# Infliximab

## NOTICE

This policy contains information which is clinical in nature. The policy is not medical advice. The information in this policy is used by Wellmark to make determinations whether medical treatment is covered under the terms of a Wellmark member's health benefit plan. Physicians and other health care providers are responsible for medical advice and treatment. If you have specific health care needs, you should consult an appropriate health care professional. If you would like to request an accessible version of this document, please contact customer service at 800-524-9242.

## BENEFIT APPLICATION

Benefit determinations are based on the applicable contract language in effect at the time the services were rendered. Exclusions, limitations or exceptions may apply. Benefits may vary based on contract, and individual member benefits must be verified. Wellmark determines medical necessity only if the benefit exists and no contract exclusions are applicable. This medical policy may not apply to FEP. Benefits are determined by the Federal Employee Program.

## DESCRIPTION

The intent of the infliximab drug policy is to ensure appropriate selection of patients for therapy based on product labeling, clinical guidelines and clinical studies for Remicade (infliximab), Inflectra (infliximab-dyyb), Renflexis (infliximab-abda), and Avsola (infliximab-axxq). For this program, Avsola, Inflectra, Renflexis, Entyvio, Ilumya, Stelara, and Simponi Aria are the preferred products. Coverage for non-preferred product, Remicade, is provided based on clinical circumstances that would exclude the use of the preferred products and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. Submission of medical records documenting relevant history, physician evaluation information, and supporting compendia or current literature (if applicable) will be required for review of these exceptions.

FDA-Approved Indications

1. Adult patients with moderately to severely active Crohn's disease (CD) and fistulizing CD
2. Pediatric patients 6 years of age and older with moderately to severely active Crohn's disease
3. Moderately to severely active ulcerative colitis (UC) in patients 6 years of age or older
4. Moderately to severely active rheumatoid arthritis (RA) in combination with methotrexate
5. Active ankylosing spondylitis (AS)
6. Active psoriatic arthritis (PsA)
7. Chronic severe plaque psoriasis (PsO)

Compendial Uses

1. Axial spondyloarthritis
2. Behçet's syndrome
3. Granulomatosis with polyangiitis (Wegener's granulomatosis)
4. Hidradenitis suppurativa

5. Juvenile idiopathic arthritis
6. Pyoderma gangrenosum
7. Sarcoidosis
8. Takayasu's arteritis
9. Uveitis
10. Reactive arthritis
11. Immune checkpoint inhibitor toxicity
12. Acute graft versus host disease
13. Moderate to severe plaque psoriasis

## POLICY

Documentation

Submission of the following information is necessary to initiate the prior authorization review:

A. Crohn's disease (CD)
   1. Initial requests:
      i. Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.
      ii. Chart notes or medical record documentation supporting diagnosis of fistulizing Crohn's disease (if applicable).
   2. Continuation requests: Chart notes or medical record documentation supporting positive clinical response to therapy or remission

B. Ulcerative colitis
   1. Initial requests
      i. Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.
      ii. Chart notes or medical record documentation of hospitalization due to acute, severe ulcerative colitis (if applicable).
   2. Continuation requests: Chart notes or medical record documentation supporting positive clinical response to therapy or remission.

C. Rheumatoid arthritis (RA)
   1. For initial requests:
      i. Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.
      ii. Laboratory results, chart notes, or medical record documentation of biomarker testing (i.e., rheumatoid factor [RF], anti-cyclic citrullinated peptide [anti-CCP], and C-reactive protein [CRP] and/or erythrocyte sedimentation rate [ESR]) (if applicable).
   2. For continuation requests: Chart notes or medical record documentation supporting positive clinical response.

D. Ankylosing spondylitis (AS), axial spondyloarthritis, juvenile idiopathic arthritis, and reactive arthritis:
   1. Initial requests: Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.
   2. Continuation requests: Chart notes or medical record documentation supporting positive clinical response.

E. Psoriatic arthritis (PsA): For continuation requests: Chart notes or medical record documentation supporting positive clinical response.

F. Plaque psoriasis

1. Initial requests:
    i. Chart notes or medical record documentation of affected area(s) and body surface area (BSA) affected (if applicable).
    ii. Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.
2. Continuation requests: Chart notes or medical record documentation of decreased body surface area (BSA) affected and/or improvement in signs and symptoms.

G. Behcet's disease (initial requests only): Chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy (if applicable).

H. Hidradenitis suppurativa
1. Initial requests: Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.
2. Continuation requests: Chart notes or medical record documentation supporting positive clinical response to therapy.

I. Uveitis
1. Initial requests: Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.
2. Continuation requests: Chart notes or medical record documentation supporting positive clinical response to therapy.

J. Granulomatosis with polyangiitis (Wegener's granulomatosis), pyoderma gangrenosum, sarcoidosis, Takayasu's arteritis, immune checkpoint inhibitor toxicity, and acute graft versus host disease (initial requests only): Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable). If therapy is not advisable, documentation of clinical reason to avoid therapy.

Must meet BOTH the Preferred Drug Plan Design and Criteria for Initial Approval/Continuation of Therapy when both are applicable.

Preferred Drug Plan Design

Coverage for a non-preferred product is provided when both of the following criteria are met:

- Member has a documented intolerable adverse event with all of the preferred products, Avsola, Inflectra, and Renflexis, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information.
- Member has a documented inadequate response or intolerable adverse event with Entyvio, Ilumya, and Simponi Aria where the product's indications overlap.

**Table. Disease-modifying antirheumatic drugs for autoimmune conditions**

| | **Products** | |
|---|---|---|
| **Preferred** | • **Avsola** (infliximab-axxq)<br>• **Entyvio** (vedolizumab)<br>• **Inflectra** (infliximab-dyyb)<br>• **Renflexis** (infliximab-abda) | • **Simponi Aria** (golimumab, intravenous)<br>• **Stelara IV** (ustekinumab)*<br>• **Ilumya** (tildrakizumab) |
| **Targeted** | • **Actemra** (tocilizumab)<br>• **Orencia** (abatacept) | • **Remicade** (infliximab)<br>• **Cimzia** (certolizumab)** |

*Stelara IV is indicated for a one time induction dose for Crohn's disease and ulcerative colitis
**Lyophilized Powder for reconstitution and administration by a healthcare professional

Criteria for Initial Approval

**A) Moderately to severely active Crohn's disease (CD)**

1. Authorization of 12 months may be granted for members who have previously received a biologic indicated for the treatment of moderately to severely active Crohn's disease.
2. Authorization of 12 months may be granted for the treatment of moderately to severely active Crohn's disease when the member has had an inadequate response, intolerance, or contraindication to at least one conventional therapy option (see Appendix A).
3. Authorization of 12 months may be granted for the treatment of fistulizing CD.

**B) Moderately to severely active ulcerative colitis (UC)**

1. Authorization of 12 months may be granted for members who have previously received a biologic or targeted synthetic drug (e.g., Xeljanz) indicated for moderately to severely active ulcerative colitis.
2. Authorization of 12 months may be granted for the treatment of moderately to severely active UC when the member has had an inadequate response, intolerance or contraindication to at least one conventional therapy option (See Appendix B).
3. Authorization of 12 months may be granted for members who have been hospitalized for acute severe UC (e.g., continuous bleeding, severe toxic symptoms, including fever and anorexia).

**C) Moderately to severely active rheumatoid arthritis (RA)**

1. Authorization of 12 months may be granted for members who have previously received a biologic or targeted synthetic DMARD (e.g., Rinvoq, Xeljanz) indicated for moderately to severely active rheumatoid arthritis. The requested medication must be prescribed in combination with methotrexate or leflunomide unless the member has a clinical reason not to use methotrexate (see Appendix C) or leflunomide.
2. Authorization of 12 months may be granted for treatment of moderately to severely active RA when all of the following criteria are met:
    i. Member meets either of the following criteria:
        a. Member has been tested for either of the following biomarkers and the test was positive:
            1. Rheumatoid factor (RF)
            2. Anti-cyclic citrullinated peptide (anti-CCP)
        b. Member has been tested for ALL of the following biomarkers:
            1. RF
            2. Anti-CCP
            3. C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR)
    ii. Member is prescribed the requested medication in combination with methotrexate or leflunomide, or has a clinical reason not to use methotrexate (see Appendix C) or leflunomide.
    iii. Member meets any of the following criteria:
        a. Member has experienced an inadequate response to at least a 3-month trial of methotrexate despite adequate dosing (i.e., titrated to at least 15 mg/week).
        b. Member has an intolerance or contraindication to methotrexate (see Appendix C).

**D) Active ankylosing spondylitis (AS) and active axial spondyloarthritis**

1. Authorization of 12 months may be granted for members who have previously received a biologic indicated for active ankylosing spondylitis or active axial spondyloarthritis.
2. Authorization of 12 months may be granted for treatment of active ankylosing spondylitis or active axial spondyloarthritis when any of the following criteria is met:
    a.) Member has experienced an inadequate response to at least two non-steroidal anti-inflammatory drugs (NSAIDs).
    b.) Member has an intolerance or contraindication to two or more NSAIDs (see Appendix D).

**E) Active psoriatic arthritis (PsA)**

Authorization of 12 months may be granted for treatment of active psoriatic arthritis (PsA).

**F) Moderate to severe plaque psoriasis**

1. Authorization of 12 months may be granted for members who have previously received Otezla or a biologic indicated for the treatment of moderate to severe plaque psoriasis.
2. Authorization of 12 months may be granted for treatment of moderate to severe plaque psoriasis in members when any of the following criteria is met:
   a.) Crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected.
   b.) At least 10% of the body surface area (BSA) is affected
   c.) At least 3% of body surface area (BSA) is affected and the member meets any of the following criteria:
      i). Member has had an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine or acitretin.
      ii). Member has a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine and acitretin (see Appendix E).

**G) Behçet's disease**

1. Authorization of 12 months may be granted for members who have previously received Otezla or a biologic indicated for the treatment of Behçet's disease.
2. Authorization of 12 months may be granted for the treatment of Behçet's disease when the member has had an inadequate response to at least one nonbiologic medication for Behçet's disease (e.g., apremilast, colchicine, systemic glucocorticoids, azathioprine).

**H) Granulomatosis with polyangiitis (Wegener's granulomatosis)**

Authorization of 12 months may be granted for treatment of granulomatosis with polyangiitis when either of the following criteria is met:

1. Member has experienced an inadequate response to corticosteroids or immunosuppressive therapy (e.g., cyclophosphamide, azathioprine, methotrexate, or mycophenolate mofetil).
2. Member has an intolerance or contraindication to corticosteroids and immunosuppressive therapy (e.g., cyclophosphamide, azathioprine, methotrexate, or mycophenolate mofetil).

**I) Hidradenitis suppurativa**

1. Authorization of 12 months may be granted for members who have previously received a biologic indicated for the treatment of severe, refractory hidradenitis suppurativa.
2. Authorization of 12 months may be granted for treatment of severe, refractory hidradenitis suppurativa when either of the following is met:
   a. Member has experienced an inadequate response to oral antibiotics for at least 90 days.
   b. Member has an intolerance or contraindication to oral antibiotics.

**J) Juvenile Idiopathic arthritis (JIA)**

1. Authorization of 12 months may be granted for members who have previously received a biologic or targeted synthetic DMARD indicated for juvenile idiopathic arthritis.
2. Authorization of 12 months may be granted for the treatment of JIA when any of the following criteria is met:
   a.) Member has an inadequate response to at least a 1-month trial of NSAIDs.
   b.) Member has an inadequate response to at least a 2-week trial of corticosteroids.
   c.) Member has an inadequate response to at least a 3-month trial of methotrexate or leflunomide.

**K) Pyoderma gangrenosum**

1. Authorization of 12 months may be granted for members who have previously received a biologic indicated for pyoderma gangrenosum.
2. Authorization of 12 months may be granted for treatment of pyoderma gangrenosum when either of the following is met:
   a.) Member has experienced an inadequate response to corticosteroids or immunosuppressive therapy (e.g., cyclosporine, or mycophenolate mofetil).
   b.) Member has an intolerance or contraindication to corticosteroids and immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil).

**L) Sarcoidosis**

Authorization of 12 months may be granted for treatment of sarcoidosis in members when any of the following criteria is met:

1. Member has experienced an inadequate response to corticosteroids or immunosuppressive therapy
2. Member has an intolerance or contraindication to corticosteroids and immunosuppressive therapy.

**M) Takayasu's arteritis**

Authorization of 12 months may be granted for treatment of refractory Takayasu's arteritis when any of the following criteria is met:

1. Member has experienced an inadequate response to corticosteroids or immunosuppressive therapy (e.g., methotrexate, azathioprine, or mycophenolate mofetil).
2. Member has an intolerance or contraindication to corticosteroids and immunosuppressive therapy (e.g., methotrexate, azathioprine, or mycophenolate mofetil).

**N) Uveitis**

1. Authorization of 12 months may be granted for members who have previously received a biologic indicated for uveitis.
2. Authorization of 12 months may be granted for treatment of uveitis when any of the following criteria is met:
   a.) Member has experienced an inadequate response to corticosteroids or immunosuppressive therapy (e.g., methotrexate, azathioprine, or mycophenolate mofetil).
   b.) Member has an intolerance or contraindication to corticosteroids and immunosuppressive therapy (e.g., methotrexate, azathioprine, or mycophenolate mofetil).

**O) Reactive arthritis**

1. Authorization of 12 months may be granted for members who have previously received a biologic indicated for reactive arthritis.
2. Authorization of 12 months may be granted for treatment of reactive arthritis when any of the following criteria is met:
   a.) Member has experienced an inadequate response to at least a 3-month trial of methotrexate despite adequate dosing (i.e., titrated to at least 15 mg/week).
   b.) Member has an intolerance or contraindication to methotrexate (see Appendix C).

**P) Immune checkpoint inhibitor toxicity**

1. Authorization of 1 month may be granted for the treatment of immune checkpoint inhibitor (e.g., CTLA-4, PD-L1 inhibitor) toxicity when any of the following is met:
   a) Member has had an inadequate response, intolerance, or contraindication to corticosteroids.
   b) Member has cardiac toxicity
   c) Member has moderate or severe diarrhea or colitis

**Q) Acute graft versus host disease**

1. Authorization of 12 months may be granted for treatment of acute graft versus host disease when either of the following criteria is met:
    a. Member has experienced an inadequate response to systemic corticosteroids
    b. Member has an intolerance or contraindication to corticosteroids

Continuation of Therapy

**A) Moderately to severely active Crohn's disease (CD)**

1. Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for moderately to severely active Crohn's disease and who achieve or maintain remission.

2. Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for moderately to severely active Crohn's disease and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:
    i. Abdominal pain or tenderness
    ii. Diarrhea
    iii. Body weight
    iv. Abdominal mass
    v. Hematocrit
    vi. Endoscopic appearance of the mucosa
    vii. Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index [CDAI] score)

**B) Moderately to severely active ulcerative colitis (UC)**

1. Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for moderately to severely active ulcerative colitis and who achieve or maintain remission.

2. Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for moderately to severely active ulcerative colitis and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:
    i. Stool frequency
    ii. Rectal bleeding
    iii. Urgency of defecation
    iv. C-reactive protein (CRP)
    v. Fecal calprotectin (FC)
    vi. Endoscopic appearance of the mucosa
    vii. Improvement on a disease activity scoring tool (e.g., Ulcerative Colitis Endoscopic Index of Severity [UCEIS], Mayo score)

**C) Moderately to severely active rheumatoid arthritis (RA)**

Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for moderately to severely active rheumatoid arthritis and who achieve or maintain a positive clinical response as evidenced by disease activity improvement of at least 20% from baseline in tender joint count, swollen joint count, pain, or disability.

**D) Active ankylosing spondylitis (AS) and active axial spondyloarthritis**

Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for active ankylosing spondylitis or active axial spondyloarthritis and who achieve or maintain a positive clinical response with the requested medication as

evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:

1. Functional status
2. Total spinal pain
3. Inflammation (e.g., morning stiffness)

**E) Active psoriatic arthritis (PsA)**

Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for active psoriatic arthritis and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:

1. Number of swollen joints
2. Number of tender joints
3. Dactylitis
4. Enthesitis
5. Skin and/or nail involvement

**F) Moderate to severe plaque psoriasis**

Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for moderate to severe plaque psoriasis and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when any of the following is met:

1. Reduction in body surface area (BSA) affected from baseline
2. Improvement in signs and symptoms from baseline (e.g., itching, redness, flaking, scaling, burning, cracking, pain)

**G) Hidradenitis suppurativa**

Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for severe, refractory hidradenitis suppurativa and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when any of the following is met:

1. Reduction in abscess and inflammatory nodule count from baseline
2. Reduced formation of new sinus tracts and scarring
3. Decrease in frequency of inflammatory lesions from baseline
4. Reduction in pain from baseline
5. Reduction in suppuration from baseline
6. Improvement in frequency of relapses from baseline
7. Improvement in quality of life from baseline
8. Improvement on a disease severity assessment tool from baseline

**H) Juvenile idiopathic arthritis (JIA)**

Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for juvenile idiopathic arthritis and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:

1. Number of joints with active arthritis (e.g., swelling, pain, limitation of motion)
2. Number of joints with limitation of movement
3. Functional ability

**I) Uveitis**

Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for uveitis and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when the patient meets any of the following:

1. Reduced frequency of recurrence compared to baseline
2. Zero anterior chamber inflammation or reduction in anterior chamber inflammation compared to baseline
3. Decreased reliance on topical corticosteroids

**J) Reactive arthritis**

Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for reactive arthritis and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition (e.g., tender joint count, swollen joint count, or pain).

**K) Immune checkpoint inhibitor toxicity and acute graft versus host disease**

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

**L) All other indications**

Authorization of 12 months may be granted for all members (including new members) who are using Remicade, Inflectra, Renflexis, or Avsola for an indication outlined in the initial authorization criteria and who achieve or maintain positive clinical response with Remicade, Inflectra, Renflexis, or Avsola as evidenced by low disease activity or improvement in signs and symptoms of the condition.

Other

For all indications: Member has had a documented negative TB test (which can include a tuberculosis skin test [PPD], an interferon-release assay [IGRA], or a chest x-ray)* within 6 months of initiating therapy for persons who are naïve to biologic DMARDs or targeted synthetic DMARDs associated with an increased risk of TB.

* If the screening testing for TB is positive, there must be further testing to confirm there is no active disease. Do not administer infliximab to members with active TB infection. If there is latent disease, TB treatment must be started before initiation of infliximab.

For all indications: Member cannot use infliximab concomitantly with any other biologic DMARD or targeted synthetic DMARD.

Remicade, Inflectra, Renflexis and Avsola are considered **not medically necessary** for members who do not meet the criteria set forth above.

Dosage and Administration

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Appendices

**Appendix A: Examples of Conventional Therapy Options for CD**

1. Mild to moderate disease – induction of remission:
   a. Oral budesonide
   b. Alternatives: metronidazole, ciprofloxacin, rifaximin

2. Mild to moderate disease – maintenance of remission:
    a. Azathioprine, mercaptopurine
    b. Alternatives: oral budesonide, methotrexate intramuscular (IM) or subcutaneous (SC), sulfasalazine
3. Moderate to severe disease – induction of remission:
    a. Prednisone, methylprednisolone intravenously (IV)
    b. Alternatives: methotrexate IM or SC
4. Moderate to severe disease – maintenance of remission:
    a. Azathioprine, mercaptopurine
    b. Alternative: methotrexate IM or SC
5. Perianal and fistulizing disease – induction of remission
    a. Metronidazole ± ciprofloxacin, tacrolimus
6. Perianal and fistulizing disease – maintenance of remission
    a. Azathioprine, mercaptopurine
    b. Alternative: methotrexate IM or SC

**Appendix B: Examples of Conventional Therapy Options for UC**

1. Mild to moderate disease – induction of remission:
    a. Oral mesalamine (e.g., Apriso, Asacol, Asacol HD, Lialda, Pentasa), balsalazide, olsalazine
    b. Rectal mesalamine (e.g., Canasa, Rowasa)
    c. Rectal hydrocortisone (e.g., Colocort, Cortifoam)
    d. Alternatives: prednisone, azathioprine, mercaptopurine, sulfasalazine
2. Mild to moderate disease – maintenance of remission:
    a. Oral mesalamine, balsalazide, olsalazine, rectal mesalamine
    b. Alternatives: azathioprine, mercaptopurine, sulfasalazine
3. Severe disease – induction of remission:
    a. Prednisone, hydrocortisone IV, methylprednisolone IV
    b. Alternatives: cyclosporine IV, tacrolimus, sulfasalazine
4. Severe disease – maintenance of remission:
    a. Azathioprine, mercaptopurine
    b. Alternative: sulfasalazine

**Appendix C: Examples of Contraindications to Methotrexate**

1. Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease
2. Breastfeeding
3. Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
4. Elevated liver transaminases
5. History of intolerance or adverse event
6. Hypersensitivity
7. Interstitial pneumonitis or clinically significant pulmonary fibrosis
8. Myelodysplasia
9. Pregnancy or currently planning pregnancy
10. Renal impairment
11. Significant drug interaction

**Appendix D: Examples of Contraindications to the Use of NSAIDs**

1. Allergic-type reaction following aspirin or other NSAID administration
2. Asthma
3. Gastrointestinal bleeding
4. History of intolerance or adverse event
5. Significant drug interaction

6. Urticaria

**Appendix E: Examples of Clinical Reasons to Avoid Pharmacologic Treatment with Methotrexate, Cyclosporine or Acitretin.**

1. Clincal diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease
2. Breastfeeding
3. Drug interaction
4. Cannot be used due to risk of treatment-related toxicity
5. Pregnancy or currently planning pregnancy
6. Significant comorbidity prohibits use of systemic agents (examples include liver or kidney disease, blood dyscrasias, uncontrolled hypertension)

## PROCEDURES AND BILLING CODES

**To report provider services, use appropriate CPT* codes, Alpha Numeric (HCPCS level 2) codes, Revenue codes, and/or ICD diagnostic codes.**

- J1745 Injection infliximab, 10 mg (applies to Remicade product only; not biosimilars)
- Q5102 Injection infliximab, biosimilar - 10mg (cancelled 4/1/2018)
- Q5103 Injection infliximab, biosimilar - Inflectra, 10mg (new code effective 4/1/2018)
- Q5104 Injection infliximab, biosimilar - Renflexis, 10mg (new code effective 4/1/2018)
- Q5109 Injection, infliximab, biosimilar - Ixifi, 10 mg (new code effective 1/1/2019)
- Q5121 Injection, infliximab-axxq, biosimilar, (Avsola), 10 mg (new code effective 7/1/20)

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