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206-988-2000
206-988-2001
prnotification@kp.org

Kaiser Foundation Health Plan of Washington
Kaiser Foundation Health Plan of Washington Options, Inc.
Provider Communications, RCR-A3W-04
PO Box 34262, Seattle WA 98124-1262

March 31, 2026

INFLIXIMAB (REMICADE) UPDATED PRIOR AUTHORIZATION CRITERIA

Dear Provider,

Infliximab (Remicade) is on the **non-Medicare** list of office-administered drugs requiring prior authorization. **Effective June 1, 2026,** the prior authorization for infliximab (Remicade) will be updated. **This letter is a notification of the change in prior authorization criteria required before administering this medication 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.

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

<table>
<tr><th>DRUG NAME</th><th>COVERAGE CRITERIA</th></tr>
<tr><td>INFLIXIMAB (Remicade)</td><td><u>Ankylosing Spondylitis</u>

Age ≥ 18 years
Diagnosis of active ankylosing spondylitis
Failed an adequate trial, or has an allergy, intolerance, or contraindication to the following:

TNF Inhibitors (all the following):
infliximab-dyyb (Inflectra)
adalimumab (e.g., Amjevita)
IL-17 Inhibitor:
secukinumab (Cosentyx)

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

<u>Crohn's Disease</u>

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 Inhibitors (all the following):
adalimumab (e.g., Amjevita)
infliximab (e.g., Inflectra)
Note: It is recommended that TNF-inhibitors are used in combination with azathioprine 6-mercaptopurine, or methotrexate
IL-12/23 Inhibitor:
ustekinumab (e.g., Yesintek)

Quantity Limit:
</td></tr>
</table>

DRUG NAME	COVERAGE CRITERIA

	- 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
	
	<u>Psoriasis</u>
	• Age ≥ 18 years
	• Diagnosis of moderate to severe psoriasis
	• Failed an adequate trial, or has an allergy, intolerance, or contraindication to the following:
	  - TNF Inhibitors:
	    ▪ infliximab-dyyb (Inflectra)
	  - IL-12/23 Inhibitor:
	    ▪ ustekinumab (e.g., Yesintek)
	• 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
	
	<u>Psoriatic Arthritis</u>
	• Age ≥ 18 years
	• Diagnosis of psoriatic arthritis
	• Failed an adequate trial, or has an allergy, intolerance, or contraindication to the following:
	  - TNF Inhibitors:
	    ▪ infliximab-dyyb (Inflectra)
	  - IL-12/23 Inhibitor:
	    ▪ ustekinumab (e.g., Yesintek)
	    ▪ Note: IL-12/23 inhibitor not required for patients with axial disease or severe (rapidly progressive, erosive) disease
	• 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
	
	<u>Rheumatoid Arthritis</u>
	• Age ≥ 18 years
	• Diagnosis of rheumatoid arthritis
	• Failed an adequate trial, or has an allergy, intolerance, or contraindication to the following:
	  - TNF Inhibitors:
	    ▪ infliximab-dyyb (Inflectra)
	  - IL-6 Inhibitor:
	    ▪ tocilizumab (e.g., Tyenne)
	• 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
	
	<u>Sarcoidosis</u>
	• Age ≥ 18 years
	• Diagnosis of sarcoidosis

DRUG NAME	COVERAGE CRITERIA

	• Failed an adequate trial, or has an allergy, intolerance, or contraindication to the following:
	    o TNF Inhibitors:
	        ▪ infliximab (e.g., Inflectra)
	• Quantity Limit:
	    o Induction: Infusion at weeks 0, 2, and 6 (max dose 1000 mg)
	    o 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:
	    o TNF Inhibitor:
	        ▪ infliximab (e.g., Inflectra)
	        ▪ Note: It is recommended that TNF-inhibitors are used in combination with azathioprine, 6-mercaptopurine or methotrexate
	    o **IL-12/23 Inhibitor:**
	        ▪ **ustekinumab (e.g., Yesintek)**
	• Quantity Limit:
	    o Induction: Infusion at weeks 0, 2, and 6 (max dose 1000 mg)
	    o 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.

Additional Information

A complete list of office-administered Part B injectable drugs requiring step therapy 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