Clinical Policy Title:	infliximab
Policy Number:	RxA.743
Drug(s) Applied:	Remicade®
Original Policy Date:	04/18/2022
Last Review Date:	04/18/2022
Line of Business Policy Applies to:	All lines of business

Background

Remicade® is a tumor necrosis factor (TNF) blocker indicated for:

- **Crohn's Disease:**
  - Reducing signs and symptoms and inducing and maintaining clinical remission in adult patients with moderately to severely active disease who have had an inadequate response to conventional therapy.
  - Reducing the number of draining enterocutaneous and rectovaginal fistulas and maintaining fistula closure in adult patients with fistulizing disease.
- **Pediatric Crohn's Disease:** reducing signs and symptoms and inducing and maintaining clinical remission in pediatric patients 6 years of age and older with moderately to severely active disease who have had an inadequate response to conventional therapy.
- **Ulcerative Colitis:** reducing signs and symptoms, inducing, and maintaining clinical remission and mucosal healing, and eliminating corticosteroid use in adult patients with moderately to severely active disease who have had an inadequate response to conventional therapy.
- **Pediatric Ulcerative Colitis**: reducing signs and symptoms and inducing and maintaining clinical remission in pediatric patients 6 years of age and older with moderately to severely active disease who have had an inadequate response to conventional therapy.
- **Rheumatoid Arthritis in combination with methotrexate**: reducing signs and symptoms, inhibiting the progression of structural damage, and improving physical function in adult patients with moderately to severely active disease.
- **Ankylosing Spondylitis:** reducing signs and symptoms in adult patients with active disease.
- **Psoriatic Arthritis:** reducing signs and symptoms of active arthritis, inhibiting the progression of structural damage, and improving physical function in adult patients.
- **Plaque Psoriasis:** treatment of adult patients with chronic severe (i.e., extensive and/or disabling) plaque psoriasis who are candidates for systemic therapy and when other systemic therapies are medically less appropriate.

Dosing Information

Drug Name	Indication	Dosing Regimen	Maximum Dose
infliximab (Remicade®)	CD, UC	Initial dose: 5 mg/kg intravenously at weeks 0, 2 and 6 Maintenance dose: 5 mg/kg intravenously every 8 weeks. Pediatric UC and CD: ≥ 6 years old For CD: Some adult patients who initially respond to treatment may benefit from increasing the dose to 10	CD – Age ≥ 18 years : 10 mg/kg every 8 weeks UC – Age ≥ 18 years : 5 mg/kg every 8 weeks

Dosing Information

Drug Name	Indication	Dosing Regimen	Maximum Dose
		mg/kg if they later lose their response.	UC, CD – Age ≥ 6 years to 17 years: 5 mg/kg every 8 weeks
	PsA, PsO	Initial dose: 5 mg/kg intravenously at weeks 0, 2 and 6 Maintenance dose: 5 mg/kg intravenously every 8 weeks	5 mg/kg every 8 weeks
	RA	In conjunction with MTX Initial dose: 3 mg/kg intravenously at weeks 0, 2 and 6 Maintenance dose: 3 mg/kg intravenously every 8 weeks Some patients may benefit from increasing the dose up to 10 mg/kg or treating as often as every 4 weeks	10 mg/kg every 4 weeks
	AS	Initial dose: 5 mg/kg intravenously at weeks 0, 2 and 6 Maintenance dose: 5 mg/kg intravenously every 6 weeks	5 mg/kg every 6 weeks

Dosage Forms

- For injection: 100 mg of infliximab as a lyophilized powder in a single-dose vial for reconstitution and dilution.

Clinical Policy

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria. The provision of provider samples does not guarantee coverage under the terms of the pharmacy benefit administered by RxAdvance. All criteria for initial approval must be met in order to obtain coverage.

I. Initial Approval Criteria

A. Ankylosing Spondylitis (must meet all):

1. Diagnosis of active ankylosing spondylitis (AS);
2. Prescribed by or in consultation with a rheumatologist;
3. Age ≥ 18 years;
4. Trial and failure of at least two (2) non-steroidal anti-inflammatory drugs (NSAIDs) at up to maximally indicated doses, each used for at ≥ 4 weeks unless contraindicated or clinically significant adverse effects are experienced;
5. Trial and failure of at least one (1) of the following agents: Inflectra® or Avsola® unless contraindicated or clinically significant adverse effects are experienced;
6. Dose does not exceed 5 mg/kg every 6 weeks.

Approval Duration

Commercial: 12 months

Medicaid: 12 months

B. Crohn's Disease (must meet all)**:**

1. Diagnosis of Crohn's disease (CD);
2. Prescribed by or in consultation with a gastroenterologist;
3. Age ≥ 6 years;
4. Member meets one of the following (a or b):
   a. Trial and failure of a ≥ 3 months of at least one (1) conventional systemic therapy (e.g., azathioprine, 6-mercaptopurine [6-MP], methotrexate [MTX]) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
   b. Trial and failure of corticosteroids (e.g., prednisone, methylprednisolone, budesonide), unless contraindicated or significant adverse effects experienced;

   *Exception: If one biologic DMARD that is FDA-approved for crohn's disease has been previously tried, then trial of a conventional systemic agent is not required;
5. Trial and failure of at least one (1) of the following agents: Inflectra® or Avsola®, unless contraindicated or clinically significant adverse effects are experienced;
6. Dose does not exceed one of the following: (a or b)
   a. Age ≥ 18 years: 10 mg/kg every 8 weeks;
   b. Age ≥ 6 years but < 18 years: 5 mg/kg every 8 weeks.

Approval Duration
Commercial: 12 monthsM
Medicaid: 12 months

C. Plaque Psoriasis (must meet all):

1. Diagnosis of Plaque Psoriasis (PsO);
2. Prescribed by or in consultation with a dermatologist or a rheumatologist;
3. Age ≥ 18 years;
4. Trial and failure of ≥ 3 months of at least one (1) conventional systemic therapy (methotrexate [MTX], cyclosporin, acitretin) or phototherapy (psoralen plus ultraviolet A light [PUVA]) at up to maximally indicated doses unless contraindicated or clinically significant adverse effects are experienced;

   *Exception: If one biologic DMARD that is FDA-approved for plaque psoriasis has been previously tried, then trial of a conventional systemic agent or phototherapy is not required;
5. Trial and failure of at least one (1) of the following agents: Inflectra® or Avsola® unless contraindicated or clinically significant adverse effects are experienced;
6. Dose does not exceed 5 mg/kg every 8 weeks.

Approval Duration
Commercial: 12 months
Medicaid: 12 months

D. Psoriatic Arthritis (must meet all):

1. Diagnosis of Psoriatic Arthritis (PsA);
2. Prescribed by or in consultation with a dermatologist or a rheumatologist;
3. Age ≥ 18 years;
4. Trial and failure of at least one (1) of the following agents: Inflectra® or Avsola® unless contraindicated or clinically significant adverse effects are experienced;
5. Dose does not exceed 5 mg/kg every 8 weeks.

Approval Duration
Commercial: 12 months
Medicaid: 12 months

E. Rheumatoid Arthritis (must meet all):
1. Diagnosis of Rheumatoid Arthritis (RA);
2. Prescribed by or in consultation with a rheumatologist;
3. Age ≥ 18 years;
4. Trial and failure of a ≥ 3 months of at least one conventional systemic therapy (methotrexate [MTX], sulfasalazine, leflunomide, hydroxychloroquine) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
   *Exception: If one biologic DMARD that is FDA-approved for rheumatoid arthritis has been previously tried, then trial of a conventional systemic agent is not required;
5. Trial and failure of at least one (1) of the following agents: Inflectra® or Avsola® unless contraindicated or clinically significant adverse effects are experienced;
6. Dose does not exceed 10 mg/kg every 4 weeks.

Approval Duration
Commercial: 12 months
Medicaid: 12 months

F. Ulcerative Colitis (must meet all)**:**
1. Diagnosis of Ulcerative Colitis (UC);
2. Prescribed by or in consultation with a gastroenterologist;
3. Age ≥ 6 years;
4. Member meets one of the following (a or b):
   a. Trial and failure of ≥ 3 months of at least one (1) conventional agent (azathioprine, 6-mercaptopurine, aminosalicylate) unless contraindicated or clinically significant adverse effects are experienced;
   b. Trial and failure of corticosteroids (e.g., prednisone, methylprednisolone, budesonide) unless contraindicated or significant adverse effects experienced;

   *Exception: If one biologic DMARD that is FDA-approved for ulcerative colitis has been previously tried, then trial of a conventional systemic agent is not required;
5. Trial and failure of at least one (1) of the following agents: Inflectra® or Avsola® unless contraindicated or clinically significant adverse effects are experienced;
6. Dose does not exceed 5 mg/kg every 8 weeks.

Approval duration
Commercial: 12 months
Medicaid: 12 months

II. Continued Therapy Approval

A. All Indications in Section I (must meet all):
1. Member is currently receiving medication that has been authorized by RxAdvance or the member has met initial approval criteria listed in this policy;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed one of the following: (a, b, c or d)
   a. For UC, PsA, PsO and pediatric CD: 5 mg/kg every 8 weeks;

b. For AS: 5 mg/kg every 6 weeks;
c. For RA: 10 mg/kg every 8 weeks.
d. For CD: Age ≥ 18 years: 10 mg/kg every 8 weeks;
Age ≥ 6 years but < 18 years: 5 mg/kg every 8 weeks.

Approval Duration
Commercial: 12 months
Medicaid: 12 months

III. Appendices

APPENDIX A: Abbreviation/Acronym Key
AS: Ankylosing Spondylitis
NSAIDs: Non-Steroidal Anti-Inflammatory Drugs
PsO: Plaque Psoriasis
PsA: Psoriatic Arthritis
RA: Rheumatoid Arthritis
CD: Crohn's Disease
TNF: Tumor necrosis factor
DMARDs: Disease-Modifying Antirheumatic Drugs
HSTCL: Hepatosplenic T-cell lymphoma
UC: Ulcerative Colitis
PUVA: psoralen plus ultraviolet A light

APPENDIX B: Therapeutic Alternatives
Below are suggested therapeutic alternatives based on clinical guidance. Please check drug formulary for preferred agents and utilization management requirements.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
acitretin	**PsO:** 25 or 50 mg orally once daily	50 mg/day
azathioprine (Azasan®, Imuran®)	**RA:** 1 mg/kg/day orally once daily or divided twice daily **CD (off label use):** 1.5 – 2 mg/kg/day orally	2.5 mg/kg/day
Corticosteroids	**CD (off label use):** prednisone 40 mg orally once daily for 2 weeks or intravenously 50 – 100 mg Q6H for 1 week budesonide (Entocort EC®) 6 – 9 mg orally once daily	Various
d-penicillamine (Cuprimine®)	**RA*:** Initial dose: 125 or 250 mg orally once daily Maintenance dose: 500 – 750 mg/day orally once daily	1,500 mg/day
cyclosporine (Sandimmune®, Neoral®)	**PsO:** 1 – 4 mg/kg/day orally divided twice daily **RA:** 2.5 – 4 mg/kg/day orally divided twice daily	PsO, RA: 4 mg/kg/day
hydroxychloroquine (Plaquenil®)	**RA (off label use):** Initial dose: 400 – 600 mg/day orally once daily Maintenance dose: 200 – 400 mg/day orally once daily	600 mg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
leflunomide (Arava®)	**RA:** 100 mg orally once daily for 3 days, then 20 mg orally once daily	20 mg/day
mercaptopurine (Purixan®)	**CD (off label use) :**50 mg orally once daily or 1 – 2 mg/kg/day orally	2 mg/kg/day
methotrexate	**CD (off label use):** 15 – 25 mg/week intramuscularly or subcutaneously **PsO:** 10 – 25 mg/week orally or 2.5 mg orally every 12 hr for 3 doses/week **RA:** 7.5 mg/week orally, subcutaneously, or intramuscularly or 2.5 mg orally every 12 hr for 3 doses/week	30 mg/week
NSAIDs (e.g., indomethacin, ibuprofen, naproxen, celecoxib)	**AS:** Varies	Varies
mesalamine (Pentasa®)	**CD:** 1,000 mg orally four times daily	4 g/day
Ridaura®	**RA:** 6 mg orally once daily or 3 mg orally twice daily	9 mg/day (3 mg Three times daily)
tacrolimus (Prograf®)	**CD (off label use:** 0.27 mg/kg/day orally in divided doses or 0.15 – 0.29 mg/kg/day orally	N/A
sulfasalazine (Azulfidine®)	**RA:** 2 g/day orally in divided doses	RA: 3 g/day
Biologic DMARDs		
Humira®	**UC:** <u>Initial dose:</u> Adults:160 mg subcutaneously on Day 1 (given in one day or split over two consecutive days), then 80 mg subcutaneously on Day 15 Pediatrics: Weight 20 kg (44 lbs) to < 40 kg (88 lbs): 80 mg subcutaneously on Day 1, then 40 mg subcutaneously on Day 8, then 40 mg subcutaneously on day Day 15 Weight ≥ 40 kg (88 lbs): 160 mg subcutaneously Day 1, then 80 mg on day 8 and day 15 <u>Maintenance dose:</u> Adults:40 mg subcutaneously every other week starting on Day 29 Pediatrics: Weight 20 kg (44 lbs) to < 40 kg (88 lbs): 40 mg every other week or 20 mg every week starting on day 29 Weight ≥ 40 kg(88 lbs): 80 mg every other week or 40 mg every week starting on day 29	40 mg every other week **UC:** Adults:40 mg every other week Pediatrics: 80 mg every other week

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	RA: Some patients with RA not receiving concomitant methotrexate may benefit from increasing the frequency to 40 mg every Week or 80 mg every other week **PsO**: Initial dose: 80 mg Maintenance dose: 40 mg subcutaneously every other week starting one week after initial dose **AS, PsA:** 40 mg subcutaneously every other week **CD:** Initial dose: Adults: 160 mg subcutaneously on Day 1, then 80 mg subcutaneously on Day 15 Pediatrics: Weight 17 kg (37 lbs) to < 40 kg (88 lbs): 80 mg subcutaneously on Day 1, then 40 mg subcutaneously on Day 15 Weight ≥ 40 kg (88 lbs)160 mg subcutaneously on Day 1, then 80 mg subcutaneously on Day 15 Maintenance dose: Adults: 40 mg subcutaneously every other week starting on Day 29 Pediatrics: Weight 17 kg (37 lbs) to < 40 kg (88 lbs): 20 mg subcutaneously every other week starting on Day 29 Weight ≥ 40 kg (88 lbs): 40 mg subcutaneously every other week starting on Day 29	
Cosentyx®	**PsA:** With loading dose: 150 mg subcutaneously at week 0, 1, 2, 3, and 4, followed by 150 mg subcutaneously every 4 weeks Without loading dose: 150 mg subcutaneously every 4 weeks If a patient continues to have active psoriatic arthritis, consider a dosage of 300 mg every 4 weeks. Pediatric Patients 2 years and older: Recommended dosage is administered by subcutaneously injection at weeks 0,1 ,2,3, and 4 and every 4 weeks after: For patients weighing ≥ 15 kg and < 50 kg the dose is 75 mg. For patients weighing ≥ 50 kg the dose is 150 mg. **AS:** With loading dose: 150 mg subcutaneously at weeks 0, 1, 2, 3, and 4, followed by 150 mg subcutaneously every 4 weeks thereafter Without loading dose:	PsA: 300 mg every 4 weeks AS: 300mg every 4 weeks PsO Adults: 300 mg/dose subcutaneously Adolescents weighing 50 kg or more: 150 mg/dose subcutaneously. weighing less than 50 kg: 75 mg/dose subcutaneously.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	150 mg subcutaneously every 4 weeks If the patient continues to have active ankylosing spondylitis: 300 mg every 4 weeks can be considered **PsO:** Adults: Recommended dosage is 300 mg by subcutaneously injection at Weeks 0, 1, 2, 3, and 4 followed by 300 mg every 4 weeks. For some patients, a dose of 150 mg may be acceptable. Children and Adolescents 6 to 17 years weighing 50 kg or more: 150 mg subcutaneously at weeks 0, 1, 2, 3, and 4. Then give 150 mg subcutaneously every 4 weeks. Children and Adolescents 6 to 17 years weighing less than 50 kg: 75 mg subcutaneously at weeks 0, 1, 2, 3, and 4. Then give 75 mg subcutaneously every 4 weeks	
infliximab (Inflectra®, Renflexis®, Avsola®)	**UC, CD:** Initial dose: 5 mg/kg intravenously at weeks 0, 2 and 6 Maintenance dose: 5 mg/kg intravenously every 8 weeks. Pediatric **UC, CD**: ≥ 6 years old For CD: Some adult patients who initially respond to treatment may benefit from increasing the dose to 10 mg/kg if they later lose their response. **PsA PsO:** Initial dose: 5 mg/kg intravenously at weeks 0, 2 and 6 Maintenance dose: 5 mg/kg intravenously every 8 weeks **RA:** In conjunction with MTX Initial dose: 3 mg/kg intravenously at weeks 0, 2 and 6 Maintenance dose: 3 mg/kg intravenously every 8 weeks Some patients may benefit from increasing the dose up to 10 mg/kg or treating as often as every 4 weeks **AS:** Initial dose: 5 mg/kg intravenously at weeks 0, 2 and 6 Maintenance dose: 5 mg/kg intravenously every 6 weeks	PsA PsO: 5 mg/kg every 8 weeks RA:10 mg/kg every 4 weeks AS: 5 mg/kg every 6 weeks CD: Adults: 10 mg/kg every 8 weeks UC, Adults: 5 mg/kg every 8 weeks Pediatrics: 5 mg/kg every 8 weeks
Simponi Aria®	**AS** **PsA, RA:** Initial dose: 2 mg/kg intravenously at weeks 0 and 4 Maintenance dose: 2 mg/kg intravenously every 8 weeks	AS PsA, RA: 2 mg/kg every 8 weeks

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Otezla®	**PsO** **PsA:** Initial dose: Day 1: 10 mg orally in morning Day 2: 10 mg orally in morning and 10 mg orally in evening Day 3: 10 mg orally in morning and 20 mg orally in evening Day 4: 20 mg orally in morning and 20 mg orally in evening Day 5: 20 mg orall in morning and 30 mg orally in evening Maintenance dose: Day 6 and thereafter: 30 mg orally twice daily	60 mg/day
Xeljanz® / Xeljanz® oral Solution, Xeljanz® XR	Xeljanz®: **PsA, RA, AS**: 5 mg orally twice daily PsA: use in combination with nonbiologic disease-modifying antirheumatic drugs RA: monotherapy or use in combination with nonbiologic disease-modifying antirheumatic drugs **UC:** Induction:10 mg orally twice daily for at least 8 weeks, based on therapeutic response, may continue 10 mg twice daily for a maximum of 16 weeks or transition to maintenance dose. Discontinue after 16 weeks of 10 mg twice daily if adequate therapeutic benefit is not achieved. Maintenance: 5 mg twice daily; if loss of response on 5 mg twice daily, then use 10 mg twice daily after assessing the benefits and risks and use for the shortest duration; use lowest effective dose to maintain response Xeljanz® XR: **PsA, RA, AS**: 11 mg orally once daily **UC:** Induction: 22 mg once daily for at least 8 weeks; may continue 22 mg once daily for a maximum of 16 weeks or transition to maintenance dose. Discontinue therapy if inadequate response achieved after 16 weeks using 22 mg once daily. Maintenance: 11 mg once daily; if loss of response on 11 mg once daily; then use 22 mg once daily for the shortest duration; use lowest effective dose to maintain response.	Xeljanz®: PsA RA AS: 10 mg/day UC: 20 mg/day Xeljanz® / Xeljanz® oral Solution: 5 mg or 5 ml twice daily Xeljanz® XR: 11 mg/day UC: 22 mg daily
Kevzara®	**RA:** 200 mg subcutaneously once every two weeks	200 mg/2 Weeks
Enbrel®	**RA:** 25 mg subcutaneously twice weekly or 50 mg subcutaneously once weekly **PsA**: Adult: 50 mg once weekly with or without methotrexate (MTX)	**RA, PsA:** Adults 50 mg/week subcutaneously. Induction therapy for psoriatic arthritis

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	AS: 50 mg once weekly **PsO:** Adult PsO: 50 mg twice weekly for 3 months, followed by 50 mg once weekly Pediatric PsO: Weight < 63 kg: 0.8 mg/kg subcutaneously once weekly Weight ≥ 63 kg: 50 mg subcutaneously once weekly	should not exceed 100 mg/week with no more than 50 mg/dose subcutaneously. **AS, PsO:** 50 mg/week
Ilumya®	**PsO:** Initial dose: 100 mg subcutaneously at weeks 0 and 4 Maintenance dose: 100 mg subcutaneously every 12 weeks Tildrakizumab should only be administered by a healthcare professional.	100 mg every 12 weeks
Orencia®	**RA, PsA:** Intravenous: weight-based dose at weeks 0, 2, and 4, followed by every 4 weeks Weight < 60 kg: 500 mg per dose Weight 60 to 100 kg: 750 mg per dose Weight > 100 kg: 1,000 mg per dose Subcutaneously: 125 mg once weekly RA and PsA: Patients switching from intravenous use to subcutaneous use, administer first subcutaneous dose instead of next scheduled intravenous dose. (For RA: Prior to the first subcutaneously dose, may administer an optional loading dose as a single intravenous infusion as per body weight categories above.) For PsA: Intravenous loading dose is not recommended	**RA, PsA:** Intravenous: 1,000 mg every 4 weeks Subcutaneous: 125 mg/week
Rinvoq®	**RA, PsA:** 15 mg orally once daily Can be used as monotherapy or in combination with methotrexate or other non-biologic DMARDs. *For use in adults who have had an inadequate response or intolerance to one or more TNF blockers	15 mg/day
Siliq®	**PsO:** Initial dose: 210 mg subcutaneously at weeks 0, 1, and 2 Maintenance dose: 210 mg subcutaneously every 2 weeks	210 mg every 2 weeks
Simponi®	**RA, AS, PsA:** 50 mg subcutaneously once monthly **UC:** Initial dose: 200 mg subcutaneously at week 0, then 100 mg subcutaneously at week 2	RA, AS, PsA :50 mg/month UC: 100 mg every 4 weeks

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	Maintenance dose: 100 mg subcutaneously every 4 weeks	
Tremfya®	**PsO, PsA:** Initial dose: 100 mg subcutaneously at weeks 0 and 4 Maintenance dose: 100 mg subcutaneously every 8 weeks Can be used alone or in combination with conventional DMARD e.g. methotrexate	100 mg every 8 weeks
Taltz®	**PsO:** Adult Plaque Psoriasis: Recommended dose is 160 mg subcutaneously (two 80 mg injections) at Week 0, followed by 80 mg at Weeks 2, 4, 6, 8, 10, and 12, then 80 mg every 4 weeks Pediatric Plaque Psoriasis (age 6 years or older): For patients weighing greater than 50 kg:160 mg subcutaneously (two 80 mg injections) at Week 0, followed by 80 mg every 4 weeks. For patients weighing 25-50 kg: 80 mg subcutaneously at Week 0, followed by 40 mg every 4 weeks. For patients weighing less than 25 kg:40 mg subcutaneously at Week 0, followed by 20 mg every 4 weeks **PsA, AS:** Initial dose: 160 mg (two 80 mg injections) subcutaneously Maintenance dose: 80 mg subcutaneously every 4 weeks.	**PsO:** 80 mg every 4 weeks **PsA, AS:** 80 mg every 4 weeks
Skyrizi®	**PsA, PsO:** 150 mg subcutaneously at weeks 0, 4, and every 12 weeks thereafter	150 mg/12 Weeks
Stelara®	**PsO:** Weight based dosing subcutaneously at weeks 0 and 4, followed by maintenance dose every 12 weeks Adult: Weight ≤ 100 kg: 45 mg (some patients may require doses of 90 mg or maintenance dosing of every 8 weeks) Weight > 100 kg: 90 mg (some patients may require maintenance dosing of every 8 weeks) Pediatrics (Age 6 years and older): Weight < 60 kg: 0.75 mg/kg Weight ≥ 60 to ≤100 kg: 45 mg Weight > 100kg: 90 mg **PsA:** 45 mg subcutaneously at weeks 0 and 4, followed by 45 mg every 12 weeks	**UC, PsO, CD:** 90 mg every 8 weeks **PsA:** 45 mg every 12 weeks

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	UC, CD: Weight based dosing intravenously at initial dose, followed by 90 mg subcutaneously every 8 weeks Weight ≤ 55 kg: 260 mg Weight 55 kg to 85 kg: 390 mg Weight > 85 kg: 520 mg	
Entyvio®	**UC, CD:** Initial dose: 300 mg intravenously at weeks 0, 2, and 6 Maintenance dose: 300 mg intravenously every 8 weeks	300 mg per dose
Tysabri®	CD: 300 mg intravenously every 4 weeks	300 mg every 4 Weeks
Actemra®	Intravenously: 4 mg/kg every 4 weeks followed by an increase to 8 mg/kg every 4 weeks based on clinical response. Subcutaneously: Weight < 100 kg: 162 mg every other week, followed by an increase to every week based on clinical response. Weight ≥ 100 kg: 162 mg every week.	Intravenously: 800 mg every 4 weeks Subcutaneously: 162 mg every week
Kineret®	**RA:**100 mg subcutaneously once daily	100 mg/day
Olumiant®	**RA:** 2 mg orally once daily	2 mg/day

Therapeutic alternatives are listed as generic (Brand name®) when the drug is available by both generic and brand, Brand name® when the drug is available by brand only and generic name when the drug is available by generic only.

APPENDIX C: Contraindications/Boxed Warnings

- Contraindication(s):
  - Remicade® doses >5 mg/kg in moderate or severe heart failure.
  - Previous severe hypersensitivity reaction to infliximab or any inactive ingredients of Remicade® or to any murine proteins.
    *Contraindications listed reflect direct statements made in the manufacturer's package insert; for additional uses, warnings, and precautions, please refer to clinical guidelines.

- Boxed Warning(s):
  - Increased risk of serious infections leading to hospitalization or death, including tuberculosis (TB), bacterial sepsis, invasive fungal infections (such as histoplasmosis) and infections due to other opportunistic pathogens.
  - Lymphoma and other malignancies, some fatal, have been reported in children and adolescent patients treated with tumor necrosis factor (TNF) blockers, including Remicade®.
  - Postmarketing cases of fatal hepatosplenic T-cell lymphoma (HSTCL) have been reported in patients treated with TNF blockers including Remicade®. Almost all had received azathioprine or 6-mercaptopurine concomitantly with a TNF blocker at or prior to diagnosis. The majority of Remicade®

cases were reported in patients with Crohn's disease or ulcerative colitis, most of whom were adolescent or young adult males.

APPENDIX D: General Information

- Ankylosing Spondylitis:
  - Several AS treatment guidelines recommend a trial of 2 or 3 NSAIDs prior to use of an anti-TNF agent. A two-year trial showed that continuous NSAID use reduced radiographic progression of AS versus on demand use of NSAID.
- Psoriatic Arthritis:
  - According to the 2019 American College of Rheumatology TNF inhibitors is recommended over other biologics for use in treatment-naïve patients with psoriatic arthritis, and in those who were previously treated with an oral therapy.
- Rheumatoid Arthritis:
  - Guidelines from the American College of Rheumatology (ACR) [2015] have TNF inhibitors and non-TNF biologics, administered with or without methotrexate, equally positioned as a recommended therapy following a trial of a conventional synthetic disease-modifying antirheumatic drug (DMARD) [e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine].

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Review/Revision History	Review/Revision Date	P&T Approval Date
RxA.592.Bilogic_DMARDs was last reviewed and updated on 01/05/2022 and archived on 04/18/2022. For details, please refer to RxA.592.Bilogics_DMARDs.	02/14/2022	04/18/2022
Drug specific policy for Remicade was	02/14/2022	04/18/2022

created based on RxA.592.Bilogics_DMARDs: 1. Initial Approval Criteria, I.A.5, I.B.5, I.C.5, I.D.4, I.E.5, I.F.5: Updated trial and failure criteria from Failure of two of the following, each used for ≥ 3 months, unless contraindicated or clinically significant adverse effects are experienced: Cimzia®, Humira®, Inflectra®, Otezla®, Renflexis™, Skyrizi™, Stelara®, Taltz® to Trial and failure of at least one (1) of the following agents: Inflectra® or Avsola® unless contraindicated or clinically significant adverse effects are experienced. 2. Initial Approval Criteria, I.B.4: Updated to remove Medical justification supports inability to use immunomodulators (see Appendix D). 3. Initial Approval Criteria, 1.C.4: Updated trial and failure criteria to include phototherapy (psoralen plus ultraviolet A light [PUVA]). 4. Appendix A: Updated to include abbreviations PUVA. 5. Appendix B, Drug Name: Updated to include brand-name therapeutic alternative of other biological DMARDs. 6. Disclaimer about contraindications "Contraindications listed reflect statements made in the manufacturer's package insert..." was added to Appendix C. 7. Appendix D, General Information: Updated information available from According to the 2018 American College of Rheumatology and National Psoriasis Foundation guidelines to According to the 2019 American College of Rheumatology guideline for Psoriatic Arthritis 8. Appendix D, General Information: Updated information available from definition of failure of MTX or DMARDs to Guidelines from the American College of Rheumatology		

(ACR) [2015] have TNF inhibitors and non-TNF biologics. 9. Appendix D, General Information: Updated to remove information regarding: (a, b, c and d) a. Ulcerative Colitis; b. Medical justification supporting inability to use an immunomodulator for Crohn's disease; c. Definition of failure of MTX or DMARDs; d. Examples of positive response to therapy. 10. References were reviewed and updated.		