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NOVEMBER 30, 2020

UPDATED PRIOR AUTHORIZATION CRITERIA FOR: AVASTIN®, HERCEPTIN®, REMICADE®, AND RITUXAN®

Dear Provider,

Effective February 1, 2021, the prior authorization criteria for Avastin®, Herceptin®, Remicade®, and Rituxan® will be revised. This letter is a notification of the upcoming change in the prior authorization criteria required before administering these medications in a physician's office.

This change applies to Kaiser Foundation Health Plan of Washington Health Maintenance Organization (HMO) members and Kaiser Foundation Health Plan of Washington Options, Inc. Point Of Service (POS) and Preferred Provider Organization (PPO) members. **This change will NOT affect Medicare Advantage members.**

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

Prior authorization is still required for these drugs, and the prior authorization criteria is outlined below for the products listed in Table 1.

Table 1. List of Medications with updated Prior Authorization Criteria

BRAND NAME	GENERIC NAME	HCPCS
AVASTIN* ***Does NOT apply to ophthalmic use**	BEVACIZUMAB	J9035
HERCEPTIN	TRASTUZUMAB	J9355
REMICADE	INFLIXIMAB	J1745
RITUXAN ***Does NOT apply to oncology diagnoses.**	RITUXIMAB	J9310, J9312

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

Drug Name	Coverage Criteria
Bevacizumab (Avastin)	• Pre-approval not required for ophthalmic diagnoses • New starts must have had an inadequate response or intolerance to a bevacizumab biosimilar declared equivalent by Kaiser Permanente Washington Pharmacy & Therapeutics Committee. Kaiser Permanente

Drug Name	Coverage Criteria
	Washington equivalent bevacizumab products include bevacizumab-awwb (Mvasi). • **Established patients on Avastin must have a documented inadequate response or intolerance to a bevacizumab biosimilar OR must provide evidence that switching to a bevacizumab biosimilar is clinically inappropriate (documentation required).**
Trastuzumab (Herceptin)	• New starts must have had an inadequate response or intolerance to a trastuzumab biosimilar declared equivalent by Kaiser Permanente Washington Pharmacy & Therapeutics Committee. Kaiser Permanente Washington equivalent trastuzumab products include: trastuzumab-anns (Kanjinti). • **Established patients on Herceptin must have a documented inadequate response or intolerance to a trastuzumab biosimilar OR must provide evidence that switching to a trastuzumab biosimilar is clinically inappropriate (documentation required)** Note: Must be administered in a non-hospital setting for certain diagnosis when used as maintenance, monotherapy. See site of care prior authorization criteria (**https://wa-provider.kaiserpermanente.org/static/pdf/provider/clinical-review/list-officeinject.pdf**) for coverage criteria in a hospital outpatient setting and exceptions for new starts.
Infliximab (Remicade)	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 Kaiser Permanente Washington Pharmacy & Therapeutics Committee. Kaiser Permanente Washington equivalent infliximab products include infliximab-dyyb (Inflectra). Pediatric Ulcerative Colitis patients are excluded from this new start requirement. 8) **Established patients on Remicade must have a documented inadequate response or intolerance to an infliximab biosimilar OR**

<table>
<tr><th>Drug Name</th><th>Coverage Criteria</th></tr>
<tr><td></td><td>
must provide evidence that switching to an infliximab biosimilar is clinically inappropriate (documentation required).
9) In-network benefit available only for Kaiser Permanente Washington Home Infusion if administered in the home infusion setting. Please submit a referral (https://wa-provider.kaiserpermanente.org/static/pdf/provider/forms/infliximab-referral.pdf) to Kaiser Permanente Washington Home Infusion Services 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. See site of care prior authorization criteria (https://wa-provider.kaiserpermanente.org/static/pdf/provider/clinical-review/list-officeinject.pdf) for coverage criteria in a hospital outpatient setting and exceptions for new starts. Site of care restriction does NOT apply to patients < 13 years old.
</td></tr>
<tr><td>Rituximab (Rituxan)</td><td>
• Pre-approval not required for oncology diagnoses
• Rheumatoid arthritis patients who have clinically failed, been intolerant to, or have contraindications to methotrexate and one formulary TNF antagonist
• ITP patients who have clinically failed corticosteroid and IVIG
• Covered for treatment of granulomatosis polyangitis (GPA or Wegener’s) or microscopic polyangiitis (MPA) in patients who are antineutrophil cytoplasmic antibody (ANCA) positive
• Covered for the treatment of multiple sclerosis (MS)
• Covered for treatment of myasthenia gravis
• New starts must have had an inadequate response or intolerance to a rituximab biosimilar declared equivalent by Kaiser Permanente Washington
</td></tr>
</table>

Drug Name	Coverage Criteria
	Pharmacy & Therapeutics Committee. Kaiser Permanente Washington equivalent rituximab products include rituximab-abbs (Truxima). • **Established patients on Rituxan must have a documented inadequate response or intolerance to a rituximab biosimilar OR must provide evidence that switching to a rituximab biosimilar is clinically inappropriate (documentation required).** Note: Must be administered in a non-hospital setting. See site of care prior authorization criteria (**https://wa-provider.kaiserpermanente.org/static/pdf/provider/clinical-review/list-officeinject.pdf**) for coverage criteria in a hospital outpatient setting and exceptions for new starts. Site of care restriction does NOT apply to patients < 13 years old. *Any oncology indication would not require patients to meet site of care criteria

Additional Information

A complete list of office-administered injectable drugs requiring prior authorization is available on Kaiser Permanente provider website at **https://wa-provider.kaiserpermanente.org** under the header "Authorization & Clinical Review."

You can request authorization using one of the following methods:

- Use the Kaiser Permanente provider website. 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 a.m. to 5 p.m. 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.

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 – Friday from 8 a.m. to 5 p.m. 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,

Bruce Wilson, MD, Chair
Pharmacy & Therapeutics Committee