April 13, 2018

INFLIXIMAB (REMICADE) UPDATED PRIOR AUTHORIZATION APPROVAL

Dear Provider,

Infliximab (Remicade®) is on the non-Medicare list of office-administered drugs requiring prior authorization.

Effective June 1, 2018, the criteria for infliximab (Remicade®) will be updated. This letter is a notification of the upcoming change in prior authorization approval required before administering this medication in a physician's office.

Kaiser Foundation Health Plan of Washington requires prior authorization for a select group of injectable drugs that may be administered under the medical benefit in a physician's office or by home infusion. These reviews are intended to ensure consistent benefit adjudication as well as appropriate utilization in accordance with the Kaiser Permanente Pharmacy & Therapeutics Committee’s evidence-based criteria for coverage.

Prior Authorization Criteria for Remicade® (changes are in bold):

1. For patients with rheumatoid arthritis with failure, intolerance or contraindications to methotrexate.
2. For patient with Crohn's disease who have failed, been intolerant to, or have contraindications to
   A. steroids, and
   B. azathioprine, 6-mercaptopurine, or methotrexate
4. For use in severe, refractory sarcoidosis with failure/intolerance to high dose corticosteroids and at least one steroid-sparing agent, such as methotrexate or azathioprine.
5. For patient with moderately to severely active ulcerative colitis who have failed, been intolerant to, or have contraindications to corticosteroids and azathioprine (or mercaptopurine).
6. For treatment of psoriatic arthritis in patients who failed methotrexate.
7. For patients with psoriasis who have failed phototherapy, at least one topical treatment, and at least one systemic agent.
8. New starts must have had an inadequate response or intolerance to an infliximab biosimilar declared therapeutically interchangeable. Pediatric ulcerative colitis patients are excluded from this new start requirement.
   - Therapeutically interchangeable infliximab products include: infliximab-dyyb (Inflectra)

Prior to initiation of infliximab therapy, providers need to perform a pre-treatment assessment for latent Tuberculosis infection with the Tuberculin skin test.

The following maximum doses and dosing frequency will apply.

Doc ID: 60-Day Notice 1804-01 Remicade Prior Authorization_web
Infusion at 0, 2, and 6 weeks (induction dose), followed by maintenance dose:

<table>
<thead>
<tr>
<th>Indication</th>
<th>Max Dose</th>
<th>Max Frequency for Maintenance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatoid arthritis</td>
<td>1000mg</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Crohn’s and ulcerative colitis</td>
<td></td>
<td>6 weeks</td>
</tr>
<tr>
<td>Psoriatic arthropathy and psoriasis</td>
<td></td>
<td>8 weeks</td>
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<tr>
<td>Ankylosing spondylitis</td>
<td></td>
<td>6 weeks</td>
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<tr>
<td>Sarcoidosis</td>
<td></td>
<td>8 weeks</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>8 weeks</td>
</tr>
</tbody>
</table>

Note: Must be administered in a non-hospital setting. See site of service prior authorization criteria for coverage criteria in a hospital outpatient setting and exceptions for new starts.

Additional Information

A complete list of office-administered injectable drugs requiring prior authorization is available on Kaiser Permanente for Providers at https://provider.ghc.org under Referrals & Clinical Review.

To request prior authorization review, please use the Referral Request online form on the provider website listed above. You can also call to Review Services toll-free at 1-888-289-1363.

Thank you for the care you provide to our members, your patients. If you have any questions about this process, please call Review Services at 1-800-289-1363.

Sincerely,

Bruce Wilson, MD, Chair
Pharmacy & Therapeutics Committee