

**SOUTH DAKOTA MEDICAID  
PRIOR AUTHORIZATION CRITERIA**

*Physician Administered Drugs, Vaccines, and Immunizations*

**Infliximab (Avsola, Inflectra, Remicade, Renflexis) – PA Criteria**

HCPC: J1745 infliximab (Remicade), Q5121 infliximab-axxg (Avsola), Q5103 infliximab-dyyb (Inflectra), Q5104 infliximab-abda (Renflexis)

<b>PREFERRED AGENT (NO PA REQUIRED)</b>	<b>NON-PREFERRED AGENT (PA REQUIRED)</b>
INFLIXIMAB	AVSOLA (infliximab-axxg)
	INFLECTRA (infliximab-dyyb)
	REMICADE (infliximab)
	RENFLEXIS (infliximab-abda)

Infliximab (Avsola, Inflectra, Remicade, Renflexis) is an antirheumatic, disease modifying monoclonal antibody indicated for the treatment of various conditions in adult and pediatric patients. It is covered by South Dakota Medicaid following prior authorization when the patient meets the following criteria:

- **Initial Therapy (must meet all):**
  - Individual meets **one** of the following regarding previous therapy trials:
    - Member has failed a ≥90 day trial for a preferred medication
    - Clinical justification is provided why the member cannot utilize a preferred product
  - Approval duration: 1 year
- **Continuation of Therapy (must meet all):**
  - Requested drug remains the preferred product with SD Medicaid
  - Reason for initial approval is still present
  - Approval duration: 1 year

**\*\* If biosimilar product varies in FDA approved age and indication compared to the parent product, exceptions may be made.**

*IV Formulation*

<b>Therapy Indication</b>	<b>INFLIXIMAB</b>	<b>AVSOLA</b>	<b>INFLECTRA</b>	<b>REMICADE</b>	<b>RENFLEXIS</b>
Ankylosing Spondylitis	18+	18+	18+	18+	18+
Colitis, immune checkpoint inhibitor induced	18+	18+	18+	18+	18+
Chrohn disease, moderate to severe, induction and maintenance of remission	6+	6+	6+	6+	6+
Plaque psoriasis	18+	18+	18+	18+	18+
Psoriatic arthritis	18+	18+	18+	18+	18+
Rheumatoid arthritis	18+	18+	18+	18+	18+
Ulcerative colitis	6+	6+	6+	6+	6+