Policy and Procedure	
PHARMACY PRIOR AUTHORIZATION POLICY AND CRITERIA ORPTCOTH021.0226	**MISCELLANEOUS PRODUCTS** **MEDICALLY INFUSED THERAPEUTIC IMMUNOMODULATORS (TIMs)** See Table 1 for Applicable Medications
Effective Date: 3/1/2026	**Review/Revised Date**: 01/17, 02/17, 03/17, 09/17, 01/17, 03/18, 05/18, 11/18, 01/19, 03/19, 09/19, 12/19, 01/20, 09/20, 05/21, 09/21, 11/21, 03/22, 08/22, 09/22, 09/23, 02/24, 05/24, 08/24, 11/24, 05/25, 08/25, 11/25, 02/26 (snm)
Original Effective Date: 02/17 **Approved by:** Oregon Region Pharmacy and Therapeutics Committee	**P&T Committee Meeting Date**: 02/17, 02/17(cv), 03/17(cv), 04/17, 02/18, 03/18 (cv), 04/18, 06/18, 12/18, 02/19, 04/19, 06/19, 10/19, 12/19 (cv), 02/20, 10/20, 10/20 (off-cycle), 06/21, 10/21, 11/21 (CV), 12/21, 02/22 (cv), 04/22, 06/22, 08/22, 10/22, 10/23, 02/24, 06/24, 10/24, 12/24, 04/25, 06/25, 10/25, 11/25 (cv), 12/25, 02/26

SCOPE:
Providence Health Plan and Providence Health Assurance as applicable (referred to individually as “Company” and collectively as “Companies”).

APPLIES TO:
Commercial

Note: The intravenous forms guselkumab, mirikizumab-mrkz, risankizumab-rzaa, and ustekinumab are indicated for induction doses and will be covered upon approval of a pharmacy benefit prior authorization for the subcutaneous form for self-administration maintenance dosing. Refer to the “Therapeutic immunomodulators” policy (ORPTCOTH016) for self-administered agents.

POLICY CRITERIA:

COVERED USES:
All Food and Drug Administration (FDA)-approved indications not otherwise excluded from the benefit. Drug Compendia supported indications may be covered.

REQUIRED MEDICAL INFORMATION:
1. For **all requests**, the patient must have an FDA labeled indication for the requested product or use to treat the indication is supported in drug compendia (e.g., the American Hospital Formulary Service-Drug Information (AHFS-DI) or Truven Health Analytics’ DRUGDEX System). Exception: biosimilar products may be covered for all FDA-approved indications that the innovator product has been granted
   AND
2. Dosing and frequency are in accordance with FDA labeling
   AND
3. The requested product will not be given concurrently with another therapeutic immunomodulator (TIM) product unless there is no product which covers all indications

AND

4. Requests for non-preferred products will require inadequate response, intolerance, or FDA-labeled contraindication to all the preferred products as outlined below in addition to any indication-specific criteria, if applicable. Accepted contraindications include contraindications listed in the package insert or an allergic reaction to an ingredient found only in the preferred product(s)
    a. Non-preferred infliximab products will require inadequate response, intolerance, or FDA-labeled contraindication to all preferred infliximab products (Inflectra and Renflexis)
    b. Non-preferred tocilizumab products will require inadequate response, intolerance, or FDA-labeled contraindication to Tyenne
    c. Non-preferred ustekinumab products will require inadequate response, intolerance, or FDA-labeled contraindication to all preferred ustekinumab products (Selarsdi, Steqeyma, and Yesintek)
5. The following indication-specific criteria*:
    Ankylosing Spondylitis/Radiographic Axial Spondyloarthritis (r-axSpA)
    Asthma
    Crohn's Disease (CD)
    Giant Cell Arteritis (GCA)
    Immune Checkpoint Inhibitor Related Toxicities
    Non-Radiographic Axial Spondyloarthritis (nr-axSpA)
    Plaque Psoriasis (Ps)
    Polyarticular Juvenile Idiopathic Arthritis (PJIA)
    Psoriatic Arthritis (PsA)
    Rheumatoid Arthritis (RA)
    Sarcoidosis
    Systemic Juvenile Idiopathic Arthritis (SJIA)
    Ulcerative Colitis (UC)
    *If indication is not listed, the requested drug may be covered if it is an FDA-approved medication for the indication and age of the patient

Notes:

- Conventional therapy requirements may be waived if the patient has previously used another therapeutic immunomodulator product or apremilast (Otezla) for the same indication
- Conventional therapy and preferred product requirements may be waived with clinically appropriate medical rationale

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Requests for indications that were approved by the FDA within the previous six (6) months may not have been reviewed by the health plan for safety and effectiveness and inclusion on this policy document. These requests will be reviewed using the New Drug and or Indication Awaiting P&T Review; Prior Authorization Request ORPTCOPS047.

Requests for a non-FDA approved (off-label) indication requires the proposed indication be listed in either the American Hospital Formulary System (AHFS), Drugdex, or the National Comprehensive Cancer Network (NCCN) and is considered subject to evaluation of the prescriber's medical rationale, formulary alternatives, the available published evidence-based research and whether the proposed use is determined to be experimental/investigational.

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case.

Ankylosing Spondylitis/ Radiographic Axial Spondyloarthritis

REQUIRED MEDICAL INFORMATION:
For initial authorization:

1. Inadequate response (after four weeks of total therapy) or intolerance to two different nonsteroidal anti-inflammatory drugs (NSAIDs) or FDA-labeled contraindication to all NSAIDs
2. Preferred and non-preferred TIMs products may be covered as outlined below when criteria 1 is met:
    a. Preferred products may be covered: preferred infliximab products (Inflectra and Renflexis)
    b. All other therapies require inadequate response (after three months of therapy), intolerance, or FDA-labeled contraindication to an infliximab product (preferred products are Inflectra and Renflexis)

For patients established on therapy:
Note: Medications obtained as samples, coupons, or any other method of obtaining medications outside of an established health plan benefit are not considered established on therapy

1. Response to therapy (e.g., slowing of disease progression or decrease in symptom severity and/or frequency)

EXCLUSION CRITERIA: N/A

AGE RESTRICTIONS:
Age must be appropriate based on FDA-approved indication (see Table 1)

PRESCRIBER RESTRICTIONS:
Must be prescribed by, or in consultation with, a rheumatologist

COVERAGE DURATION:
Initial authorization will be approved for one year. Reauthorization will be approved until no longer eligible with the plan, subject to formulary or benefit changes

QUANTITY LIMITS: See Table 2

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Asthma

REQUIRED MEDICAL INFORMATION:
For initial authorization:

1. Indication-specific diagnostic criteria are met as outlined below:
    a. Eosinophilic asthma, defined as one of the following while on high-dose inhaled corticosteroids or daily corticosteroids:
        i. Blood eosinophil count of at least 150 cells/microliter
        ii. Fraction of exhaled nitric oxide (FeNO) of at least 20 parts per billion
        iii. Sputum eosinophils of at least 2%
2. Adherence to treatment (for three months) with maximally tolerated doses of a combination of the following, unless patient has an intolerance or FDA-labeled contraindication to all therapies (This may be verified by pharmacy claims information):
    a. Inhaled corticosteroid
    b. One of the following:
        i. Long-acting inhaled beta 2-agonist (LABA)
        ii. Leukotriene receptor antagonist (LTRA)
        iii. Long-acting muscarinic antagonist (LAMA)
3. Inadequate asthma control despite above therapy, defined as one of the following:
    a. Asthma Control Test (ACT) score less than 20 or Asthma Control Questionnaire (ACQ) score greater than or equal to 1.5
    b. At least one asthma exacerbation in the last 12 months
    c. Controlled asthma that worsens when the doses of inhaled and/or systemic corticosteroids are tapered
    d. Baseline (prior to therapy with the requested product) Forced Expiratory Volume (FEV1) that is less than 80% of predicted
4. Patient must be using medication with standard maintenance therapy
5. Inadequate response (after three months of therapy) to either Fasenra or Nucala, unless there is an intolerance or FDA-labeled contraindication to both

For patients established on therapy:
Note: Medications obtained as samples, coupons, or any other method of obtaining medications outside of an established health plan benefit are not considered established on therapy

1. Response to therapy indicating improvement or stabilization of condition as defined by one of the following:
    a. Increase in percent predicted Forced Expiratory Volume (FEV1)
    b. Decrease in the dose of inhaled corticosteroid required to control the

patient's asthma
   c. Decrease in need for treatment with systemic corticosteroids due to exacerbations of asthma
   d. Decrease in the number of hospitalizations, need for mechanical ventilation, or visits to the emergency room or urgent care due to exacerbations of asthma
2. Patient is currently treated within the past 90 days and is compliant with asthma control therapy

EXCLUSION CRITERIA: N/A

AGE RESTRICTIONS:
Age must be appropriate based on FDA-approved indication (see Table 1)

PRESCRIBER RESTRICTIONS:
Must be prescribed by or in consultation with a pulmonologist, immunologist, or allergist

COVERAGE DURATION:
Initial authorization will be approved for six months. Reauthorization will be approved until no longer eligible with the plan, subject to formulary or benefit changes

QUANTITY LIMITS: See Table 2

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Crohn's Disease

REQUIRED MEDICAL INFORMATION:
For initial authorization:
1. Diagnosis of moderate to severe Crohn's disease
2. Preferred and non-preferred TIMs products may be covered as outlined below when criterion 1 is met:
    a. Preferred products may be covered: preferred infliximab products (Inflectra and Renflexis) and vedolizumab (Entyvio)
    b. All other products require inadequate response (after three months of therapy), intolerance, or FDA-labeled contraindication to an infliximab product (preferred products are Inflectra and Renflexis) or vedolizumab (Entyvio)

For patients established on therapy:
Note: Medications obtained as samples, coupons, or any other method of obtaining medications outside of an established health plan benefit are not considered established on therapy
1. Response to therapy (e.g., slowing of disease progression or decrease in symptom severity and/or frequency)

EXCLUSION CRITERIA: N/A

AGE RESTRICTIONS:
Age must be appropriate based on FDA-approved indication (see Table 1)

PRESCRIBER RESTRICTIONS:
Must be prescribed by, or in consultation with, a gastroenterologist

COVERAGE DURATION:
Initial authorization will be approved for one year. Reauthorization will be approved until no longer eligible with the plan, subject to formulary or benefit changes

QUANTITY LIMITS: See Table 2

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Giant Cell Arteritis

REQUIRED MEDICAL INFORMATION:
For initial authorization:
1. Inadequate response, intolerance, or FDA-labeled contraindication to systemic corticosteroid therapy
2. Preferred and non-preferred TIMs products may be covered as outlined below if criterion 1 is met:
    a. Preferred products may be covered: preferred tocilizumab product (Tyenne)
    b. All other therapies require inadequate response (after three months of therapy), intolerance, or FDA-labeled contraindication to a tocilizumab product (preferred product is Tyenne)

For patients established on therapy:
Note: Medications obtained as samples, coupons, or any other method of obtaining medications outside of an established health plan benefit are not considered established on therapy
1. Response to therapy (e.g., slowing of disease progression or decrease in symptom severity and/or frequency)

EXCLUSION CRITERIA: N/A

AGE RESTRICTIONS:
Age must be appropriate based on FDA-approved indication (see Table 1)

PRESCRIBER RESTRICTIONS:
Must be prescribed by, or in consultation with, a rheumatologist or neurologist

COVERAGE DURATION:
Initial authorization will be approved for one year. Reauthorization will be approved until no longer eligible with the plan, subject to formulary or benefit changes

QUANTITY LIMITS: See Table 2

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Immune Checkpoint Inhibitor Related Toxicities

REQUIRED MEDICAL INFORMATION:
For initial authorization:
1. One of the following:
    a. Mild diarrhea or colitis if persistent or progressive symptoms and positive lactoferrin/calprotectin
    b. Moderate to severe diarrhea or colitis unresponsive to high-dose systemic corticosteroids
    c. Moderate to severe pneumonitis if no improvement after 48 hours of high-dose systemic corticosteroids
    d. Severe (stage 3) kidney injury or elevated serum creatinine if toxicity remains greater than stage 2 after 4-6 weeks of corticosteroids
    e. Myocarditis if unresponsive to high-dose systemic corticosteroids
    f. Moderate, severe, or life-threatening inflammatory arthritis unresponsive to corticosteroids or anti-inflammatory products
    g. Grade 1-4 uveitis that is refractory to high-dose systemic corticosteroids
2. Preferred and non-preferred TIMs products may be covered as outlined below when criterion 1 is met:
    a. Preferred products may be covered: preferred infliximab products (Inflectra and Renflexis)
    b. All other therapies require inadequate response (after three months of therapy), intolerance, or FDA-labeled contraindication to an infliximab product (preferred products are Inflectra and Renflexis)

For patients established on therapy:
Note: Medications obtained as samples, coupons, or any other method of obtaining medications outside of an established health plan benefit are not considered established on therapy
1. Response to therapy (e.g., slowing of disease progression or decrease in symptom severity and/or frequency)

EXCLUSION CRITERIA: N/A

AGE RESTRICTIONS:
Age must be appropriate based on FDA-approved indication (see Table 1)

PRESCRIBER RESTRICTIONS:
Must be prescribed by, or in consultation with, an oncologist, gastroenterologist, pulmonologist, ophthalmologist, or rheumatologist

COVERAGE DURATION:
Authorization will be approved until no longer eligible with the plan, subject to formulary or benefit changes

QUANTITY LIMITS: See Table 2

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Non-Radiographic Axial Spondyloarthritis

REQUIRED MEDICAL INFORMATION:
For initial authorization:
1. Preferred and non-preferred TIMs products may be covered as outlined below:
    a. Preferred products may be covered: certolizumab (Cimzia)
    b. All other therapies require inadequate response (after three months of therapy), intolerance, or FDA-labeled contraindication to one product listed in criteria 1a

For patients established on therapy:
Note: Medications obtained as samples, coupons, or any other method of obtaining medications outside of an established health plan benefit are not considered established on therapy
1. Response to therapy (e.g., slowing of disease progression or decrease in symptom severity and/or frequency)

EXCLUSION CRITERIA: N/A

AGE RESTRICTIONS:
Age must be appropriate based on FDA-approved indication (see Table 1)

PRESCRIBER RESTRICTIONS:
Must be prescribed by, or in consultation with, a rheumatologist

COVERAGE DURATION:
Initial authorization will be approved for one year. Reauthorization will be approved until no longer eligible with the plan, subject to formulary or benefit changes

QUANTITY LIMITS: See Table 2

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Plaque Psoriasis

REQUIRED MEDICAL INFORMATION:
For initial authorization:

1. Diagnosis of moderate to severe plaque psoriasis
2. Inadequate response (after four weeks of therapy) or intolerance to a topical product (i.e., anthralin, coal tar preparations, corticosteroids, emollients, immunosuppressives, keratolytics, tapinarof, roflumilast, retinoic acid derivatives, and/or vitamin D analogues) or FDA-labeled contraindication to all topical products
3. Inadequate response (after three months of therapy) or intolerance to one non-biologic systemic product (i.e., immunosuppressives, retinoic acid derivatives, and/or methotrexate) or FDA-labeled contraindication to all non-biologic systemic products
4. Inadequate response (after three months of therapy), intolerance, or FDA-labeled contraindication to phototherapy
5. Preferred and non-preferred TIMs products may be covered as outlined below when criteria 1-4 are met:
    a. Preferred products may be covered: preferred infliximab products (Inflectra and Renflexis)
    b. All other therapies require inadequate response, intolerance, or FDA-labeled contraindication to an infliximab product (preferred products are Inflectra and Renflexis)

For patients established on therapy:
Note: Medications obtained as samples, coupons, or any other method of obtaining medications outside of an established health plan benefit are not considered established on therapy

1. Response to therapy (e.g., slowing of disease progression or decrease in symptom severity and/or frequency)

EXCLUSION CRITERIA: N/A

AGE RESTRICTIONS:
Age must be appropriate based on FDA-approved indication (see Table 1)

PRESCRIBER RESTRICTIONS:
Must be prescribed by, or in consultation with, a dermatologist

COVERAGE DURATION:

Initial authorization will be approved for one year. Reauthorization will be approved until no longer eligible with the plan, subject to formulary or benefit changes

QUANTITY LIMITS: See Table 2

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Polyarticular Juvenile Idiopathic Arthritis

REQUIRED MEDICAL INFORMATION:
For initial authorization:
1. Inadequate response (after one month of therapy) or intolerance to either an oral non-steroidal anti-inflammatory drug (NSAID) or an oral disease-modifying anti-rheumatic product (DMARD) (e.g., methotrexate, leflunomide, sulfasalazine) or FDA-labeled contraindication to both therapies
2. Preferred and non-preferred TIMs products may be covered as outlined below when criterion 1 is met:
    a. Preferred products may be covered: preferred tocilizumab product (Tyenne)
    b. All other therapies require inadequate response (after three months of therapy), intolerance, or FDA-labeled contraindication to a tocilizumab product (preferred product is Tyenne)

For patients established on therapy:
Note: Medications obtained as samples, coupons, or any other method of obtaining medications outside of an established health plan benefit are not considered established on therapy
1. Response to therapy (e.g., slowing of disease progression or decrease in symptom severity and/or frequency)

EXCLUSION CRITERIA: N/A

AGE RESTRICTIONS:
Age must be appropriate based on FDA-approved indication (see Table 1)

PRESCRIBER RESTRICTIONS:
Must be prescribed by, or in consultation with, a rheumatologist

COVERAGE DURATION:
Initial authorization will be approved for one year. Reauthorization will be approved until no longer eligible with the plan, subject to formulary or benefit changes

QUANTITY LIMITS: See Table 2

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Psoriatic Arthritis

REQUIRED MEDICAL INFORMATION:
For initial authorization:

1. Inadequate response (after three months of therapy) or intolerance to one conventional therapy (e.g., non-steroidal anti-inflammatory drug (NSAID), cyclosporine, methotrexate, leflunomide, or sulfasalazine) or FDA-labeled contraindication to all conventional products
2. Preferred and non-preferred TIMs products may be covered as outlined below when criterion 1 is met:
    a. Preferred products may be covered: preferred infliximab products (Inflectra and Renflexis)
    b. All other therapies require inadequate response (after three months of therapy), intolerance, or FDA-labeled contraindication to an infliximab product (preferred products are Inflectra and Renflexis)

For patients established on therapy:
Note: Medications obtained as samples, coupons, or any other method of obtaining medications outside of an established health plan benefit are not considered established on therapy

1. Response to therapy (e.g., slowing of disease progression or decrease in symptom severity and/or frequency)

EXCLUSION CRITERIA: N/A

AGE RESTRICTIONS:
Age must be appropriate based on FDA-approved indication (see Table 1)

PRESCRIBER RESTRICTIONS:
Must be prescribed by, or in consultation with, a rheumatologist

COVERAGE DURATION:
Initial authorization will be approved for one year. Reauthorization will be approved until no longer eligible with the plan, subject to formulary or benefit changes

QUANTITY LIMITS: See Table 2

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Rheumatoid Arthritis

REQUIRED MEDICAL INFORMATION:
For initial authorization:
1. Diagnosis of moderate to severe active rheumatoid arthritis
2. Inadequate response (after three months of therapy) or intolerance to one oral disease modifying anti-rheumatic product (DMARD) (e.g., methotrexate, azathioprine, auranofin, hydroxychloroquine, penicillamine, sulfasalazine, leflunomide) or FDA-labeled contraindication to all oral DMARDs
3. Preferred and non-preferred TIMs products may be covered as outlined below when criteria 1 and 2 are met:
    a. Preferred products may be covered: preferred infliximab products (Inflectra and Renflexis)
    b. All other therapies require inadequate response (after three months of therapy), intolerance, or FDA-labeled contraindication to an infliximab product (preferred products are Inflectra and Renflexis)

For patients established on therapy:
Note: Medications obtained as samples, coupons, or any other method of obtaining medications outside of an established health plan benefit are not considered established on therapy
1. Response to therapy (e.g., slowing of disease progression or decrease in symptom severity and/or frequency)

EXCLUSION CRITERIA: N/A

AGE RESTRICTIONS:
Age must be appropriate based on FDA-approved indication (see Table 1)

PRESCRIBER RESTRICTIONS:
Must be prescribed by, or in consultation with, a rheumatologist

COVERAGE DURATION:
Initial authorization will be approved for one year. Reauthorization will be approved until no longer eligible with the plan, subject to formulary or benefit changes

QUANTITY LIMITS: See Table 2

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Sarcoidosis

REQUIRED MEDICAL INFORMATION:
For initial authorization:

1. Inadequate response (after one month of therapy) or intolerance to one oral corticosteroid (e.g., prednisone, methylprednisolone) or FDA-labeled contraindication to all oral corticosteroids
2. Inadequate response (after three months of therapy) or intolerance to one immunosuppressant (e.g., methotrexate, cyclophosphamide, azathioprine) or FDA-labeled contraindication to all immunosuppressants
3. Preferred and non-preferred TIMs products may be covered as outlined below when criteria 1 and 2 are met:
    a. Preferred products may be covered: preferred infliximab products (Inflectra and Renflexis)
    b. All other therapies require inadequate response (after three months of therapy), intolerance, or FDA-labeled contraindication to an infliximab product (preferred products are Inflectra and Renflexis)

For patients established on therapy:
Note: Medications obtained as samples, coupons, or any other method of obtaining medications outside of an established health plan benefit are not considered established on therapy

1. Response to therapy (e.g., slowing of disease progression or decrease in symptom severity and/or frequency)

EXCLUSION CRITERIA: N/A

AGE RESTRICTIONS:
Age must be appropriate based on FDA-approved indication (see Table 1)

PRESCRIBER RESTRICTIONS:
Must be prescribed by, or in consultation with a pulmonologist, ophthalmologist, neurologist, cardiologist, rheumatologist, or dermatologist

COVERAGE DURATION:
Initial authorization will be approved for one year. Reauthorization will be approved until no longer eligible with the plan, subject to formulary or benefit changes

QUANTITY LIMITS: See Table 2

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Systemic Juvenile Idiopathic Arthritis

REQUIRED MEDICAL INFORMATION:
For initial authorization:
1. Preferred and non-preferred TIMs products may be covered as outlined below:
    a. Preferred products may be covered: preferred tocilizumab product (Tyenne)
    b. All other therapies require inadequate response (after three months of therapy), intolerance, or FDA-labeled contraindication to a tocilizumab product (preferred product is Tyenne)

For patients established on therapy:
Note: Medications obtained as samples, coupons, or any other method of obtaining medications outside of an established health plan benefit are not considered established on therapy
1. Response to therapy (e.g., slowing of disease progression or decrease in symptom severity and/or frequency)

EXCLUSION CRITERIA: N/A

AGE RESTRICTIONS:
Age must be appropriate based on FDA-approved indication (see Table 1)

PRESCRIBER RESTRICTIONS:
Must be prescribed by, or in consultation with, a rheumatologist

COVERAGE DURATION:
Initial authorization will be approved for one year. Reauthorization will be approved until no longer eligible with the plan, subject to formulary or benefit changes

QUANTITY LIMITS: See Table 2

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Ulcerative Colitis

REQUIRED MEDICAL INFORMATION:
For initial authorization:
1. Diagnosis of moderate to severe ulcerative colitis
2. Preferred and non-preferred TIMs products may be covered as outlined below when criterion 1 is met:
    a. Preferred products may be covered: preferred infliximab products (Inflectra and Renflexis) and vedolizumab (Entyvio)
    b. All other therapies require inadequate response (after three months of therapy), intolerance, or FDA-labeled contraindication to an infliximab product (preferred products are Inflectra and Renflexis) or vedolizumab (Entyvio)

For patients established on therapy:
Note: Medications obtained as samples, coupons, or any other method of obtaining medications outside of an established health plan benefit are not considered established on therapy
1. Response to therapy (e.g., slowing of disease progression or decrease in symptom severity and/or frequency)

EXCLUSION CRITERIA: N/A

AGE RESTRICTIONS:
Age must be appropriate based on FDA-approved indication (see Table 1)

PRESCRIBER RESTRICTIONS:
Must be prescribed by, or in consultation with a gastroenterologist

COVERAGE DURATION:
Initial authorization will be approved for one year. Reauthorization will be approved until no longer eligible with the plan, subject to formulary or benefit changes

QUANTITY LIMITS: See Table 2

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INTRODUCTION:
Therapeutic Immunomodulators (TIMs) have become standard of care in patients with moderate to severe, chronic inflammatory diseases where conventional therapies have not been adequate. These products work by targeting specific steps in the inflammatory and immune cascade.

FDA APPROVED INDICATIONS: See Table 1

POSITION STATEMENT:
Preferred use of biosimilar medically infused therapeutic immunomodulators
Biosimilars have been approved for use in the United States for several disease states that are currently treated with therapeutic immunomodulators. The United States Food and Drug Administration (FDA) defines a biosimilar as a "biological product that is highly similar to and had no clinically meaningful differences from an existing FDA-approved reference product." The Companies have chosen to favor the use of biosimilar products to provide quality clinical care to our members in the most cost-effective manner.

Infliximab
There are currently three approved biosimilars for infliximab: Inflectra (infliximab-dyyb), Renflexis (infliximab-abda), and Avsola (infliximab-axxq). These products have been FDA approved for all indications that the reference product (Remicade) has been approved for. Therefore, it is clinically appropriate to use these products instead of Remicade. Additionally, there have been several moderate-to-high quality studies that support non-medical switching from Remicade to infliximab biosimilars.

The NOR-SWITCH trial was a prospective, randomized double-blind study of 482 patients with inflammatory diseases in Norway. Disease states included in this study were: Crohn's disease (CD), ulcerative colitis (UC), spondylarthritis, rheumatoid arthritis, psoriatic arthritis, and chronic plaque psoriasis. This study included patients who had been treated on the reference drug Remicade for an average of 6.9 years before switching to the biosimilar Inflectra. Inflectra was shown to be non-inferior to Remicade when switching after at least six months of Remicade treatment. There were no significant differences between the groups in terms of safety, objective measures of disease activity, infliximab trough levels, or immunogenicity (anti-drug antibodies). There was a discontinuation rate of 4% for the Remicade group and 3% for the Inflectra group. A notable limitation of the NOR-SWITCH study is that it was not powered to make conclusions about treatment outcomes in the individual indications that were studied, so it is possible that outcomes for certain subgroups may differ. To address this limitation, the authors conducted an open-label extension (OLE) and further subgroup analysis of the inflammatory bowel disease cohorts of

the original NOR-SWITCH study. In the OLE, 100 patients who had been in the Remicade arm of the initial study were switched in an unblinded fashion to Inflectra. The author's found no difference in clinical outcomes with this open-label switch, adjusted risk of disease worsening with switch to Inflectra for Crohn's disease 7.9% (95% CI –5.2 to 21) and ulcerative colitis 12.4% (-0.1 to 25). Both CD and UC outcomes had wide confidence intervals due to the low number of disease worsening events that occurred. Overall, the NOR-SWITCH study and subsequent open-label extension demonstrates that non-medical change of therapy from Remicade to a biosimilar is not expected to have an inferior outcome to continuing Remicade. [2,3]

Bergqvist et al conducted a prospective, observational, open-label study switching 313 consecutive patients receiving Remicade for inflammatory bowel disease to Inflectra. This was a multi-center study performed in County of Skåne, Sweden that was funded by a variety of non-industry sponsored grants. All but one of these patients was in the maintenance phase of therapy (i.e., there was one patient still in the induction phase of therapy) and the average time on Remicade was 4.6 years (range 0.4-16.6 years) for CD and 3.6 years (range 0.2-9.6 years) for UC. At baseline, 33.8% of CD patients and 28.4% of UC patients had clinical disease activity, although no patients would have been considered to have relapsed disease. Comparisons were made between baseline and follow-up clinical disease scores [Harvey-Bradshaw Index (CD) and Simple Clinical Colitis Activity Index (UC)], objective biomarkers [e.g., fecal calprotectin, erythrocyte sedimentation rate (ESR), C-reactive protein (CRP), etc.], and patient quality of life (Short Health Scale composite scores). The authors found no differences between groups after switching to Inflectra. In a similar analysis to NOR-SWITCH, 14.0% of patients in the CD group and 13.8% in the UC group had clinical worsening after the switch. This is lower than what was reported in NOR-SWITCH and acts to refute non-inferiority concerns some have expressed regarding NOR-SWITCH. The overall number of patients in remission at baseline increased from 68.2% to 78.9% for CD and 66.2% to 71.6% for UC; these were not statistically significant results.[4]

The DANBIO registry study observed the effects of a nationwide non-medical switch from Remicade to Inflectra in Denmark. Patients (n=802) were identified as switching from Remicade to Inflectra; these patients had an average treatment duration of 6.8 years on Remicade. The authors found no differences in clinical outcomes between the three months before and after the mandated switch. There were similar one-year retention rates between the Inflectra switch group and a historic Remicade cohort, 84.1% (95% CI 81.3-86.5) and 86.2% (95% CI 84.8-88.8), respectively. The authors note that compared to the blinded NOR-SWITCH study, the discontinuation rate was higher in this analysis possibly due to the "nocebo" effect in addition to loss of

efficacy and side effects. The nocebo effect is the negative counterpart to the placebo effect wherein an active therapy or sham therapy causes a negative outcome based on psychological factors (e.g., negative expectations associated with a change in therapy).[5]

Smolen *et al* conducted a randomized, double-blind, switching study as a continuation of a phase III study of Renflexis in patients with moderate-to-severe rheumatoid arthritis. Patients (n=396) who completed the initial study which randomized 1:1 initial treatment with Renflexis vs Remicade agreed to participate in the follow-up switching study. In the switching study, patients who received Remicade in the initial study (n=195) were randomized to receive either continued Remicade (n=101) or switched to Renflexis (n=94) at week 54 of treatment. Clinical outcomes, safety, and immunogenicity were followed through week 78. Overall, no differences were found between the groups for any of the measured efficacy, safety, or immunogenicity outcomes.[6]

Based on the above moderate-to-high quality studies, a switch from Remicade to an infliximab biosimilar is expected to have similar clinical efficacy, safety, and immunogenic outcomes as remaining on Remicade, even in patients who have been long established on Remicade. Therefore, in the absence of a contraindication, adverse event, or clinical failure of the preferred biosimilar infliximab products, it is appropriate to transition members from Remicade to more cost-effective formulations of infliximab.

Asthma:
The Global Initiative for Asthma (GINA) guidelines are evidence-based international guidelines that are updated annually. The current guidelines include add-on biologic Type 2 inflammation targeted therapies if available and affordable in patients with exacerbations or poor symptom control despite the use of high dose inhaled corticosteroid (ICS) and long-acting beta agonist (LABA), and who have allergic or eosinophilic biomarkers or need maintenance oral corticosteroid (OCS).[24]

Guidelines:

- Global Initiative for Asthma (2025): https://ginasthma.org/reports/

Axial Spondyloarthritis (includes Ankylosing Spondylitis (AS)/Radiographic Axial Spondyloarthritis (r-axSpA) and Non-Radiographic Axial Spondyloarthritis (nr-axSpA):
Axial spondyloarthritis is a chronic inflammatory rheumatic musculoskeletal condition primarily impacting the axial skeleton. The spectrum of disease includes patients with radiographic sacroiliitis (AS/r-axSpA) and without radiographic sacroiliitis (nr-

axSpA). The primary goal in the management of axial spondyloarthritis is to reduce symptoms, inflammation, and progressive structural damage and improve quality of life. Non-pharmacological therapies which are recommended include exercise, smoking cessation, and physiotherapy. First-line pharmacological therapy for pain and stiffness is non-steroidal anti-inflammatory drugs (NSAIDs). Glucocorticoid injections may be considered for local musculoskeletal inflammation. Sulfasalazine may be considered for peripheral arthritis. Patients with highly active disease despite conventional treatments may benefit from treatment with biological therapies [e.g., tumor necrosis factor (TNF) inhibitors, interleukin (IL) inhibitors, and Janus Kinase (JAK) inhibitors][16].

The two strongest predictors of TNF inhibitor efficacy are an elevated C-reactive protein (CRP) and the presence of inflammation on magnetic resonance imaging of the sacroiliac joints (MRI-SIJ). While there are no head-to-head trials to compare biological products, current practice is to start with a TNF inhibitor or an IL-17A inhibitor due to more extensive experience with the drugs including more evidence regarding their safety and efficacy. Treatment should be reviewed for continuation after at least 12 weeks. A taper may be considered after at least 6 months in remission[16].

Guidelines:

- Assessment of SpondyloArthritis International Society (ASAS)-European Alliance of Associations for Rheumatology (EULAR): https://ard.bmj.com/content/82/1/19

Crohn's Disease (CD):

Based on the available evidence and national practice guidelines, TIMs are effective products in inducing and maintaining remission in severe, active CD. These products are typically used when conventional therapies (e.g., corticosteroids, mesalamine, 6-MP and azathioprine) have failed to induce remission. Overall, there is insufficient direct comparative evidence for the efficacy of TIMs in the treatment of severe, active CD; all FDA approved products have shown to be superior to placebo and are considered to have comparable efficacy.

The American Gastroenterological Association (AGA), in their 2021 guidelines, defines moderate to severe luminal Crohn's disease as any of the following:

- CDAI score of at least 220
- High risk of adverse disease-related complications, e.g., surgery, hospitalizations, and disability based on a combination of structural damage, inflammatory burden, and impact on quality of life

The AGA recommends the use of infliximab, adalimumab, ustekinumab, or vedolizumab over certolizumab for the induction of remission in patients without

previous use of TIMs products. In primary non-responders to TNF products, they recommend use of ustekinumab to induce remission (vedolizumab may be considered). For those that loss response to infliximab, they recommend adalimumab or ustekinumab to induce remission (vedolizumab may be considered). For patients with moderate to severe disease, biologic therapy is recommended to induce remission instead of 5-aminosalicylates and/or corticosteroids.[7]

Guidelines:

- ACG Clinical Guideline Management of Crohn's Disease in Adults (2018): https://journals.lww.com/ajg/Fulltext/2018/04000/ACG_Clinical_Guideline__Management_of_Crohn_s.10.aspx
- AGA Medical management of moderate to severe luminal and perianal fistulizing Crohn's disease (2021): https://gastro.org/clinical-guidance/medical-management-of-moderate-to-severe-luminal-and-perianal-fistulizing-crohns-disease/

Immune checkpoint inhibitor (ICI) related diarrhea/colitis:

Diarrhea and colitis, inflammatory arthritis, and elevated serum creatinine are a few common symptoms of treatment with ICI therapy. The National Comprehensive Cancer Network (NCCN) recommends addition of infliximab when there is no response to other conventional therapy (if applicable). [15]

Polyarticular Juvenile Idiopathic Arthritis (PJIA):

Juvenile Idiopathic Arthritis (JIA) is an umbrella term for a group of seven chronic arthritic conditions which affect children under 16 years of age. These subtypes are oligoarthritis, rheumatoid factor (RF) positive polyarthritis, RF negative polyarthritis, systemic arthritis, psoriatic arthritis, enthesitis-related arthritis, and undifferentiated arthritis. Treatment options for JIA depend on the subtype, severity, damage, and associated disease[21].

The American College of Rheumatology 2019 Guidelines recommend the following pharmacological therapy for PJIA[22]:

- Initial therapy with a disease-modifying anti-rheumatic drug (DMARD) is strongly recommended over nonsteroidal anti-inflammatory drug (NSAID) monotherapy
- Methotrexate monotherapy as initial therapy is conditionally recommended over triple DMARD therapy
- For patients without risk factors, initial therapy with a DMARD is conditionally recommended over a biologic
- For patients with risk factors, initial therapy with a DMARD is conditionally recommended over a biologic, recognizing that there are situations where initial therapy that includes a biologic may be preferred

- If low disease activity remains, escalating therapy is conditionally recommended over no escalation of therapy
- If moderate to high disease activity remains, adding a biologic to the original DMARD is conditionally recommended over:
    - switching to another DMARD
    - changing to triple DMARD therapy
- If moderate to high disease with tumor necrosis factor (TNF) inhibitor, switching to a non-TNF inhibitor biologic is conditionally recommended over switching to a second TNF inhibitor

Guidelines:

- American College of Rheumatology 2019 Guidelines: https://rheumatology.org/juvenile-idiopathic-arthritis-guideline

Plaque Psoriasis (Ps):

Psoriasis is a chronic, inflammatory skin condition commonly characterized by well-demarcated, erythematous plaques with silvery scales. The morphology varies, however, resulting in five primary subtypes of psoriasis[13]:

- Plaque: erythematous plaques covered in silvery scales primarily found over the extensor surfaces of the extremities (e.g., elbows, knees, scalp, and back)
- Guttate/Eruptive: erythematous raindrop-shaped plaques with silvery scales primarily found over the trunk and the back and commonly seen in children who have had an upper respiratory tract infection
- Pustular: either localized or generalized small non-infectious, pus-filled lesions surrounded by erythema
- Erythrodermic: generalized inflammation with erythema and skin exfoliation of over 90% of the body resulting from plaque psoriasis exacerbation
- Inverse/Flexural/Intertriginous: smooth, erythematous patches primarily found in areas e.g., the groin and armpits

In clinical trials, psoriasis is commonly measured utilizing the psoriasis area severity index (PASI) with a score of 0 representing no disease and 72 representing the most severe disease. In practice, severity may also be measured by body surface area (BSA) with mild as less than 3% BSA, moderate as 3-10% BSA, and severe as greater than 10% BSA. Severe disease may also be diagnosed for patients with 10% BSA or less if it results in decreased quality of life or is present in locations e.g., the hands, feet, scalp, face, or genital region[14].

The Joint American Academy of Dermatology (AAD) and National Psoriasis Foundation (NPF) guidelines from 2019 do not recommend one biologic product over another[14].

Psoriatic Arthritis (PsA):

PsA is a chronic inflammatory arthritis with clinical features similar to other spondyloarthropathies and rheumatoid arthritis. These features are classified as either articular/periarticular or extra-articular. Articular/periarticular features include peripheral arthritis, enthesitis, dactylitis, tenosynovitis, axial disease, and spondylitis. Extra-articular features include psoriatic skin disease, nail disease, and ocular disease. Treatment is guided by the severity of disease, joint damage, extra-articular disease, comorbidities, and patient preference[17].

The European Alliance of Associations for Rheumatology (EULAR) 2023 Guidelines provide the following recommendations[18]:

- For musculoskeletal signs and symptoms: non-steroidal anti-inflammatory drugs (NSAIDs), adjunctive local injections of glucocorticoids
- For polyarthritis or monoarthritis/oligoarthritis with poor prognostic factors: conventional synthetic disease-modifying antirheumatic drug (csDMARD) with a preference for methotrexate with skin involvement
- For peripheral arthritis with an inadequate response to a csDMARD: biological disease-modifying antirheumatic drug (bDMARD)
- For peripheral arthritis with an inadequate response to a csDMARD and a bDMARD: Janus kinase inhibitor (JAKi)
- For peripheral arthritis with an inadequate response to a csDMARD, bDMARD, and JAKi: phosphodiesterase-4 (PDE4) inhibitor
- For unequivocal enthesitis with an inadequate response to NSAIDs or local glucocorticoid injections: bDMARD
- For clinically relevant axial disease with an inadequate response to NSAIDs: Interleukin (IL)-17A inhibitor, Tumor Necrosis Factor (TNF) inhibitor, IL-17A/F inhibitor, JAKi

Guidelines:

- European Alliance of Associations for Rheumatology (EULAR) 2023 Guidelines: https://ard.bmj.com/content/83/6/706

Rheumatoid arthritis (RA):

Rheumatoid arthritis (RA) is a systemic autoimmune disease which includes both inflammatory arthritis as well as extra-articular involvement. The most common symptoms are joint pain and swelling, often starting in the smaller joints and progressing to the larger joints. The most common extra-articular features are rheumatoid nodules, commonly found on pressure points. Classification of RA involves the number and size of joints involved, serological testing for rheumatoid factor or anti-citrullinated peptide/protein antibody, elevated acute phase reactants (ESR or CRP), and symptom duration of at least six weeks[19].

The 2022 European Alliance of Associations for Rheumatology (EULAR) Guidelines provide the following pharmacological recommendations[20]:

- Conventional synthetic disease-modifying antirheumatic drugs (csDMARDs) should be considered as first-line medications, specifically methotrexate. Leflunomide or sulfasalazine may be considered in patients unable to take methotrexate
- If failure of csDMARD and no poor prognostic factors, switch to another csDMARD
- If failure of csDMARD and poor prognostic factors, switch to a biological DMARD (bDMARD). A Janus kinase (JAK) inhibitor may also be considered however risk must be considered
- bDMARD and tsDMARD (targeted synthetic DMARDs), e.g., JAK inhibitors, should be combined with a csDMARD if possible
- If failure of b/tsDMARD, switch to another b/tsDMARD

In 2017, the Institute for Clinical and Economic Review (ICER) published a review of the Targeted Immune Modulators for Rheumatoid Arthritis. They reviewed the following therapies:

- TNFα inhibitors: adalimumab (Humira), certolizumab pegol (Cimzia), etanercept (Enbrel), golimumab (Simponi and Simponi Aria), infliximab (Remicade):
- CD20-directed cytolytic B-cell antibody: rituximab (Rituxan)
- T-cell inhibitor: abatacept (Orencia)
- IL-6 inhibitors: tocilizumab (Actemra,), sarilumab (Kevzara™)
- JAK inhibitors: tofacitinib (Xeljanz), baricitinib (Olumiant™)

Using a network meta-analysis, the review suggests that all products are superior to conventional DMARD monotherapy. There have been some head-to-head trials conducted between the TIMs products and adalimumab was found to be inferior to monotherapy with tocilizumab or sarilumab in terms of achieving clinical remission or ACR responses; these products were rated as B+ over adalimumab (Moderate certainty of a small or substantial net health benefit, with high certainty of at least a small net health benefit). Abatacept was given the same B+ rating over infliximab. Tofacitinib is considered more costly and less effective than adalimumab.[11]

In 2020, ICER published an updated report including newer JAK Inhibitors and biosimilars used for Rheumatoid Arthritis. The review concludes that the JAK inhibitors upadacitinib and tofacitinib are superior to conventional DMARD therapy. These products both received an A rating over DMARDs (high certainty of substantial net health benefit) in TIM-naïve patients and B+ in TIM-experienced

patients. Upadacitinib was rated B+ over adalimumab, tofacitinib was rated C (comparable) to adalimumab, and the infliximab biosimilar (Inflectra) was rated C to Remicade in TIM-naïve patients.[12]

Guidelines:
- European Alliance of Associations for Rheumatology (EULAR) 2022 Guidelines: https://ard.bmj.com/content/82/1/3

Systemic Juvenile Idiopathic Arthritis (SJIA)

Juvenile Idiopathic Arthritis (JIA) is an umbrella term for a group of seven chronic arthritic conditions which affect children under 16 years of age. These subtypes are oligoarthritis, rheumatoid factor (RF) positive polyarthritis, RF negative polyarthritis, systemic arthritis, psoriatic arthritis, enthesitis-related arthritis, and undifferentiated arthritis. Treatment options for JIA depend on the subtype, severity, damage, and associated disease[21].

SJIA is differentiated from other forms of JIA by fever, rash, and visceral involvement and may be considered an autoimmune disorder. The pathogenesis of the disease and the involvement of cytokines differ from other forms of JIA as well. In up to 40% of cases, SJIA is associated with Macrophase Activation Syndrome (MAS) which is a life-threatening complication.

The American College of Rheumatology 2021 Guidelines recommend the following pharmacological therapy for SJIA[22]:
- For SJIA without MAS:
  - Biologic disease-modifying anti-rheumatic drugs (bDMARDs), specifically Interleukin (IL)-1 and -6 inhibitors, are conditionally recommended as initial monotherapy
  - Nonsteroidal anti-inflammatory drugs (NSAIDs) are conditionally recommended as initial monotherapy
- For SJIA with MAS:
  - bDMARDs (specifically IL-1 and IL-6 inhibitors) are conditionally recommended over calcineurin inhibitor monotherapy
  - Glucocorticoids are conditionally recommended as part of initial treatment
  - bDMARD or conventional synthetic DMARDs (csDMARDs) are strongly recommended over long-term glucocorticoids if incomplete response to bDMARD

Guidelines:
- American College of Rheumatology 2021 Guidelines: https://rheumatology.org/juvenile-idiopathic-arthritis-guideline

Ulcerative Colitis (UC):

Based on the available evidence and national practice guidelines, TIMs are effective products in inducing and maintaining remission in moderate to severe UC. These products are typically used when conventional therapies (e.g., aminosalicylates, topical mesalamine, corticosteroids, 6-mercaptopurine, and azathioprine) have failed to induce remission. Infliximab may be more consistently efficacious for inducing remission and mucosal healing than adalimumab. Vedolizumab is a non-anti-TNF therapy option for the treatment of UC. Overall, there is insufficient direct comparative evidence for the efficacy of TIMs in the treatment of moderate to severe UC; all FDA approved products have shown to be superior to placebo and are considered to have comparable efficacy.

The 2025 ACG guidelines recommend the following in patients with moderate to severe ulcerative colitis to induce remission: oral budesonide, oral systemic corticosteroids, ozanimod, etrasimod, ustekinumab, guselkumab, mirikizumab, risankizumab, vedolizumab, infliximab, adalimumab, golimumab, tofacitinib, upadacitinib. Data on combination anti-TNF and immunomodulators in moderately to severely active UC only exist for infliximab and thiopurines.[25]

In 2020, the Institute for Clinical and Economic Review (ICER) published a report on TIMs for UC, assessing the following therapies: adalimumab, golimumab, infliximab and biosimilars, tofacitinib, and ustekinumab. All products were found to be clinically superior than placebo, and all were found to be comparable to adalimumab. It was noted that vedolizumab was “found to produce greater rates of clinical response and remission over adalimumab, the market leader, in both patients who had used TIMs previously (“biologic-experienced”) as well as those who did not (“biologic-naïve”).” No products were found to be cost-effective at current drug costs, but infliximab and its biosimilars represent the best value for money for UC.[8]

The AGA, in their 2020 guidelines, defines moderate to severely active UC as any of the following:

- Patients deemed to be at high-risk for colectomy
- Mayo Clinic Score 6–12, with Mayo Endoscopic Subscore 2 or 3
- Severely active endoscopic disease, with ulcers
- Patients with corticosteroid dependence, or refractory to oral corticosteroids

The AGA recommends infliximab, adalimumab, golimumab, vedolizumab, tofacitinib, or ustekinumab over no treatment; however, they suggest the use of infliximab or vedolizumab over adalimumab for the induction of remission in patients without previous use of TIMs products. They do not recommend the use of tofacitinib in this setting, unless in a clinical trial. In primary non-responders to infliximab, they

suggest use of ustekinumab or tofacitinib rather than vedolizumab or adalimumab for induction of remission.[9]

Guidelines:

- American Gastroenterological Association (2020): http://www.gastro.org/guidelines
- American College of Gastroenterology (2025): https://gi.org/clinical-guidelines/clinical-guidelines-sortable-list/

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Policy and Procedure	
PHARMACY PRIOR AUTHORIZATION POLICY AND CRITERIA ORPTCOTH021.0226	**MISCELLANEOUS PRODUCTS** **MEDICALLY INFUSED THERAPEUTIC IMMUNOMODULATORS (TIMs)** See Table 1 for Applicable Medications
Effective Date: 3/1/2026	**Review/Revised Date**: 01/17, 02/17, 03/17, 09/17, 01/17, 03/18, 05/18, 11/18, 01/19, 03/19, 09/19, 12/19, 01/20, 09/20, 05/21, 09/21, 11/21, 03/22, 08/22, 09/22, 09/23, 02/24, 05/24, 08/24, 11/24, 05/25, 08/25, 11/25, 02/26 (snm)
Original Effective Date: 02/17 **Approved by:** Oregon Region Pharmacy and Therapeutics Committee	**P&T Committee Meeting Date**: 02/17, 02/17(cv), 03/17(cv), 04/17, 02/18, 03/18 (cv), 04/18, 06/18, 12/18, 02/19, 04/19, 06/19, 10/19, 12/19 (cv), 02/20, 10/20, 10/20 (off-cycle), 06/21, 10/21, 11/21 (CV), 12/21, 02/22 (cv), 04/22, 06/22, 08/22, 10/22, 10/23, 02/24, 06/24, 10/24, 12/24, 04/25, 06/25, 10/25, 11/25 (cv), 12/25, 02/26

Table 1. Infusible therapeutic immunomodulators (TIMs) and their respective FDA-approved Indications. FDA approvals listed below are for adult patients, unless otherwise indicated.

Drug	MOA	AS	CD	Ps	PsA	RA	UC	Other
abatacept (Orencia)	T-cell inhibitor				X[1] (age 2+)	X		aGVHD (age 2+) PJIA (age 2+)
certolizumab (Cimzia)[3]	Anti-TNF	X	X	X	X	X		NRAS PJIA (age 2+)
guselkumab (Tremfya)	IL-23 inhibitor		X[2]	X[3] (age 6+, 40kg)	X[3] (age 6+, 40kg)		X[2]	
golimumab IV (Simponi Aria)	Anti-TNF	X			X (age 2+)	X		PJIA (age 2+)
infliximab (Remicade)	Anti-TNF	X	X (age 6+)	X	X	X	X (age 6+)	
infliximab-abda (Renflexis)	Anti-TNF	X	X (age 6+)	X	X	X	X (age 6+)	
infliximab-axxq (Avsola)	Anti-TNF	X	X (age 6+)	X	X	X	X (age 6+)	
infliximab-dyyb (Inflectra)	Anti-TNF	X	X (age 6+)	X	X	X	X (age 6+)	
mirikizumab-mrkz (Omvoh)	IL-23 inhibitor		X[2]				X[2]	
omalizumab (Xolair)[3]	IgE Inhibitor	X (age 6+)						CSU (12+) CRSwNP IgE-Mediated Food Allergy (1+)
reslizumab (Cinqair)	IL-5 inhibitor							Eosinophilic Asthma

Drug	MOA	AS	CD	Ps	PsA	RA	UC	Other
risankizumab-rzaa (Skyrizi IV)	IL-23 inhibitor		X[2]				X[2]	
secukinumab (Cosentyx IV)	IL-17A inhibitor	X			X			NRAS
tezepelumab-ekko (Tezspire)[3]	TSLP Inhibitor	X (age 12+)						CRSwNP (age 12+)
tildrakizumab-asmn (Ilumya)	IL-23 inhibitor			X				
tocilizumab (Actemra)	IL-6 inhibitor					X		COVID-19 CRS (age 2+) GCA PJIA (age 2+) SJIA (age 2+)
tocilizumab-aazg (Tyenne)	IL-6 inhibitor					X		GCA PJIA (age 2+) SJIA (age 2+)
tocilizumab-anoh (Avtozma)	IL-6 Inhibitor					X		COVID-19 CRS (age 2+) GCA PJIA (age 2+) SJIA (age 2+)
tocilizumab-bavi (Tofidence)	IL-6 Inhibitor					X		COVID-19 GCA PJIA (age 2+) SJIA (age 2+)
ustekinumab (Stelara IV)	IL-12/23 inhibitor		X[2]				X[2]	
ustekinumab-aaub (Wezlana IV)	IL-12/23 inhibitor		X[2]				X[2]	
ustekinumab-aauz (Otulfi IV)	IL-12/23 inhibitor		X[2]				X[2]	
ustekinumab-aekn (Selarsdi IV)	IL-12/23 inhibitor		X[2]				X[2]	
ustekinumab-kfce (Yesintek IV)	IL-12/23 inhibitor		X[2]				X[2]	
ustekinumab-stba (Steqeyma IV)	IL-12/23 inhibitor		X[2]				X[2]	
ustekinumab-ttwe (Pyzchiva IV)	IL-12/23 inhibitor		X[2]				X[2]	
vedolizumab (Entyvio)	α4β7 inhibitor		X				X	

[1] Intravenous abatacept is only indicated for use in adults with psoriatic arthritis. The subcutaneous injection is approved for use in pediatric patients aged 2 years and above.
[2] Intravenous guselkumab, mirikizumab-mrkz, risankizumab-rzaa, ustekinumab are indicated for induction doses for ulcerative colitis and Crohn's disease.

[3] Medication and/or indication is considered a self-administered drug and is excluded from the medical benefit as outlined in the *ORPTCOTH042 'Self-Administered Drugs (SAD)'* clinical policy. Medications may be eligible for a medical transition period for initiation of therapy.

Abbreviations: aGVHD = acute graft versus host disease; AS = ankylosing spondylitis; CD = Crohn's disease; CRS = cytokine release syndrome; CRSwNP = chronic rhinosinusitis with nasal polyps; GCA = giant cell arteritis; MOA = mechanism of action; NRAS = non-radiographic axial spondyloarthritis; PJIA = Polyarticular Juvenile Idiopathic Arthritis; Ps = psoriasis; PsA = psoriatic arthritis; RA = rheumatoid arthritis; SJIA = Systemic juvenile idiopathic arthritis; SSc-ILD = systemic sclerosis-associated interstitial lung disease; UC = ulcerative colitis

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Table 2. FDA-approved dosing for medically infused medications

Drug	FDA-Approved Dosing
abatacept IV (Orencia)	**aGVHD:** For 6 years and older: Give 10 mg/kg (max dose 1000 mg) IV the day before transplantation (day 1) and on days 5, 14, and 28 after transplantation For 2 to less than 6 years of age: Give 15 mg/kg the day before transplantation (day 1) and 12 mg/kg on days 5, 14, and 28 after transplantation **Adult PsA, Adult RA:** Give appropriate dose at weeks 0, 2, and 4 followed by every 4 weeks Body weight less than 60 kg = 500 mg Body weight 60-100 kg = 750 mg Body weight more than 100 kg = 1000 mg **PJIA**: Give appropriate dose at weeks 0, 2, and 4 followed by every 4 weeks Body weight 10 to less than 25 kg = 50 mg Body weight 25 to less than 50 kg = 87.5 mg Body weight 50 kg or more = 125 mg
certolizumab (Cimzia)	**AS/r-axSpA, nr-axSpA, PsA, RA:** Give 400 mg at weeks 0, 2 and 4, followed by 200 mg every 2 weeks or 400 mg every 4 weeks **CD:** Give 400 mg initially and at weeks 2 and 4. If clinical response, continue therapy with 400 mg every 4 weeks **PJIA**: Body weight 10 to less than 20 kg = Give 100 mg at weeks 0, 2, and 4 followed by 50 mg every 2 weeks Body weight 20 to less than 40 kg = Give 200 mg at weeks 0, 2, and 4 followed by 100 mg every 2 weeks Body weight 40 kg or more = Give 400 mg at weeks 0, 2, and 4 followed by 200 mg every 2 weeks **Ps**: Body weight 90 kg or more = Give 400 mg every week Body weight less than 90 kg (can be considered) = Give 400 mg at weeks 0, 2, and 4 followed by 200 mg every other week
golimumab IV (Simponi Aria)	**Adults with AS/r-axSpA, PsA, RA:** Give 2 mg/kg at weeks 0 and 4 followed by every 8 weeks **Pediatrics with PJIA, PsA:** Give 80 mg/m^2 at weeks 0 and 4 followed by every 8 weeks
guselkumab (Tremfya)	**CD, UC Induction:** Give 200 mg at weeks 0, 4, and 8
infliximab (Avsola, Inflectra, Remicade, Renflexis)	**Adult CD:** Give 5 mg/kg at weeks 0, 2, and 6 followed by 5 mg/kg every 8 weeks

Drug	FDA-Approved Dosing
	For patients who respond then lose their response (can be considered): Give 10 mg/kg every 8 weeks. Patients who do not respond by week 14 are unlikely to respond with continued dosing **Adult UC, Pediatric CD, Pediatric UC, Ps, PsA:** Give 5 mg/kg at weeks 0, 2, and 6 followed by 5 mg/kg every 8 weeks **AS/r-axSpA:** Give 5 mg/kg at weeks 0, 2, and 6 followed by 5 mg/kg every 6 weeks **RA:** Give 3 mg /kg at weeks 0, 2, and 6 followed by 3 mg/kg every 8 weeks For patients with an incomplete response (can be considered): Give 10 mg/kg every 4 or 8 weeks
mirikizumab-mrkz (Omvoh)	**CD Induction:** Give 900 mg at weeks 0, 4, and 8 **UC Induction:** Give 300 mg at weeks 0, 4, and 8
reslizumab (Cinqair)	**Asthma:** Give 3 mg/kg every 4 weeks
risankizumab-rzaa (Skyrizi)	**CD Induction:** Give 600 mg at weeks 0, 4, and 8 **UC Induction:** Give 1200 mg at weeks 0, 4, and 8
secukinumab IV (Cosentyx)	**AS/r-axSpA, nr-axSpA, PsA:** Give 6 mg/kg loading dose at week 0 followed by 1.75 mg/kg every 4 weeks. Total dose should not exceed 300 mg.
tildrakizumab-asmn (Ilumya)	**Ps:** Give 100 mg at weeks 0 and 4 followed by every 12 weeks
tocilizumab (Actemra, Tofidence Tyenne)	**COVID-19 (Actemra, Tofidence), CRS (Actemra):** Body weight less than 30 kg = 12 mg/kg Body weight 30 kg or more = 8 mg/kg Total dose should not exceed 800 mg **GCA:** Give 6 mg/kg every 4 weeks. Total dose should not exceed 600 mg **PJIA:** Give appropriate dose every 4 weeks Body weight less than 30 kg = 10 mg/kg Body weight 30 kg or more = 8 mg/kg **RA:** Give 5 mg/kg every 4 weeks followed by an increase to 8 mg/kg every 4 weeks based on clinical response. Total dose should not exceed 800 mg **SJIA:** Give appropriate dose every 2 weeks Body weight less than 30 kg = 12 mg/kg Body weight 30 kg or more = 8 mg/kg

Drug	FDA-Approved Dosing
ustekinumab (Otulfi, Pyzchiva, Selarsdi, Stelara, Steqeyma, Wezlana, Yesintek)	**CD, UC Induction:** Body weight less than 55 kg = 260 mg Body weight 55 kg to 85 kg = 390 mg Body weight 85 kg or more = 520 mg
vedolizumab (Entyvio)	**CD, UC:** Give 300 mg at weeks 0, 2, and 6 followed by 300 mg every 8 weeks

Abbreviations: aGVHD = acute graft versus host disease; AS = ankylosing spondylitis; CD = Crohn's disease; CRS = cytokine release syndrome; CRSwNP= chronic rhinosinusitis with nasal polyps; CSU = chronic spontaneous urticaria; EGPA = eosinophilic granulomatosis with polyangiitis; GCA = giant cell arteritis; HES = hypereosinophilic syndrome; MOA = mechanism of action; nr-axSpA = non-radiographic axial spondyloarthritis; PJIA = Polyarticular Juvenile Idiopathic Arthritis; Ps = psoriasis; PsA = psoriatic arthritis; r-axSpA = radiographic spondyloarthritis; RA = rheumatoid arthritis; SJIA = Systemic juvenile idiopathic arthritis; SSc-ILD = systemic sclerosis-associated interstitial lung disease; UC = ulcerative colitis

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Appendix 1. BILLING GUIDELINES AND CODING FOR MEDICALLY INFUSED THERAPIES

CODES◊ǂ		
J0129†	Injection, abatacept, 10 mg (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)	Orencia IV
J0717	Injection, certolizumab pegol, 1 mg (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)	Cimzia lyophilized powder vial
J1602	Injection, golimumab, 1 mg, for intravenous use	Simponi Aria
J1745	Injection, infliximab, excludes biosimilar, 10 mg	Remicade
Q5104	Injection, infliximab-abda, biosimilar, (Renflexis), 10 mg	Renflexis
Q5121	Injection, infliximab-axxq, biosimilar, (Avsola), 10 mg	Avsola
Q5103	Injection, infliximab-dyyb, biosimilar, (Inflectra), 10 mg	Inflectra
J2786	Injection, reslizumab, 1 mg	Cinqair
J3245	Injection, tildrakizumab, 1 mg	Ilumya
J3247	Injection, secukinumab, intravenous, 1 mg	Cosentyx IV
Q5135†J3262†	Injection, tocilizumab, 1 mg	Actemra IV
Q5133	Injection, tocilizumab-bavi (Tofidence), biosimilar, 1 mg	Tofidence
J3380	Injection, vedolizumab, intravenous, 1 mg	Entyvio
Products Indicated for Induction Dosing Only		
J1628†	Injection, guselkumab, 1 mg	Tremfya Vial*
J2267†	Injection, mirikizumab-mrkz, 1 mg	Omvoh Vial*
J2327†	Injection, risankizumab-rzaa, intravenous, 1 mg	Skyrizi Vial*
Q9998	Ustekinumab-aekn, injection, 1 mg	Selarsdi Vial*
C9399 J3950	Ustekinumab-stba, intravenous	Steqeyma Vial*
C9399 J3950	Ustekinumab-kfce, intravenous	Yesintek Vial*

J3358	Ustekinumab, for intravenous injection, 1 mg	Stelara Vial*
Q5138	Ustekinumab-auub, intravenous, 1 mg	Wezlana Vial*
Q9997	Ustekinumab-ttwe, intravenous, 1 mg	Pyzchiva Vial*
Q9999	Ustekinumab-aauz, intravenous, 1 mg	Otulfi Vial*
ADMINISTRATION◊		
96365	Ther/proph/diag iv inf init	
96366	Ther/proph/diag iv inf addon	
96372	Ther/proph/diag inj sc/im	
96374	Ther/proph/diag inj iv push	
96413	Chemo iv infusion 1 hr	
96415	Chemo iv infusion addl hr	
MODIFIERS†		
-JA	Administered Intravenously	
-JB	Administered Subcutaneously	
-JW	Drug Amount Discarded/Not Administered to Any Patient	

*intravenous guselkumab, mirikizumab-mrkz, risankizumab-rzaa, ustekinumab are indicated for induction doses for ulcerative colitis and Crohn's disease. Subcutaneous guselkumab, risankizumab-rzaa, ustekinumab are eligible for coverage and are considered a preferred product under the pharmacy benefit. Subcutaneous mirikizumab-mrkz is eligible for coverage and is considered a non-preferred product under the pharmacy benefit. Medical benefit induction doses will be covered upon approval of a pharmacy benefit prior authorization.

[t]Any self-administered TIMs product that is requested for coverage through the medical benefit will be subject to requirements outlined in this policy.

† Must be billed with the JA modifier for the intravenous infusion of the drug or billed with the JB modifier for the subcutaneous injection form of administration

◊ Coding/Administration Notes:

• The above code list is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit.

• HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as "medically unlikely edits" (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.