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May 26, 2020

Infliximab Products in the Home Infusion Setting Restricted to Administration by Kaiser Permanente Home Infusion

Dear Provider,

Effective August 1, 2020, the criteria for the specialty home infusion products listed in Table 1 will change. For home infusion, these specialty home infusion products and administration of these products is limited to Kaiser Permanente Home Infusion for **non-Medicare** Health Maintenance Organization (HMO) members.

Table 1. List of Specialty Home Infusion Products that are limited to administration by Kaiser Permanente Home Infusion (KPHIS)

BRAND NAME	GENERIC NAME	HCPCS
REMICADE	INFLIXIMAB	J1745
INFLECTRA	INFLIXIMAB-DYYB	Q5103

To transition any patients or for additional questions specific to this change, contact Kaiser Permanente Home Infusion by telephone at 206-326-2990 Monday – Friday from 8:30 am to 5 pm.

The criteria for outpatient standalone clinic, infusion center, provider's office, and hospitals are not affected. Hospital outpatient settings require site of care approval.

Prior authorization is still required for these drugs, and the prior authorization criteria is outlined below for the specialty home infusion products listed in Table 1. Kaiser Foundation Health Plan of Washington requires prior authorization for a select group of injectable drugs that may be administered under the medical benefit in a physician's office or by home infusion. These reviews are intended to ensure consistent benefit adjudication as well as appropriate utilization in accordance with the clinical review criteria established Kaiser Foundation Health Plan of Washington's Medical Policy Committee.

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

<table>
<tr><th>DRUG NAME</th><th>COVERAGE CRITERIA</th></tr>
<tr><td>REMICADE</td><td>
1) For patients with rheumatoid arthritis with failure, intolerance or contraindications to methotrexate.
2) For use in patients with active ankylosing spondylitis.
3) For use in severe, refractory sarcoidosis with failure/intolerance to high dose corticosteroids and at least one steroid-sparing agent, such as methotrexate or azathioprine.
4) For patient with moderately to severely active ulcerative colitis or Crohn’s disease. It is recommended that infliximab is used in combination with azathioprine, 6-mercaptopurine, or methotrexate.
5) For treatment of psoriatic arthritis in patients who failed methotrexate.
6) For patients with moderate to severe plaque psoriasis who have not had an adequate response to topical psoriasis treatments, and at least two of the following:
a. 12-week trial of phototherapy
b. acitretin
c. apremilast
d. induction trial of cyclosporine
e. methotrexate
7) New starts must have had an inadequate response or intolerance to an infliximab biosimilar declared equivalent by KPWA P&T Committee. KPWA equivalent infliximab products include infliximab-dyyb (Inflectra). Pediatric Ulcerative Colitis patients are excluded from this new start requirement.
8) For home infusion, the in-network benefit is available only if administered by Kaiser Permanente Home Infusion. Please submit a referral to KPHIS at 206-326-2139.

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

Limit dosing as follows:

Induction dosing for all indications as follows: Infusion at 0, 2, and 6 weeks followed by maintenance dose:

<table>
<tr><th>Indication</th><th>Max Dose</th><th>Max Frequency</th></tr>
<tr><td>Rheumatoid Arthritis</td><td rowspan="7">1000mg</td><td>4 weeks</td></tr>
<tr><td>Crohn’s and Ulcerative Colitis</td><td>6 weeks</td></tr>
<tr><td>Psoriatic arthropathy and psoriasis</td><td>8 weeks</td></tr>
<tr><td>Ankylosing spondylitis</td><td>6 weeks</td></tr>
<tr><td>Sarcoidosis</td><td>8 weeks</td></tr>
<tr><td>Other</td><td>8 weeks</td></tr>
</table>

Note: Must be administered in a non-hospital setting. Site of care restriction does NOT apply to patients <13 years old.
</td></tr>
</table>

<table>
<tr><th>DRUG NAME</th><th>COVERAGE CRITERIA</th></tr>
<tr><td>INFLECTRA</td><td>
1) For patients with rheumatoid arthritis with failure, intolerance or contraindications to methotrexate.
2) For use in patients with active ankylosing spondylitis.
3) For use in severe, refractory sarcoidosis with failure/intolerance to high dose corticosteroids and at least one steroid-sparing agent, such as methotrexate or azathioprine.
4) For patient with moderately to severely active ulcerative colitis or Crohn's disease. It is recommended that infliximab is used in combination with azathioprine, 6-mercaptopurine, or methotrexate.
5) For treatment of psoriatic arthritis in patients who failed methotrexate.
6) For patients with moderate to severe plaque psoriasis who have not had an adequate response to topical psoriasis treatments, and at least two of the following:
a) 12-week trial of phototherapy
b) acitretin
c) apremilast
d) induction trial of cyclosporine
e) methotrexate
7) For home infusion, the in-network benefit is available only if administered by Kaiser Permanente Home Infusion. Please submit a referral to KPHIS at 206-326-2139.

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

Limit dosing as follows:

Induction dosing for all indications as follows: Infusion at 0, 2, and 6 weeks followed by maintenance dose:

<table>
<tr><th>Indication</th><th>Max Dose</th><th>Max Frequency</th></tr>
<tr><td>Rheumatoid Arthritis</td><td rowspan="6">1000 mg</td><td>4 weeks</td></tr>
<tr><td>Crohn's and Ulcerative Colitis</td><td>6 weeks</td></tr>
<tr><td>Psoriatic arthritis</td><td>8 weeks</td></tr>
<tr><td>Ankylosing spondylitis</td><td>6 weeks</td></tr>
<tr><td>Plaque psoriasis</td><td>8 weeks</td></tr>
<tr><td>Others</td><td>8 weeks</td></tr>
</table>
Note: Must be administered in a non-hospital setting. Site of care restriction does NOT apply to patients <13 years old.
</td></tr>
</table>

Additional Information

Exclusion: The use of KPHIS will not be required for patients residing in Idaho.

A complete list of office-administered injectable and specialty home infusion drugs requiring prior authorization is available on Kaiser Permanente for Providers at https://wa-provider.kaiserpermanente.org/provider-manual under the "Authorizations & Clinical Review" section.

You can request authorization using one of the following methods:

- Use the Kaiser Permanente for Providers web site. You can send your request for authorization using our Referral Request tool. Using this method is easy and is the quickest way to obtain your authorization, sometimes immediately if your request is auto approved.
- Fax your request to the Review Services department at 1-888-282-2685.

- Contact Review Services at 1-800-289-1363, Monday – Friday from 8 am to 5 pm. After business hours, please leave a voice message with your contact information. Messages received after normal business hours are returned on the next business day.

Sincerely,

Marc Mora, MD
Senior Medical Director Networks and Care Management
Washington Permanente Medical Group