Clover Health

EXCEPTIONS CRITERIA
INFLIXIMAB

PREFERRED PRODUCTS: INFLECTRA

POLICY
This policy informs prescribers of preferred products and provides an exception process for targeted products through prior authorization.

I. PLAN DESIGN SUMMARY

This program applies to the infliximab products specified in this policy. Coverage for targeted products is provided based on clinical circumstances that would exclude the use of the preferred product and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to members who are new to treatment with a targeted product for the first time.

Each referral is reviewed based on all utilization management (UM) programs implemented for the client.

Table. Infliximab products

	Product(s)
Preferred*	• **Inflectra** (infliximab-dyyb)
Targeted (non-preferred)	• **Avsola** (infliximab-axxq) • **infliximab** • **Remicade** (infliximab) • **Renflexis** (infliximab-abda)

*: Medications considered formulary or preferred on your plan may still require a clinical prior authorization review.

II. EXCEPTION CRITERIA

Coverage for a targeted product is provided when any of the following criteria is met:

A. Member has received treatment with the targeted product in the past 365 days.
B. Member has had a documented intolerable adverse event to the of the preferred products, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference product and biosimilar products).

REFERENCES

1. Avsola [package insert]. Thousand Oaks, CA: Amgen; September 2021.
2. Inflectra [package insert]. New York, NY: Pfizer Inc; March 2022.
3. Remicade [package insert]. Horsham, PA: Janssen Biotech, Inc.; October 2021.
4. Renflexis [package insert]. Jersey City, NJ: Organon & Co.; January 2022.