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December 30, 2025

UPDATED PRIOR AUTHORIZATION CRITERIA FOR INFLIXIMAB BIOSIMILARS

Dear Provider,

Effective March 1, 2026, the criteria for the infliximab biosimilars in Table 1 will be updated. These products are on the **non-Medicare** list of office-administered drugs requiring prior authorization. **This letter is a notification of the change in prior authorization criteria required before administering these medications in a physician's office.**

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

Table 1. List of Infliximab Biosimilars that have prior authorization criteria:

BRAND NAME	GENERIC NAME	HCPCS
Avsola	Infliximab-axxq	Q5121
Inflectra	Infliximab-dyyb	Q5103
Ixifi	Infliximab-qbtx	Q5109
Renflexis	Infliximab-abda	Q5104

Prior Authorization Criteria for Infliximab Biosimilars (changes are in bold):

DRUG NAME	COVERAGE CRITERIA

INFLIXIMAB-DYYB	Ankylosing Spondylitis
	• **Age ≥ 18 years**
	• Diagnosis of active ankylosing spondylitis
	• Quantity Limit:
	  ○ Induction: Infusion at weeks 0, 2, and 6 (max dose 1000 mg)
	  ○ Maintenance: Every 6 weeks (max frequency)
	• Not covered for use in combination with disease modifying or other biologic therapies
	
	Crohn's Disease
	• **Age ≥ 6 years**
	• Diagnosis of moderately to severely active Crohn's disease
	• Quantity Limit:
	  ○ Induction: Infusion at weeks 0, 2, and 6 (max dose 1000 mg)
	  ○ Maintenance: Every 6 weeks (max frequency)
	• Not covered for use in combination with disease modifying or other biologic therapies
	
	Psoriasis

DRUG NAME	COVERAGE CRITERIA

	• **Age ≥ 18 years**
	• Diagnosis of moderate to severe psoriasis
	• Quantity Limit:
	  ○ Induction: Infusion at weeks 0, 2, and 6 (max dose 1000 mg)
	  ○ Maintenance: Every 8 weeks (max frequency)
	• Not covered for use in combination with disease modifying or other biologic therapies
	
	Psoriatic Arthritis
	• **Age ≥ 18 years**
	• Diagnosis of psoriatic arthritis
	• Quantity Limit:
	  ○ Induction: Infusion at weeks 0, 2, and 6 (max dose 1000 mg)
	  ○ Maintenance: Every 8 weeks (max frequency)
	• Not covered for use in combination with disease modifying or other biologic therapies
	
	Rheumatoid Arthritis
	• **Age ≥ 18 years**
	• Diagnosis of rheumatoid arthritis
	• Quantity Limit:
	  ○ Induction: Infusion at weeks 0, 2, and 6 (max dose 1000 mg)
	  ○ Maintenance: Every 4 weeks (max frequency)
	• Not covered for use in combination with disease modifying or other biologic therapies
	
	Sarcoidosis
	• **Age ≥ 18 years**
	• Diagnosis of sarcoidosis
	• Quantity Limit:
	  ○ Induction: Infusion at weeks 0, 2, and 6 (max dose 1000 mg)
	  ○ Maintenance: Every 8 weeks (max frequency)
	• Not covered for use in combination with disease modifying or other biologic therapies
	
	Ulcerative Colitis
	• **Age ≥ 6 years**
	• Diagnosis of moderately to severely active ulcerative colitis
	• Quantity Limit:
	  ○ Induction: Infusion at weeks 0, 2, and 6 (max dose 1000 mg)
	  ○ Maintenance: Every 6 weeks (max frequency)
	• Not covered for use in combination with disease modifying or other biologic therapies
	
	Note: Must be administered in a non-hospital setting. See site of care policy for criteria, reauthorization, and exceptions for new starts.
	
	Members will have in-network benefit coverage for select home-infused medications and supplies only when they get these medicines and supplies through Kaiser Permanente Specialty Home Infusion. There is no out-of-network benefit coverage for home infusion. See Infused Drugs Restricted to Kaiser Permanente Washington's Specialty Pharmacy Network for medications impacted by this change.

INFLIXIMAB-AXXQ INFLIXIMAB-QBTX INFLIXIMAB-AXXQ	Ankylosing Spondylitis • **Age ≥ 18 years** • Diagnosis of active ankylosing spondylitis

DRUG NAME	COVERAGE CRITERIA

	• Failed an adequate trial, or has an allergy, intolerance, or contraindication to the following:
	  ○ TNF Inhibitor:
	  ▪ infliximab-dyyb (Inflectra)
	• Quantity Limit:
	  ○ Induction: Infusion at weeks 0, 2, and 6 (max dose 1000 mg)
	  ○ Maintenance: Every 6 weeks (max frequency)
	• Not covered for use in combination with disease modifying or other biologic therapies
	
	Crohn's Disease
	• **Age ≥ 6 years**
	• Diagnosis of moderately to severely active Crohn's disease
	• Failed an adequate trial, or has an allergy, intolerance, or contraindication to the following:
	  ○ TNF Inhibitor:
	  ▪ infliximab-dyyb (Inflectra)
	• Quantity Limit:
	  ○ Induction: Infusion at weeks 0, 2, and 6 (max dose 1000 mg)
	  ○ Maintenance: Every 6 weeks (max frequency)
	• Not covered for use in combination with disease modifying or other biologic therapies
	
	Psoriasis
	• **Age ≥ 18 years**
	• Diagnosis of moderate to severe psoriasis
	• Failed an adequate trial, or has an allergy, intolerance, or contraindication to the following:
	  ○ TNF Inhibitor:
	  ▪ infliximab-dyyb (Inflectra)
	• Quantity Limit:
	  ○ Induction: Infusion at weeks 0, 2, and 6 (max dose 1000 mg)
	  ○ Maintenance: Every 8 weeks (max frequency)
	• Not covered for use in combination with disease modifying or other biologic therapies
	
	Psoriatic Arthritis
	• **Age ≥ 18 years**
	• Diagnosis of psoriatic arthritis
	• Failed an adequate trial, or has an allergy, intolerance, or contraindication to the following:
	  ○ TNF Inhibitor:
	  ▪ infliximab-dyyb (Inflectra)
	• Quantity Limit:
	  ○ Induction: Infusion at weeks 0, 2, and 6 (max dose 1000 mg)
	  ○ Maintenance: Every 8 weeks (max frequency)
	• Not covered for use in combination with disease modifying or other biologic therapies
	
	Rheumatoid Arthritis
	• **Age ≥ 18 years**
	• Diagnosis of rheumatoid arthritis
	• Failed an adequate trial, or has an allergy, intolerance, or contraindication to the following:

DRUG NAME	COVERAGE CRITERIA
	○ TNF Inhibitor: ▪ infliximab-dyyb (Inflectra) • Quantity Limit: ○ Induction: Infusion at weeks 0, 2, and 6 (max dose 1000 mg) ○ Maintenance: Every 4 weeks (max frequency) • Not covered for use in combination with disease modifying or other biologic therapies Sarcoidosis • **Age ≥ 18 years** • Diagnosis of sarcoidosis • Failed an adequate trial, or has an allergy, intolerance, or contraindication to the following: ○ TNF Inhibitor: ▪ infliximab-dyyb (Inflectra) • Quantity Limit: ○ Induction: Infusion at weeks 0, 2, and 6 (max dose 1000 mg) ○ Maintenance: Every 8 weeks (max frequency) • Not covered for use in combination with disease modifying or other biologic therapies Ulcerative Colitis • **Age ≥ 6 years** • Diagnosis of moderately to severely active ulcerative colitis • Failed an adequate trial, or has an allergy, intolerance, or contraindication to the following: ○ TNF Inhibitor: ▪ infliximab-dyyb (Inflectra) • Quantity Limit: ○ Induction: Infusion at weeks 0, 2, and 6 (max dose 1000 mg) ○ Maintenance: Every 6 weeks (max frequency) • Not covered for use in combination with disease modifying or other biologic therapies Note: Must be administered in a non-hospital setting. See site of care policy for criteria, reauthorization, and exceptions for new starts.

Additional Information

A complete list of office-administered injectable drugs requiring prior authorization can be found on the Kaiser Permanente provider website at https://wa-provider.kaiserpermanente.org/provider-manual/clinical-review/officeinject.

To request prior authorization review, please use the Referral Request online form (login required) located on the Kaiser Permanente provider website. You can also fax your request to the Review Services department toll-free at 1-888-282-2685.

Thank you for the care you provide to our members, your patients. If you have any questions about this process, please call Review Services at 1-800-289-1363, Monday through Friday, from 8:00 a.m. to 5:00 p.m.

Sincerely,

Ravi Ubriani, MD, Chair
Pharmacy & Therapeutics Committee