exchange	**Program Type**	☒ Prior Authorization ☒ Quantity Limit ☐ Step Therapy
Benefit	☐ Pharmacy Benefit ☒ Medical Benefit (NLX)		
Specialty Limitations			
Contact Information	**Specialty Medications**		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	Non-Specialty Medications		
	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
	Medical Specialty Medications (NLX)		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
Exceptions			

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, unbranded
	Remicade® (infliximab)
	Renflexis® (infliximab-abda)

Coverage Guidelines

Authorizations requests will be reviewed on a case by case basis for members new to the plan 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. Diagnosis of moderate to severe rheumatoid arthritis
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†
4. Provider provides clinical rationale for use of the requested agent instead of Enbrel® and Humira®

Psoriatic arthritis (PsA)

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

1. Diagnosis of psoriatic arthritis
2. Appropriate dosing†
3. Provider provides clinical rationale for use of the requested agent instead of Enbrel® and Humira®

Ankylosing Spondylitis

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

1. Diagnosis of ankylosing spondylitis
2. Paid claims or physician attestation of inadequate response or adverse reaction to **TWO** or contraindication to **ALL** NSAIDs
3. Appropriate dosing†
4. Provider provides clinical rationale for use of the requested agent instead of Enbrel® and Humira®

Moderate to severe plaque psoriasis

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

1. Diagnosis of moderate to severe plaque psoriasis
2. Member meets **ONE** of the following:
    a. Paid claims or physician attestation of inadequate response or adverse reaction to **ONE** or contraindication to **ALL** conventional therapies: (see appendix)
        a. topical agent
        b. phototherapy
        c. systemic agent
    b. Paid claims or physician attestation of inadequate response or adverse reaction to **ONE** biologic DMARD that is FDA-approved for plaque psoriasis
3. Appropriate dosing†
4. Provider provides clinical rationale for use of the requested agent instead of Enbrel® and Humira®

Moderate to severe Crohn's Disease

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

1. Diagnosis of moderate to severe Crohn's disease
2. Appropriate dosing†
3. Provider provides clinical rationale for use of the requested agent instead of Humira®

Fistulizing Crohn's disease
Prescriber provides documentation of **ALL** of the following:
1. Diagnosis of fistulizing Crohn's disease
2. Appropriate dosing †

Moderate-to-severe ulcerative colitis
Prescriber provides documentation of **ALL** of the following:
1. Diagnosis of moderate to severe ulcerative colitis
2. Appropriate dosing†
3. Provider provides clinical rationale for use of the requested agent instead of Humira®

† Requests for more frequent or higher doses - see Appendix

Off-Label Indications
Behçet's Disease (BD)
Prescriber provides documentation of **ALL** of the following:
1. Diagnosis of Behçet's Disease
2. Paid claims or physician attestation of inadequate response or adverse reaction to **ONE** or contraindication to **ALL** topical corticosteroids
3. Paid claims or physician attestation of inadequate response or adverse reaction to **ONE** or contraindication to **ALL** systemic corticosteroids
4. Paid claims or physician attestation of inadequate response or adverse reaction to **ONE** or contraindication to **ALL** of the following:
    a. azathioprine
    b. colchicine
    c. cyclophosphamide
    d. cyclosporine
    e. methotrexate
    f. Otezla® (apremilast)
5. Clinical rationale for use of the requested agent instead of Enbrel® and Humira®

Moderate to severe 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 within 6 months or physician attestation of inadequate response or adverse reaction to **ONE** 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® (adalimumab)

Neurologic sarcoidosis
Prescriber provides documentation of **ALL** of the following:
1. Diagnosis of neurologic sarcoidosis

2. Paid claims or physician attestation of 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

Pulmonary Sarcoidosis
Prescriber provides documentation of **ALL** of the following*:*
1. Diagnosis of pulmonary sarcoidosis
2. Inadequate response, adverse reaction, or contraindication to **BOTH** of the following:
    a. Systemic glucocorticoids
    b. **ONE** traditional DMARD (methotrexate, azathioprine, leflunomide, or mycophenolate)
3. Prescriber must also document **ONE** of the following:
    a. Paid claims or physician attestation of inadequate response, adverse reaction or contraindication to Humira® (adalimumab)
    b. Clinical rationale for use of Avsola® (infliximab-axxq), unbranded infliximab, Remicade® (infliximab) Inflectra® (infliximab-dyyb), or Renflexis® (infliximab-abda) instead of Humira® (adalimumab)

Synovitis-acne-pustulosis-hyperostosis-osteitis syndrome (SAPHO)
Prescriber provides documentation of **ALL** of the following:
1. Diagnosis of SAPHO
2. Paid claims or physician attestation of inadequate response or adverse reaction to **ONE** NSAID or contraindication to **ALL** NSAIDs
3. Paid claims or physician attestation of inadequate response or adverse reaction to **ONE** systemic corticosteroid or contraindication to **ALL** systemic corticosteroids
4. Clinical rationale for use of the requested agent instead of Enbrel® and Humira®

Scleritis
Prescriber provides documentation of **ALL** of the following:
1. Diagnosis of scleritis
2. Paid claims or physician attestation of inadequate response, adverse reaction, or contraindication to **BOTH** of the following*:*
    a. ophthalmic (topical), oral or injectable glucocorticoids
    b. oral or injectable immunosuppressive therapy (e.g., azathioprine, mycophenolate, methotrexate, cyclosporine, tacrolimus, and cyclophosphamide)

Takayasu Arteritis (TAK)
Prescriber provides documentation of **ALL** of the following*:*
1. Diagnosis of Takayasu arteritis
2. Paid claims or physician attestation of inadequate response, adverse reaction, or contraindication to **BOTH** of the following:
    a. systemic glucocorticoids
    b. **ONE** traditional DMARD (methotrexate, azathioprine, leflunomide, or mycophenolate)

3. Prescriber must also document **ONE** of the following:
    a. Paid claims or physician attestation of inadequate response, adverse reaction, or contraindication to Humira® (adalimumab) and Enbrel® (etanercept)
    b. Clinical rationale for use of Avsola® (infliximab-axxq), unbranded infliximab, Remicade® (infliximab) Inflectra® (infliximab-dyyb), or Renflexis® (infliximab-abda) instead of Humira® (adalimumab) and Enbrel® (etanercept)

Uveitis

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

1. Diagnosis of uveitis
2. Paid claims or physician attestation of inadequate response, adverse reaction, or contraindication to **BOTH** of the following*:*
    a. Ophthalmic (topical), oral or injectable glucocorticoids
    b. Oral or injectable immunosuppressive therapy (e.g., azathioprine, mycophenolate, methotrexate, cyclosporine, tacrolimus, and cyclophosphamide)
3. **ONE** of the following:
    a. Paid claims or physician attestation of inadequate response, adverse reaction, or contraindication to Humira® (adalimumab)
    b. Clinical rationale for use of the requested agent instead of Humira® (adalimumab)

New members currently stable on Avsola® or unbranded infliximab can be approved without documentation of failed trials with the conventional therapies for any FDA-approved indication at an FDA-approved dose.

New members currently stable on Inflectra® or Renflexis® can be approved without documentation of failed trials with the preferred infliximab agents for ankylosing spondylitis or Crohn's disease.

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. Plaque psoriasis and Off Label indications: 3 months
    b. All other indications: 6 months
2. Reauthorizations for all diagnoses will be granted for 12 months

Appendix A. Examples of Traditional DMARDs

Traditional DMARDS*	
azathioprine	methotrexate*
cyclosporine	sulfasalazine*
hydroxychloroquine*	thalidomide
leflunomide	
If a member has a contraindication to **ALL** 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® (infliximab-axxq), Inflectra® (infliximab-dyyb), infliximab, Remicade® (infliximab), or Renflexis® (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.
- The requested regimen is Avsola®(infliximab-axxq), Inflectra®(infliximab-dyyb), unbranded infliximab, Remicade®(infliximab), or Renflexis®(infliximab-abda) and the request documents that standard-weight based dosing would not be adequate in a pediatric member.

References

1. Remicade (infliximab) [prescribing information]. Horsham, PA: Janssen Biotech, Inc; June 2018.
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]
5. Park W, Yoo DH, Jaworski J, et al. Comparable long-term efficacy, as assessed by patient-reported outcomes, safety and pharmacokinetics, of CT-P13 and reference infliximab in patients with ankylosing spondylitis: 54-week results from the randomized, parallel-group PLANETAS study. *Arthritis Res Ther*. 2016;18:25.[PubMed 26795209]
6. van der Heijde D, Ramiro S, Landewe R, et al. 2016 Update of the international ASAS-EULAR management recommendations for axial spondyloarthritis. *Ann Rheum Dis.* 2017;0:1-14.
7. Meyer A, Rudant J, Drouin J, et al. Effectiveness and Safety of Reference Infliximab and Biosimilar in Crohn Disease: A French Equivalence Study. Ann Intern Med 2019; 170:99.
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13. Peluso R, Lervolino S, Vitiello M, et al. Extra-articular manifestations in psoriatic arthritis patients. Clin Rheumatol. 2014 May 8. [Epub ahead of print].
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15. Ward MM, Deodhar A, Akl EA, et al. American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network 2015 recommendations for the treatment of ankylosing spondylitis and nonradiographic axial spondyloarthritis. *Arthritis Rheumatol.* 2015: 10.1002/art.39298. [Epub ahead of print].
16. Baughman RP, Lower EE. Infliximab for refractory sarcoidosis. Sarcoidosis Vasc Diffuse Lung Dis 2001; 18:70
17. Della Rossa A, Tavoni A, Merlini G, et al. Two Takayasu arteritis patients successfully treated with infliximab: a potential disease-modifying agent? Rheumatology (Oxford) 2005; 44:1074
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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21. Laharie D, Bourreille A, Branche J, et al. Long-term outcome of patients with steroid-refractory acute severe UC treated with ciclosporin or infliximab. Gut 2017Avsola (infliximab-axxq) [prescribing information]. Thousand Oaks, CA: Amgen Inc; December 2019.

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.
11/16/2022 – Reviewed and updated for Nov P&T; matched MH. Clinical rationale for use of Inflectra or Renflexis instead of unbranded infliximab or Avsola updated to include clinical rationale instead of both agents. Added criteria for off label use in Neurologic Sarcoidosis. Effective 11/01/2022
01/11/2023 – Reviewed and updated for Jan P&T. Appropriate diagnosis was replaced with a specific indication throughout. Off-label indications added for: Behcet's disease, HS, neurologic sarcoidosis, pulmonary sarcoidosis, SAPHO, scleritis, TAK, uveitis. Added language regarding stability of requested medication for new members: Requests for Avsola and unbranded infliximab that document stability for any FDA-approved indication at an FDA-approved dose can be approved. Requests for Inflectra or Renflexis that document stability can be approved without documentation of failed trials with the preferred infliximab agents for ankylosing spondylitis or Crohn's disease. Clarified initial approval durations. Effective 3/1/23.
05/10/23 – Reviewed and updated for P&T. The appendix for More Frequent or Higher Doses of Injectable Biologics was updated to allow more aggressive dosing of infliximab products to be approved if the request documents concern that standard-weight based dosing would not be adequate in a pediatric member. Separating Rx vs MB policies and removed preferred product requirement. Effective 6/5/23.