Pharmacotherapy of Inflammatory Bowel Disorder

Effective Date: Feb. 4, 2022
Last Revised: Dec. 21, 2021
Replaces: Extracted from 5.01.550

RELATED MEDICAL POLICIES:
11.01.523 Site of Service: Infusion Drugs and Biologic Agents

Select a hyperlink below to be directed to that section.

POLICY CRITERIA | DOCUMENTATION REQUIREMENTS | CODING
RELATED INFORMATION | EVIDENCE REVIEW | REFERENCES | HISTORY

∞ Clicking this icon returns you to the hyperlinks menu above.

Introduction

Inflammatory bowel disorder describes several diseases where the lining of the digestive tract becomes chronically inflamed. Inflammation may cause internal sores or ulcers in the gut and symptoms of abdominal pain, cramping, diarrhea, bleeding, feeling tired, and weight loss. The two most common diseases include Crohn’s disease (CD) and ulcerative colitis (UC). In Crohn’s disease the entire digestive tract may be involved. In ulcerative colitis the disease is limited to the colon or large bowel only. Both disorders can be chronic; so far there is not a cure for either. However, there are many different medications that can be used to treat these disorders. This policy describes treatment for the most common inflammatory bowel disease and which drugs may need pre-approval.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs providers about when a service may be covered.
We will review specific intravenous (IV) and injectable drugs for medical necessity for all ages.

For those age 13 and older, we also will review the site of service for medical necessity. Site of service is defined as the location where the drug is administered, such as a hospital-based outpatient setting, an infusion center, a physician’s office, or at home.

**Drugs subject to site of service review addressed in this policy are:**

- Avsola™ (infliximab-axxq)
- Entyvio® (vedolizumab)
- Inflectra® (infliximab-dyyb)
- Remicade® (infliximab)
- Renflexis® (infliximab-abda)
- Stelara® (ustekinumab) IV
- Stelara® (ustekinumab) SC
- Tysabri® (natalizumab)

**Click on the links below to be directed to the related medical necessity criteria:**

<table>
<thead>
<tr>
<th>Crohn’s Disease</th>
<th>Ulcerative Colitis</th>
<th>Site of Service Infusion</th>
</tr>
</thead>
</table>

**Site of Service Administration**

- Medically necessary sites of service
  - Physician’s office
  - Infusion center
  - Home infusion

**Medical Necessity**

- IV infusion therapy of various medical or biologic agents will be covered in the most appropriate, safe and cost-effective site:
  - These are the preferred **medically necessary** sites of service for specified drugs.
<table>
<thead>
<tr>
<th>Site of Service Administration</th>
<th>Medical Necessity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital-based outpatient setting</td>
<td>IV infusion therapy of various medical or biologic agents will be covered in the most appropriate, safe and cost-effective site.</td>
</tr>
<tr>
<td>• Outpatient hospital IV infusion department</td>
<td>This site is considered medically necessary for the first 90 days for the following:</td>
</tr>
<tr>
<td>• Hospital-based outpatient clinical level of care</td>
<td>• The initial course of infusion of a pharmacologic or biologic agent</td>
</tr>
<tr>
<td></td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td>• Re-initiation of an agent after 6 months or longer following discontinuation of therapy*</td>
</tr>
<tr>
<td>Note:</td>
<td>*This does not include when standard dosing between infusions is 6 months or longer</td>
</tr>
</tbody>
</table>

This site is considered medically necessary when there is no outpatient infusion center within 50 miles of the patient’s home and there is no contracted home infusion agency that will travel to their home, or a hospital is the only place that offers infusions of this drug.

This site is considered medically necessary only when the patient has a clinical condition which puts him or her at increased risk of complications for infusions, including any ONE of the following:

• Known cardiac condition (eg, symptomatic cardiac arrhythmia) or pulmonary condition (eg, significant respiratory disease, serious obstructive airway disease, %FVC ≤ 40%) that may increase the risk of an adverse reaction
• Unstable renal function which decreases the ability to respond to fluids
• Difficult or unstable vascular access
• Acute mental status changes or cognitive conditions that impact the safety of infusion therapy
### Site of Service Administration

<table>
<thead>
<tr>
<th>Medical Necessity</th>
</tr>
</thead>
<tbody>
<tr>
<td>• A known history of severe adverse drug reactions and/or anaphylaxis to prior treatment with a related or similar drug</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospital-based outpatient setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Outpatient hospital IV infusion department</td>
</tr>
<tr>
<td>• Hospital-based outpatient clinical level of care</td>
</tr>
</tbody>
</table>

These sites are considered not medically necessary for infusion and injectable therapy services of various medical and biologic agents when the site-of-service criteria in this policy are not met.

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### Medical and Biological Agents

Please note that claims billed for the drugs described in this policy that are administered via an intravenous route (IV) must be processed through a medical benefit only (not pharmacy).

Medications listed in this policy may also be subject to quantity limits per the FDA labeled dosing.

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**Step therapy tiers are listed below, please refer to the Policy section for details:**

<table>
<thead>
<tr>
<th>Crohn’s Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First-line Agents</strong></td>
</tr>
<tr>
<td>TNF-α Inhibitors (first-line)</td>
</tr>
<tr>
<td>Remicade® (IV)</td>
</tr>
<tr>
<td>Humira® (SC)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Second-line Agents</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>TNF-α Inhibitors (second-line)</td>
</tr>
<tr>
<td>Inflectra® (IV)</td>
</tr>
<tr>
<td>Renflexis® (IV)</td>
</tr>
<tr>
<td>Drug</td>
</tr>
<tr>
<td>------</td>
</tr>
<tr>
<td><strong>First-line TNF-α Antagonists</strong></td>
</tr>
</tbody>
</table>
| **Humira® (adalimumab) SC**  
• First-line | **Humira® (adalimumab) may be considered medically necessary as the first-line agent in the treatment of Crohn’s disease when:**  
• Patient has had an adequate trial and treatment failure with:  
  o One corticosteroid (eg, prednisone, prednisolone, dexamethasone, budesonide, etc.)  
  **OR**  
  o One other agent for Crohn's disease (eg, azathioprine, 6-mercaptopurine, methotrexate, etc.)  
  **OR**  
  • Patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas  
  **OR**  
  • Patient has had ileocolonic resection (to reduce the chance of Crohn's disease recurrence)  
  **AND**  
  • Humira® (adalimumab) is being prescribed by or in consultation with a gastroenterologist |
| **Remicade® (infliximab) IV**  
• First-line | **Remicade® (infliximab) is subject to review for site of service administration.**  
  **Remicade® (infliximab) may be considered medically necessary as a first-line agent in the treatment of Crohn’s disease when:**  
  • Patient has had an adequate trial and treatment failure with:  
    o One corticosteroid (eg, prednisone, prednisolone, dexamethasone, budesonide, etc.)  
    **OR**  
  • Humira® (adalimumab) may be considered medically necessary as the first-line agent in the treatment of Crohn’s disease when:**  
    • Patient has had an adequate trial and treatment failure with:  
      o One corticosteroid (eg, prednisone, prednisolone, dexamethasone, budesonide, etc.)  
      **OR** |
<table>
<thead>
<tr>
<th>Drug</th>
<th>Medical Necessity for Crohn’s Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>o One other agent for Crohn’s disease (eg, azathioprine, 6-mercaptopurine, methotrexate, etc.) OR • Patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas OR • Patient has had ileocolonic resection (to reduce the chance of Crohn’s disease recurrence) AND • Remicade® (infliximab) is being prescribed by or in consultation with a gastroenterologist</td>
</tr>
</tbody>
</table>

**First-line α-4 Integrin Inhibitors**

- **Entyvio® (vedolizumab) IV**
  - First-line

  Entyvio® (vedolizumab) is subject to review for site of service administration.

  Entyvio® (vedolizumab) may be considered medically necessary as a first-line agent in the treatment of Crohn’s disease when:
  - Patient has had an adequate trial and treatment failure with:
    - One corticosteroid (eg, prednisone, prednisolone, dexamethasone, budesonide, etc.)
      
  OR
  - One other agent for Crohn’s disease (eg, azathioprine, 6-mercaptopurine, methotrexate, etc.)
  OR
  - Patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas
  OR
  - Patient has had ileocolonic resection (to reduce the chance of Crohn’s disease recurrence)

  AND
  - Entyvio® (vedolizumab) is being prescribed by or in consultation with a gastroenterologist

**First-line IL-12 and IL-23 Antagonist**
<table>
<thead>
<tr>
<th>Drug</th>
<th>Medical Necessity for Crohn’s Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stelara® (ustekinumab) IV and Stelara® (ustekinumab) SC</td>
<td>• First-line &lt;br&gt;Stelara® (ustekinumab) IV and Stelara® (ustekinumab) SC are subject to review for site of service administration. &lt;br&gt;Stelara® (ustekinumab) IV may be considered medically necessary as a first-line agent in the treatment of moderately to severely active Crohn’s disease when: &lt;br&gt;• Patient has had an adequate trial and treatment failure with: &lt;br&gt;  o One corticosteroid (eg, prednisone, prednisolone, dexamethasone, or budesonide, etc.)&lt;br&gt;  OR&lt;br&gt;  o One other agent for Crohn’s disease (eg, azathioprine, 6-mercaptopurine, methotrexate, etc.)&lt;br&gt;AND&lt;br&gt;• Stelara® (ustekinumab) IV is being prescribed by or in consultation with a gastroenterologist&lt;br&gt;AND&lt;br&gt;• Stelara® (ustekinumab) IV is used for only a one-time induction dose &lt;br&gt;Stelara® (ustekinumab) SC may be considered medically necessary as a first-line agent in the treatment of moderately to severely active Crohn’s disease when: &lt;br&gt;• Patient has received a single induction dose with Stelara® (ustekinumab) IV &lt;br&gt;AND&lt;br&gt;• Patient has had an adequate trial and treatment failure with: &lt;br&gt;  o One corticosteroid (eg, prednisone, prednisolone, dexamethasone, or budesonide, etc.) &lt;br&gt;  OR&lt;br&gt;  o One other agent for Crohn’s disease (eg, azathioprine, 6-mercaptopurine, methotrexate, etc.)&lt;br&gt;AND&lt;br&gt;• Stelara® (ustekinumab) SC is being prescribed by or in consultation with a gastroenterologist</td>
</tr>
<tr>
<td>Second-line TNF-α Antagonists</td>
<td></td>
</tr>
<tr>
<td>Drug</td>
<td>Medical Necessity for Crohn’s Disease</td>
</tr>
<tr>
<td>------</td>
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</tr>
</tbody>
</table>
| Cimzia® (certolizumab pegol) SC  | Cimzia® (certolizumab pegol) may be considered medically necessary as a second-line agent in the treatment of Crohn’s disease when:  
  - Patient has had an adequate trial and treatment failure with:  
    - One corticosteroid (eg, prednisone, prednisolone, dexamethasone, budesonide, etc.)  
    **OR**  
    - One other agent for Crohn’s disease (eg, azathioprine, 6-mercaptopurine, methotrexate, etc.)  
  **AND**  
  - Patient has had a trial and treatment failure with Humira® (adalimumab)  
  **AND**  
  - Cimzia® (certolizumab pegol) is being prescribed by or in consultation with a gastroenterologist |
| Inflectra® (infliximab-dyyb) IV, Renflexis® (infliximab-abda) IV and Avsola™ (infliximab-axxq) IV  | Inflectra® (infliximab-dyyb), Renflexis® (infliximab-abda), and Avsola™ (infliximab-axxq) are subject to review for site of service administration.  
  Inflectra® (infliximab-dyyb), Renflexis® (infliximab-abda) and Avsola™ (infliximab-axxq) may be considered medically necessary as a second-line agent in the treatment of Crohn’s disease when:  
  - Patient has had an adequate trial and treatment failure with:  
    - One corticosteroid (eg, prednisone, prednisolone, dexamethasone, budesonide, etc.)  
    **OR**  
    - One other agent for Crohn’s disease (eg, azathioprine, 6-mercaptopurine, methotrexate, etc.)  
  **OR**  
  - Patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas  
  **OR**  
  - Patient has had ileocolonic resection (to reduce the chance of Crohn’s disease recurrence)  
  **AND** |
**Drug** | **Medical Necessity for Crohn’s Disease**
--- | ---
 | • The patient has had an inadequate response or intolerance to Remicade® (infliximab)  
AND  
• Inflectra® (infliximab-dyyb), Renflexis® (infliximab-abda) or Avsola™ (infliximab-axxq) is being prescribed by or in consultation with a gastroenterologist

### Second-line α-4 Integrin Inhibitors

| Tysabri® (natalizumab) IV | Tysabri® (natalizumab) is subject to review for site of service administration.
--- | ---
 | • Second-line |  
Tysabri® (natalizumab) may be considered medically necessary as a second-line agent in the treatment of Crohn’s disease when:
 | • Patient has had an adequate trial and treatment failure with:  
 | o One corticosteroid (eg, prednisone, prednisolone, dexamethasone, or budesonide, etc.)  
 | OR  
 | o One other agent for Crohn’s disease (eg, azathioprine, 6-mercaptopurine, methotrexate, etc.)  
 | AND  
 | • Tysabri® (natalizumab) is being prescribed by or in consultation with a gastroenterologist

### Step therapy tiers are listed below, please refer to the Policy section for details:

<table>
<thead>
<tr>
<th>Ulcerative Colitis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First-line Agents</strong></td>
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<tr>
<td>TNF-α Inhibitors (first-line)</td>
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</table>
# Ulcerative Colitis

<table>
<thead>
<tr>
<th>Drug</th>
<th>Medical Necessity for Ulcerative Colitis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First-line TNF-α Antagonists</strong></td>
<td></td>
</tr>
</tbody>
</table>
| **Humira® (adalimumab) SC**     | Humira® (adalimumab) may be considered medically necessary as the first-line agent in the treatment of ulcerative colitis when:  
• Patient has had an adequate trial and treatment failure with one systemic agent (eg, azathioprine, 6-mercaptopurine, cyclosporine, tacrolimus, prednisone, methylprednisolone, etc.)  
OR  
• Patient has pouchitis and has tried therapy with one of the following medications:  
  o An antibiotic (eg, metronidazole, ciprofloxacin), probiotic, corticosteroid enema/suppository, or mesalamine enema/suppository  
AND  
• Humira® (adalimumab) is being prescribed by or in consultation with a gastroenterologist |
| **Remicade® (infliximab) IV**   | Remicade® (infliximab) is subject to review for site of service administration.  
Remicade® (infliximab) may be considered medically necessary as a first-line agent in the treatment of ulcerative colitis when:  
• Patient has had an adequate trial and treatment failure with one systemic agent (eg, azathioprine, 6-mercaptopurine, cyclosporine, tacrolimus, prednisone, methylprednisolone, etc.)  
OR |
<table>
<thead>
<tr>
<th>Drug</th>
<th>Medical Necessity for Ulcerative Colitis</th>
</tr>
</thead>
</table>
|      | • Patient has pouchitis and has tried therapy with one of the following medications:  
|      |   o An antibiotic (eg metronidazole, ciprofloxacin), probiotic, corticosteroid enema/suppository, or mesalamine enema/suppository  
|      |   AND  
|      | • Remicade® (infliximab) is being prescribed by or in consultation with a gastroenterologist  
|      | • Remicade® (infliximab) is being prescribed by or in consultation with a gastroenterologist  
|      | • First-line α-4 Integrin Inhibitor  
| Entyvio® (vedolizumab) IV | Entyvio® (vedolizumab) is subject to review for site of service administration.  
|      | Entyvio® (vedolizumab) may be considered medically necessary as a first-line agent in the treatment of ulcerative colitis when:  
|      | • Patient has had an adequate trial and treatment failure with one systemic agent (eg, azathioprine, 6-mercaptopurine, cyclosporine, tacrolimus, prednisone, methylprednisolone, etc.)  
|      | OR  
|      | • Patient has pouchitis and has tried therapy with one of the following medications:  
|      |   o An antibiotic (eg metronidazole, ciprofloxacin), probiotic, corticosteroid enema/suppository, or mesalamine enema/suppository  
|      |   AND  
|      | • Entyvio® (vedolizumab) is being prescribed by or in consultation with a gastroenterologist  
|      | • First-line IL-12 and IL-23 Antagonist  
| Stelara® (ustekinumab) IV and Stelara® (ustekinumab) SC | Stelara® (ustekinumab) IV and Stelara® (ustekinumab) SC are subject to review for site of service administration.  
|      | Stelara® (ustekinumab) IV may be considered medically necessary as a first-line agent in the treatment of ulcerative colitis when:  
|      |   AND  
|      | • Entyvio® (vedolizumab) is being prescribed by or in consultation with a gastroenterologist  
|      | • Entyvio® (vedolizumab) is being prescribed by or in consultation with a gastroenterologist  
|      | • ...
### Drug | Medical Necessity for Ulcerative Colitis
--- | ---

| • Patient has had an adequate trial and treatment failure with one systemic agent (eg, azathioprine, 6-mercaptopurine, cyclosporine, tacrolimus, prednisone, methylprednisolone, etc.) OR • Patient has pouchitis and has tried therapy with one of the following medications:  
  o An antibiotic (eg metronidazole, ciprofloxacin), probiotic, corticosteroid enema/suppository, or mesalamine enema/suppository  
  
  **AND** • Stelara® (ustekinumab) IV is being prescribed by or in consultation with a gastroenterologist  
  
  **AND** • Stelara® (ustekinumab) IV is used for only a one-time induction dose |

Stelara® (ustekinumab) SC may be considered medically necessary as a first-line agent in the treatment of ulcerative colitis when:

| • Patient has received a single induction dose with Stelara® (ustekinumab) IV  
  
  **AND** • Patient has had an adequate trial and treatment failure with one systemic agent (eg, azathioprine, 6-mercaptopurine, cyclosporine, tacrolimus, prednisone, methylprednisolone, etc.) OR • Patient has pouchitis and has tried therapy with one of the following medications:  
  o An antibiotic (eg metronidazole, ciprofloxacin), probiotic, corticosteroid enema/suppository, or mesalamine enema/suppository  
  
  **AND** • Stelara® (ustekinumab) SC is being prescribed by or in consultation with a gastroenterologist |

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**Second-line Janus Kinase Inhibitors**
<table>
<thead>
<tr>
<th>Drug</th>
<th>Medical Necessity for Ulcerative Colitis</th>
</tr>
</thead>
</table>
| Xeljanz® (tofacitinib) (oral, immediate-release), Xeljanz XR® (tofacitinib) (oral, extended-release) | Xeljanz® (tofacitinib) and Xeljanz XR® (tofacitinib extended-release) may be considered medically necessary as a second-line agent in the treatment of adult patients with ulcerative colitis when:  
- Patient has had a trial and treatment failure with Humira® (adalimumab)  
AND  
- Xeljanz® (tofacitinib) immediate-release or Xeljanz XR® (tofacitinib extended-release) is prescribed by or in consultation with a gastroenterologist |
| **Second-line Sphingosine 1-Phosphate Receptor Modulators** | Zeposia® (ozanimod) oral may be considered medically necessary as a second-line agent in the treatment of adult patients with ulcerative colitis when:  
- Patient has had an adequate trial and treatment failure with one systemic agent (eg, azathioprine, 6-mercaptopurine, cyclosporine, tacrolimus, prednisone, methylprednisolone, etc.)  
AND  
- Patient has had a trial and treatment failure with Humira® (adalimumab) and Stelara® (ustekinumab)  
AND  
- Zeposia® (ozanimod) is prescribed by or in consultation with a gastroenterologist |
| **Second-line TNF-α Antagonists** | Simponi® (golimumab) SC may be considered medically necessary as a second-line agent in the treatment of ulcerative colitis when:  
- Patient has had an adequate trial and treatment failure with one systemic agent (eg, azathioprine, 6-mercaptopurine, cyclosporine, tacrolimus, prednisone, methylprednisolone, etc.)  
OR  
- Patient has pouchitis and has tried therapy with one of the following medications:  
  - An antibiotic (eg metronidazole, ciprofloxacin), probiotic, corticosteroid enema/suppository, or mesalamine enema/suppository |
### Drug | Medical Necessity for Ulcerative Colitis
---|---
AND
- Patient has had a trial and treatment failure with Humira® (adalimumab)

AND
- Simponi® (golimumab) SC is being prescribed by or in consultation with a gastroenterologist

| Inflectra® (infliximab-dyyb) IV, Renflexis® (infliximab-abda) IV and Avsola™ (infliximab-axxq) IV | Inflectra® (infliximab-dyyb), Renflexis® (infliximab-abda), and Avsola™ (infliximab-axxq) are subject to review for site of service administration.

Inflectra® (infliximab-dyyb), Renflexis® (infliximab-abda) and Avsola™ (infliximab-axxq) IV may be considered medically necessary as a second-line agent in the treatment of ulcerative colitis when:
- Patient has had an adequate trial and treatment failure with one systemic agent (eg, azathioprine, 6-mercaptopurine, cyclosporine, tacrolimus, prednisone, methylprednisolone, etc.)

OR
- Patient has pouchitis and has tried therapy with one of the following medications:
  - An antibiotic (eg metronidazole, ciprofloxacin), probiotic, corticosteroid enema/suppository, or mesalamine enema/suppository

AND
- Patient has had an inadequate response or intolerance to Remicade® (infliximab)

AND
- Inflectra® (infliximab-dyyb), Renflexis® (infliximab-abda) or Avsola™ (infliximab-axxq) is being prescribed by or in consultation with a gastroenterologist

### Drug | Investigational
---|---
As listed | All other uses of the above-named agents when used in combination with each other, in quantities that exceed the FDA labeled dosing for condition, or for conditions not
Drug: Investigational

Outlined in this policy or policy 5.01.550 are considered investigational.

Drug: Not Medically Necessary

As listed

All other uses of the drugs for approved conditions listed in this policy are considered not medically necessary.

Length of Approval

<table>
<thead>
<tr>
<th>Approval</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial authorization</td>
<td>Stelara® (ustekinumab) IV may be approved for 30-days to allow for a one-time induction dose. All other drugs listed in policy may be approved up to 12 months.</td>
</tr>
<tr>
<td>Re-authorization criteria</td>
<td>Future re-authorization of all drugs, excluding Stelara® (ustekinumab) IV, listed in policy may be approved up to 3 years as long as the drug-specific coverage criteria are met, and chart notes demonstrate that the patient continues to show a positive clinical response to therapy.</td>
</tr>
</tbody>
</table>

Documentation Requirements

The patient’s medical records submitted for review for all conditions should document that medical necessity criteria are met. The record should include the following:

- Office visit notes that contain the diagnosis, relevant history, physical evaluation and medication history

Coding

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reviewed for Medical Necessity</td>
<td></td>
</tr>
<tr>
<td>HCPCS</td>
<td></td>
</tr>
<tr>
<td>J0135</td>
<td>Injection, adalimumab (Humira®). 20mg</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>J0717</td>
<td>Injection, certolizumab pegol (Cimzia®), 1 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)</td>
</tr>
<tr>
<td>J1745</td>
<td>Injection, infliximab (Remicade®), 10mg</td>
</tr>
<tr>
<td>J2323</td>
<td>Injection, natalizumab, (Tysabri®), 1mg</td>
</tr>
<tr>
<td>J3357</td>
<td>Injection, ustekinumab (Stelara®), 1 mg</td>
</tr>
<tr>
<td>J3358</td>
<td>Usteokinumab, for intravenous injection, (Stelara®), 1 mg</td>
</tr>
<tr>
<td>J3380</td>
<td>Injection, vedolizumab (Entyvio®), 1 mg</td>
</tr>
<tr>
<td>J3590</td>
<td>Unclassified biologics (Simponi®)</td>
</tr>
<tr>
<td>Q5103</td>
<td>Injection, infliximab-dyyb, biosimilar, (Inflectra®), 10 mg</td>
</tr>
<tr>
<td>Q5104</td>
<td>Injection, infliximab-abda, biosimilar, (Renflexis®), 10 mg</td>
</tr>
<tr>
<td>Q5121</td>
<td>Injection, infliximab-axxq, biosimilar, (Avsola™), 10 mg</td>
</tr>
</tbody>
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### Related Information

### Age Considerations

Age limits specified in this policy are determined according to FDA-approved indications, where applicable.

For site of service for medical necessity the age described in this policy is 13 years of age or older. Site of service is defined as the location where the drug is administered, such as a hospital-based outpatient setting, an infusion center, a physician’s office, or at home. The age criterion for site of service for medical necessity is based on the following: Pediatric patients are not small adults. Pediatric patients differ physiologically, developmentally, cognitively, and emotionally from adult patients, and vary by age groups from infancy to teen. Children often require smaller doses than adults, lower infusion rates, appropriately sized equipment, the right venipuncture site determined by therapy and age, and behavioral management during administration of care. Specialty infusion training is therefore necessary for pediatric IV insertions and therapy. Due to pediatrics unique physiology and psychology, site of service review is limited to patients above the age of 13.
Crohn’s Disease (CD)

The American College of Gastroenterology indicates current therapeutic recommendations depend on disease location, disease severity, and the presence of disease-associated complications. Pharmacologic approaches include various 5-aminosalicylates (5-ASAs), corticosteroids, and immunosuppressants. While the effectiveness of the 5-ASAs is less than corticosteroids, their side effect profile is more favorable. Azathioprine and sulfasalazine are also associated with clinically significant long-term toxicity, according to the National Cooperative Crohn’s Disease Study. Azathioprine, sulfasalazine, and prednisone have not been demonstrated to prevent recurrence of disease flares.

Surgical resection is a common occurrence in CD, with up to 57% of patients requiring at least one surgery in any given year. Within 10 years of disease onset, 71% of patients undergo this therapy.

Clinical trials with Remicade® (infliximab) in patients with moderate to severe CD have shown that Remicade significantly reduces symptoms, improves quality of life, provides endoscopic evidence of mucosal healing, and reduces recurrence rates allowing for fewer hospitalizations and invasive procedures. Additionally, patients with fistulizing disease were able to achieve a reduction in the number of draining enterocutaneous and rectovaginal fistulas.

Inflectra (infliximab-dyyb) is a biosimilar to Remicade (infliximab) approved for the same indications, with the exception of ulcerative colitis in pediatric patients. For a full list of indications and details on the clinical trials information please refer to the package insert for Inflectra. The safety and efficacy of adalimumab (Humira) for the induction and/or maintenance of remission in patients with moderately to severely active CD (Crohn’s Disease Activity Index [CDAI] ≥220 and ≤450) was evaluated in four randomized placebo-controlled studies. Two of these studies evaluated Humira for induction of remission (defined as a CDAI <150), one study in patients who were TNF antagonist naïve (CLASSIC-I) and the other in patients who had lost response or were intolerant to Remicade (GAIN). Two of these studies evaluated Humira for maintenance of remission, both studies in patients who were TNF antagonist naïve (CLASSIC-II and CHARM).

In CLASSIC-I, 299 patients with moderately to severely active CD, including patients with draining fistulas, were randomized to two subcutaneous injections at Weeks 0 and 2 with
Humira 40 mg/20 mg, 80 mg/40 mg, or 160 mg/80 mg or placebo. Enrollees were also able to maintain existing therapy with immunomodulatory agents, corticosteroids, and/or aminosalicylates. The primary efficacy endpoint was induction of remission (CDAI <150) at Week 4. The rate of remission was significantly higher in the 160 mg/80 mg group (36%, p=0.001), but not for the 40 mg/20 mg (18%, p=0.36) or 80 mg/40 mg (24%, p=0.06) groups compared with placebo (12%). Injection site reactions occurred more frequently in Humira-treated patients; otherwise adverse events occurred at similar frequencies in all four treatment groups.

In GAIN, 325 patients with moderately to severely active CD who were intolerant of, who had lost response, or who had an inadequate response to Remicade were randomized to two subcutaneous injections at Weeks 0 and 2 with Humira 160 mg/80 mg or placebo. Primary efficacy endpoint was induction of remission (CDAI <150) at Week 4. Clinical response (decrease in CDAI score ≥70 or 100) at Week 4 was also assessed. More Humira-treated patients (21%, p<0.001) achieved clinical remission compared to those treated with placebo (7%). More Humira-treated patients (52%, p<0.01) achieved a clinical response-70 compared with the placebo group (34%).

A total of 276 patients participating in CLASSIC-I enrolled in CLASSIC-II and received open-label Humira 40 mg subcutaneously at Weeks 0 and 2 with Humira 160 mg/80 mg or placebo. Patients who were not in remission at both Weeks 0 and 4 were treated with open-label Humira 40 mg QOW. These patients were allowed to have their dose increase to 40 mg QW for non-response or disease flare. The re-randomized patients were also allowed to “escape” into this open-label arm with disease flare. The primary efficacy endpoint was maintenance of remission (CDAI <150) in randomized patients through week 56. Of the 55 patients randomized at Week 4, a greater proportion receiving Humira (79% of the Humira 40 mg QOW group and 83% of the 40 mg QW group, both p<0.05) were in remission compared to the placebo group (44%). Of 204 patients entering the open-label arm, 46% were in remission at Week 56. Humira was generally well-tolerated.

In CHARM, a total of 854 patients with moderately to severely active CD were treated with open-label Humira 80 mg at Week 0 followed by 40 mg at Week 2 as induction therapy. At Week 4, patients were stratified by clinical response (decrease of CDAI ≥70) and randomized to double-blind treatment with subcutaneous Humira 40 mg QOW, Humira 40 mg QW, or placebo weekly for 52 additional weeks. The proportion of randomized clinical responders achieving clinical remission at Weeks 26 and 56 were coprimary endpoints. At Week 4, 499/854 (58%) of patients achieved a clinical response-70 and were randomized to Humira or placebo. The percentage of randomized responders in remission was significantly greater in the Humira 40 mg QOW and 40 mg QW groups compared to the placebo group at Week 26 (40%, 47%, and 17%, respectively;
and at Week 56 (36%, 41%, and 12%, respectively; p<0.001). No significant differences in efficacy were observed between the two active treatment groups. Patients who did not achieve clinical response after 12 weeks were unlikely to achieve response. The safety profile for Humira was consistent with previous experience with the drug. More patients receiving placebo (13.4%) discontinued treatment for an adverse event than those receiving Humira (6.9% in the 40 mg QOW and 4.7% in the 40 mg QW group).

Two randomized controlled Phase III trials, PRECiSE 1 and PRECiSE 2, demonstrated the safety and efficacy of Cimzia 400 mg SC at Weeks 0, 2, 4 and then every four weeks versus placebo for up to 24 weeks. In the induction study, patients who had C-reactive protein (CRP) levels >10 mg/L at baseline who were treated with certolizumab had higher response rates than placebo-treated patients (37% versus 26%; p=0.04) at Week 6. In the overall population, response rates were significantly higher with certolizumab vs. placebo (23% versus 16%; p=0.02). There were no significant differences in remission rates at Week 6 or 26 between certolizumab and placebo. Overall, certolizumab was well tolerated. The other trial investigated the efficacy of maintenance therapy in patients that had completed a standard induction course. In this study 64% of all initially enrolled patients achieved a clinical response (decrease in CDAI ≥150) at 6-weeks. Certolizumab produced significantly better maintenance of clinical response than placebo through Week 26 (62% versus 34%, p < 0.001) in patients with CRP ≥ 10 mg/L. Maintenance treatment with CIMZIA showed significantly better remission rates than placebo at Week 26 (48% versus 29%, p < 0.001) in the ITT population. The adverse event profiles observed in these studies was similar to that seen with other anti-TNF agents.

The ENCORE, ENACT-1 and ENACT-2 trials found that the use of Tysabri in adults with moderate to severe CD significantly increased the percent of patients with a clinical response and those in clinical remission. In patients shown to be responders after 12-weeks of induction therapy, response rates and remission rates were significantly greater with Tysabri.

The percent of patients with sustained remission after withdrawal of oral steroids was also significantly greater with Tysabri versus placebo at Weeks 36 and 60. For assessment of quality of life, patients treated with Tysabri experienced statistically and clinically significant improvements in both general measures (SF-36) and disease specific measures (IBDQ) beginning at Week 24 and continuing through Week 60 compared with placebo. From Week 24 through 60, patients treated with Tysabri had quality of life scores consistent with remission.

A 12-week trial in CD patients found a significantly higher incidence of headache, nasopharyngitis, and hypersensitivity-like reactions at Week 12. Development of anti-natalizumab antibodies at any post-baseline visit through Week 12 was more common with natalizumab vs. placebo. Exacerbation of CD and discontinuations due to adverse events were more common with placebo than with Tysabri at Week 60. There was a higher incidence at
Week 60 of influenza with natalizumab compared to placebo. Viral infections were more common with natalizumab compared to placebo. At Week 12, there was a higher incidence of hypersensitivity reactions during infusion with natalizumab versus placebo.

Tysabri was initially approved for the treatment of multiple sclerosis in November 2004. It was withdrawn from the market by the manufacturer in February 2005 after three patients in clinical trials developed progressive multifocal leukoencephalopathy (PML). The FDA stopped clinical trials for the product in February 2005. Following no new cases of PML, the FDA allowed Tysabri to return to the market in June 2006 with the requirement of a risk minimization program to be in place to limit use. Patient registration and periodic follow-up is also required. In August 2008, two additional cases of PML were reported in European Tysabri patients, bringing the total to five. Both patients were taking the drug for multiple sclerosis. Both had received at least one year of therapy, and neither was receiving any other biologic immunomodulator concurrently. The implications for Crohn’s patients remain unclear.

The TOUCH® program requires distribution of Tysabri only through centralized or specialty pharmacies that have registered and follow the strict requirements of patient assessment, monitoring, education, and follow-up. Tysabri is currently only approved for monotherapy as it is unclear if the risks of PML increase with concurrent use of other immunosuppressives. Notably, the use of concomitant immunosuppressives was associated with PML in three cases, of which two patients were being treated for MS and one for CD.

The safety and efficacy of vedolizumab (Entyvio) were evaluated in 3 Phase III, double blinded, placebo controlled, multicenter, randomized clinical trials—two in Crohn’s disease and one in ulcerative colitis. There were total of 3,326 patients participated in these trials. There were high discontinuation rates across all arms of the trials (51% to 62%), most often for a lack of efficacy (59% to 69%). Discontinuation did not appear to be different between placebo and drug arms and intention-to-treat efficacy analysis was performed to generate the data.

GEMINI 2 trial shows efficacy of vedolizumab in patients with Crohn’s disease. The study populations had a mean duration of disease of 9 (SD: 7.8) years and 51% of patients were on glucocorticoids with median prednisone dose of 20 mg. At week 6, 15% of patients in the vedolizumab arm and 7% of the patients in the placebo arm had a clinical response (p=0.02). In the maintenance trial, which included only those responded to the induction therapy, 39% of those assigned to VDZ Q8W were in clinical remission at week 52, compared with 22% assigned to placebo (p<0.001). Clinical remission is defined as CDAI score ≤150. Durable clinical remission was 21% in the VDZ Q8W group compared with 14% in the placebo group (p=NS). Glucocorticoid-free remission was 32% in the VDZ Q8W compared with 16% in the placebo group (p=0.02).
GEMINI 3 trial tested the efficacy of vedolizumab in patients with Crohn’s disease, but it was discontinued after the induction phase due to lack of efficacy. The study authors explained that the statistically non-significant effect of vedolizumab as induction therapy could be related to the baseline disease severity and heavily pretreated disease state in the study population. Only the abstract is available on GEMINI 3 trial.

During the trial, 56 of 1434 (4%) of patients treated with vedolizumab had detectable anti-vedolizumab antibody at any time during the 52 weeks of continuous treatment. Nine of 56 patients were persistently positive for anti-vedolizumab antibody and 33 of 56 patients developed neutralizing antibodies to vedolizumab. Among eight of these nine subjects with persistently positive anti-vedolizumab antibody, six had undetectable and two had reduced vedolizumab concentrations. None of the nine subjects with persistently positive anti-vedolizumab antibody achieved clinical remission at Weeks 6 or 52 in the controlled trials.

In April 2013, Feuerstein, et al., reported results of a systematic review of treatment recommendations by international guidelines for Crohn’s disease. Of the 89% of guidelines that graded evidence, only 23% of treatment recommendations were supported by level A evidence, and 28% by level B; thus, approximately half the recommendations were based on lower quality evidence or expert opinion. This reflects the difficulties encountered in treating this perplexing disease. Policy updated to include new labeled indication of golimumab to treat ulcerative colitis. A full review of this policy will be scheduled later in the year.

August 2013: As the most recent U.S. and European guidelines for the treatment of adults with Crohn’s disease call into question the efficacy of 5-ASAs for induction or maintenance of remission for this condition, their use prior to approval of a TNF-α inhibitor is no longer a requirement in Crohn’s disease. The efficacy of 5-ASAs for induction or maintenance of remission in ulcerative colitis remains established and use prior to approval of a TNF α inhibitor remains a requirement in this condition.

However, several new themes or trends have been identified and should be followed. These included a potential new therapeutic goal of “deep remission”, defined as a Cohn disease activity index (CDAI) score <150 and complete mucosal healing on endoscopy. A Crohn’s Disease Digestive Damage Score (Lémann score) has been developed to measure cumulative bowel damage in patients with this condition. Similar to the Sharp score for assessing joint damage in rheumatoid arthritis (RA), the Lémann score may be used to assess the effect of various pharmacological therapies, function as a clinical trial endpoint, and allow better identification of high-risk patients in regard to identification or progression of bowel damage. Also analogous to RA, there is momentum growing in Crohn’s for use of disease modifying agents (eg, TNF-α inhibitors) early in the disease course to avoid later complications and need for surgery, particularly in patients with poor prognostic factors. Combination therapy with an
immunosuppressive and a TNF-α inhibitor is also promising. However, robust supporting scientific evidence for these emerging trends is still lacking. New compounds currently in phase II and/or III development for use in IBD include ustekinumab (Stelara®), Xeljanz® (tofacitinib), and vedolizumab.

Stelara® (ustekinumab)

Stelara® (ustekinumab) is a human IgG1κ monoclonal antibody that binds with specificity to the p40 protein subunit used by both the IL-12 and IL-23 cytokines. IL-12 and IL-23 are naturally occurring cytokines that are involved in inflammatory and immune responses, such as natural killer cell activation and CD4+ T-cell differentiation and activation. In in vitro models, ustekinumab was shown to disrupt IL-12 and IL-23 mediated signaling and cytokine cascades by disrupting the interaction of these cytokines with a shared cell-surface receptor chain, IL-12Rβ1. The cytokines IL-12 and IL-23 have been implicated as important contributors to the chronic inflammation that is a hallmark of Crohn’s Disease. In animal models of colitis, genetic absence or antibody blockade of the p40 subunit of IL-12 and IL-23, the target of ustekinumab, was shown to be protective.

Stelara (ustekinumab) was evaluated in three randomized, double-blind, placebo-controlled clinical studies in adult patients with moderately to severely active Crohn’s disease (Crohn’s Disease Activity Index [CDAI] score of 220 to 450). There were two 8-week intravenous induction studies (CD-1 and CD-2) followed by a 44-week subcutaneous randomized withdrawal maintenance study (CD-3) representing 52 weeks of therapy. Studies CD-1 and CD-2 In studies CD-1 and CD-2, 1409 patients were randomized, of whom 1368 (CD-1, n=741; CD-2, n=627) were included in the final efficacy analysis. Induction of clinical response (defined as a reduction in CDAI score of greater than or equal to 100 points or CDAI score of less than 150) at Week 6 and clinical remission (defined as a CDAI score of less than 150) at Week 8 were evaluated. In both studies, patients were randomized to receive a single intravenous administration of Stelara® at either approximately 6 mg/kg, placebo, or 130 mg (a lower dose than recommended).

In Study CD-1, patients had failed or were intolerant to prior treatment with a TNF blocker: 29% patients had an inadequate initial response (primary non-responders), 69% responded but subsequently lost response (secondary non-responders) and 36% were intolerant to a TNF blocker. Of these patients, 48% failed or were intolerant to one TNF blocker and 52% had failed 2 or 3 prior TNF blockers. At baseline and throughout the study, approximately 46% of the patients were receiving corticosteroids and 31% of the patients were receiving
immunomodulators (azathioprine, 6-mercaptopurine, methotrexate). The median baseline CDAI score was 319 in the Stelara approximately 6 mg/kg group and 313 in the placebo group.

In Study CD-2, patients had failed or were intolerant to prior treatment with corticosteroids (81% of patients), at least one immunomodulator (6-mercaptopurine, azathioprine, methotrexate; 68% of patients), or both (49% of patients). Additionally, 69% never received a TNF blocker and 31% previously received but had not failed a TNF blocker. At baseline, and throughout the study, approximately 39% of the patients were receiving corticosteroids and 35% of the patients were receiving immunomodulators (azathioprine, 6-mercaptopurine, methotrexate). The median baseline CDAI score was 286 in the STELARA and 290 in the placebo group. In these induction studies, a greater proportion of patients treated with Stelara achieved clinical response at Week 6 and clinical remission at Week 8 compared to placebo. Clinical response and remission were significant as early as Week 3 in Stelara treated patients and continued to improve through Week 8.

**Study CD-3**

The maintenance study (CD-3) evaluated 388 patients who achieved clinical response (≥100-point reduction in CDAI score) at Week 8 of induction with Stelara in studies CD-1 or CD-2. Patients were randomized to receive a subcutaneous maintenance regimen of either 90 mg STELARA every 8 weeks or placebo for 44 weeks. At Week 44, 47% of patients who received STELARA were corticosteroid-free and in clinical remission, compared to 30% of patients in the placebo group. At Week 0 of Study CD-3, 34/56 (61%) Stelara treated patients who previously failed or were intolerant to TNF blocker therapies were in clinical remission and 23/56 (41%) of these patients were in clinical remission at Week 44. In the placebo arm, 27/61 (44%) patients were in clinical remission at Week 0 while 16/61 (26%) of these patients were in remission at Week 44. At Week 0 of Study CD-3, 46/72 (64%) Stelara treated patients who had previously failed immunomodulator therapy or corticosteroids (but not TNF blockers) were in clinical remission and 45/72 (63%) of these patients were in clinical remission at Week 44. In the placebo arm, 50/70 (71%) of these patients were in clinical remission at Week 0 while 31/70 (44%) were in remission at Week 44. In the subset of these patients who were also naïve to TNF blockers, 34/52 (65%) of Stelara treated patients were in clinical remission at Week 44 as compared to 25/51 (49%) in the placebo arm. Patients who were not in clinical response 8 weeks after STELARA induction were not included in the primary efficacy analyses for Study CD-3; however, these patients were eligible to receive a 90 mg subcutaneous injection of Stelara® upon entry into Study CD-3. Of these patients, 102/219 (47%) achieved clinical response eight weeks later and were followed for the duration of the study.
Ulcerative Colitis (UC)

Remicade® (infliximab)

The safety and efficacy of Remicade were assessed in two randomized, double-blind, placebo-controlled clinical studies in 728 patients with moderately to severely active ulcerative colitis (UC) with an inadequate response to conventional oral therapies. In both studies, patients were randomized to receive either placebo, 5 mg/kg Remicade or 10 mg/kg Remicade at Weeks 0, 2, 6, 14 and 22.

Patients in study 1 had failed to respond or were intolerant to oral corticosteroids, 6-mercaptopurine (6-MP), or azathioprine (AZA). Patients in study 2 had failed to respond or were intolerant to the above treatments and/or aminosalicylates. Similar proportions of patients in studies 1 and 2 were receiving corticosteroids (61% and 51%, respectively), 6-MP/azathioprine (49% and 43%) and aminosalicylates (70% and 75%) at baseline. More patients in study 2 then 1 were taking solely aminosalicylates for UC (26% versus 11%, respectively). Clinical response was defined as a decrease from baseline in the Mayo score by 30% and 3 points, accompanied by a decrease in the rectal bleeding subscore of 1 or a rectal bleeding subscore of 0 or 1.

In both studies, greater percentages of patients in both Remicade groups achieved a clinical response, a sustained clinical response (response at both Weeks 8 and 30), clinical remission and other assessed clinical outcomes than in the placebo group. Of patients on corticosteroids at baseline, greater proportions of patients in the Remicade treatment groups were in clinical remission and able to discontinue corticosteroids at Week 30 compared with the patients in the placebo treatment groups (22% in Remicade treatment groups vs. 10% in placebo group in study 1; 23% in Remicade treatment groups vs. 3% in placebo group in study 2). Clinical outcomes were generally similar in the Remicade 5 mg/kg and 10 mg/kg dose groups.

Humira® (adalimumab)

After positive reports in small open-label trials, the safety and efficacy of adalimumab (Humira) was assessed in a multicenter, double-blinded randomized controlled trial in patients with moderate to severe ulcerative colitis who were anti-TNF naïve and on stable suppressive therapy with oral corticosteroids and/or immunomodulators. A total of 576 patients were randomized to receive either placebo, high dose (HD), or low dose (LD) adalimumab. HD was 180/60/40/40mg and LD was 80/40/40/40mg of adalimumab at Weeks 0, 2, 4, 6, respectively. Clinical remission
was defined as a Mayo score ≤ 2 with subscores no greater than 1. Secondary outcomes included absolute score decrease plus decrease in rectal bleeding subscore, proportion with mucosal healing, and proportion with mild disease (including physician global assessment [PGA], rectal bleeding, and stool frequency subscores). Because the European regulatory authorities wanted to include a LD of adalimumab, there were two parts to the study, a 1:1 with HD (n=186) and a 1:1:1 portion of the study (n=390); results were pulled from the latter.

Twice as many patients reached clinical remission at Week 8 with HD (p=0.031) therapy, while LD patients were not significantly different versus placebo. Of the secondary outcomes, subscores in rectal bleeding and PGA showed improvement with significance vs. placebo in the HD arm. Patients with higher baseline CRP levels had less instances of remission, and higher placebo rates were seen in Canadian and Eastern European centers than those in the US. Discontinuation rates were similar in each arm, with UC being the most common reason. Injection site pain was minimal and infection incidence was similar across groups, and malignancy was only seen in the placebo arm.

**Simponi® (golimumab)**

The safety and efficacy of golimumab (Simponi) were evaluated in two multi-center, randomized, double-blind, placebo-controlled clinical trials in patients ≥ 18 years of age (Trials UC-1 and UC-2). Trial UC-1 was an induction trial conducted in patients with moderately to severely active UC, defined as a Mayo score of 6 to 12 [the Mayo score ranges from 0 to 12 and has four subscales that are each scored from 0 (normal) to 3 (most severe): stool frequency, rectal bleeding, findings on endoscopy, and physician global assessment]. At baseline, subjects also had an endoscopy subscore of 2 or 3 on a 3-point scale (an endoscopy score of 2 is defined by marked erythema, absent vascular pattern, friability, erosions; and a score of 3 is defined by spontaneous bleeding, ulceration). Patients were corticosteroid dependent (ie, an inability to successfully taper corticosteroids without a return of the symptoms of UC) or had an inadequate response to or had failed to tolerate at least one of the following therapies: oral aminosalicylates, oral corticosteroids, azathioprine, or 6-mercaptopurine.

Trial UC-1 was divided into 2 parts. In Part 1 (dose finding), patients were randomized to one of 4 treatment groups: 400 mg golimumab administered subcutaneously (SC) at Week 0 and 200 mg at Week 2 (400/200 mg), 200 mg golimumab SC at Week 0 and 100 mg at Week 2 (200/100 mg), 100 mg golimumab SC at Week 0 and 50 mg at Week 2 (100/50 mg), or placebo SC at Weeks 0 and 2. golimumab 100/50 mg SC was not evaluated in
Part 2; its safety and effectiveness has not been established in UC. Concomitant stable doses of oral aminosalicylates (5-ASA), oral corticosteroids (less than 40 mg/day), azathioprine (AZA), 6-mercaptopurine (6-MP), and/or methotrexate (MTX) were permitted. Patients who received previous TNF inhibitors were excluded. The primary endpoint was the percent of patients in clinical response at Week 6, defined as a decrease from baseline in the Mayo score by ≥30% and ≥3 points, accompanied by a decrease in the rectal bleeding subscore of ≥1 or a rectal bleeding subscore of 0 (no blood seen) or 1 (streaks of blood with stool less than half the time).

Trial UC-2 was a randomized-withdrawal maintenance trial that evaluated 463 patients who achieved clinical response with golimumab induction and tolerated golimumab treatment. Patients were randomized to receive golimumab 50 mg, golimumab 100 mg or placebo administered subcutaneously every 4 weeks. Concomitant stable doses of oral aminosalicylates, azathioprine, 6-mercaptopurine, and/or methotrexate were permitted. Corticosteroids were to be tapered at the start of the maintenance trial. The primary endpoint was the percent of patients maintaining clinical response through Week 54.

In Trial UC-1, a greater proportion of patients achieved clinical response, clinical remission and had improvement of endoscopic appearance of the mucosa at Week 6 in the golimumab 200/100 mg group compared with the placebo group. The golimumab 400/200 mg group did not demonstrate additional clinical benefit over the golimumab 200/100 mg group. Clinical remission was defined as a Mayo score ≤ 2 points, with no individual subscore > 1. Improvement of endoscopic appearance of the mucosa was defined as a Mayo endoscopy subscore of 0 (normal or inactive disease) or 1 (erythema, decreased vascular pattern, mild friability).

In Trial UC-2, a greater proportion of patients maintained clinical response through Week 54 in the golimumab 100 mg group compared with the placebo group. In Trial UC-2, golimumab-treated patients in clinical response (which included the subset of patients in clinical remission) in Trial UC-1, were again assessed for clinical remission at Week 30 and Week 54. A greater proportion of patients achieved clinical remission at both Weeks 30 and 54 without demonstrating a loss of response at any time point through Week 54 in the golimumab 100 mg group compared with the placebo group.

**Entyvio® (vedolizumab)**

The GEMINI 1 trial tested the efficacy of vedolizumab in patients with ulcerative colitis. The study populations had a mean duration of disease of 6.9 (SD: 6.4) years and 53% of patients were on glucocorticoids with median prednisone dose of 20 mg. At week 6, 47.1% of patients in the
vedolizumab arm and 25.5% of the patients in the placebo arm had a clinical response (p<0.001). In the maintenance trial, which included only those responded to the induction therapy, 41.8% of those assigned to VDZ Q8W were in clinical remission at week 52, compared with 15.9% assigned to placebo (p<0.001). Clinical remission is defined as complete Mayo score of ≤2 points and no individual subscore >1 point. Durable clinical remission was 20.5% in the VDZ Q8W group compared with 8.7% in the placebo group (p=0.008). Glucocorticoid-free remission was 31.4% in the VDZ Q8W compared with 13.9% in the placebo group (p<0.001).

**Xeljanz® (tofacitinib)**

Xeljanz® (tofacitinib) 10mg twice daily was studied in two eight-week induction trials, OCTAVE Induction 1 (n=598) and Induction 2 (n=541), in moderate-severe ulcerative colitis in patients previously treated with TNF-α antagonists. The primary end point was remission at 8 weeks. Patients achieving remission were randomized to continue on maintenance therapy with either 5 or 10 mg twice daily or placebo. The primary end point was remission at 52 weeks. In OCTAVE Induction 1, remission at 8 weeks occurred in 18.5% of the tofacitinib patients versus 8.2% in the placebo group (P = 0.007); in OCTAVE Induction 2, remission occurred in 16.6% versus 3.6% (P<0.001). In the OCTAVE Sustain trial, 34.3% of the patients in the 5-mg group and 40.6% in the 10-mg group versus 11.1% in the placebo group (P<0.001 for both comparisons with placebo). In OCTAVE Induction, rates of serious infection were higher with tofacitinib than placebo. In OCTAVE Sustain, the rate of serious infection was similar across the three treatment groups, and the rates of overall infection and herpes zoster infection were higher with tofacitinib than placebo. Across all three trials, nonmelanoma skin cancer occurred in five tofacitinib patients and one placebo patient. Cardiovascular events occurred in five tofacitinib and no placebo patients. Tofacitinib was associated with increased lipid levels versus placebo.

**Zeposia® (ozanimod)**

The efficacy and safety of ozanimod were evaluated in two multicenter, randomized, double-blind, placebo-controlled clinical studies [UC Study 1 (induction) and UC Study 2 (maintenance) (NCT02435992)] in adult patients with moderately to severely active ulcerative colitis.

In UC Study 1, a total of 645 patients were randomized 2:1 to either ozanimod 0.92 mg given orally once daily or placebo for 10 weeks, beginning with a dosage titration. The trial included adult patients with moderately to severely active UC who had an inadequate response or were intolerant to any of the following: oral aminosalicylates, corticosteroids, immunomodulators
(e.g., 6-mercaptopurine and azathioprine), or a biologic (e.g., TNF blocker and/or vedolizumab). Patients were required to be on stable doses of oral aminosalicylates and/or corticosteroids (prednisone daily dose up to 20 mg equivalent or budesonide extended-release tablets) prior to enrollment. Seventy-one percent of patients were receiving mesalamine, 13% sulfasalazine, and 33% oral corticosteroids. A total of 30% of patients had previously failed or were intolerant to TNF blockers. Of these patients, 63% received at least two biologics including TNF blockers. The primary endpoint was clinical remission at Week 10, defined using a 3-component Mayo score without the physician global assessment: rectal bleeding subscore = 0, stool frequency subscore = 0 or 1 (and a decrease of ≥ 1 point from the baseline stool frequency subscore), and endoscopy subscore = 0 or 1 (an endoscopy subscore of 0 defined as normal or inactive disease, and an endoscopy subscore of 1 defined as presence of erythema, decreased vascular pattern and no friability). A significantly greater proportion of patients treated with ozanimod achieved clinical remission, clinical response, endoscopic improvement, and endoscopic-histologic mucosal improvement compared to placebo at Week 10.

In UC Study 2, a total of 457 patients who received ozanimod in either UC Study 1 or in an open-label arm and achieved clinical response at Week 10 were re-randomized 1:1 and were treated with either ozanimod 0.92 mg (n=230) or placebo (n=227) for 42 weeks (UC Study 2), for a total of 52 weeks of treatment. Patients were permitted to be on stable doses of oral aminosalicylates. Corticosteroid tapering was required upon entering this study for patients who were receiving corticosteroids during the induction period. Concomitant oral immunomodulators or biologic therapies were not permitted. At study entry, 35% of patients were in clinical remission; 29% of patients were on corticosteroids; and 31% of patients had an inadequate response, loss of response, or intolerance to TNF blockers. The primary endpoint was the proportion of patients in clinical remission at Week 52. After Week 52, 37% of ozanimod treated patients and 19% percent of placebo treatment patients had clinical remission for a treatment difference of 19% (p<0.0001).

Toxicities of TNF-α Antagonists

There have been no prospective trials evaluating safety among the TNF-α inhibitors. The risk of malignancies and serious infections has been studied to some depth retrospectively with the three older agents (adalimumab, etanercept and infliximab). The FDA did a meta-analysis of the available data in 2006 and found that the malignancy rates of patients on TNF-α inhibitors are no higher than what is to be expected in this patient population. Another study done in 2007 found a higher incidence of cutaneous cancers among the TNF-α inhibitor treated patients, irrespective of the agent. The newer agents are limited in their data breadth to demonstrate
safety with respect to malignancies, but so far they compare similarly to the older agents. Long-term safety evaluations are necessary to validate this finding.

With regards to serious infections and tuberculosis, there are higher rates of serious infections while on the TNF-α inhibitors, compared to MTX alone. However, the retrospective studies do not come to an agreement on the actual risk. Infliximab showed higher rates of any infection compared to etanercept and adalimumab, and also showed higher rates of serious infections with the 10mg/kg dosing regimen versus the 3mg/kg dosing regimen. The newer agents (certolizumab and golimumab) showed increased risk of serious infections, but this data is not comparable with the older agents. This class of agents also has been associated with hepatitis B reactivation, CHF exacerbations, and new onset or exacerbation of demyelinating disorders.

2018 Update

A literature search was conducted from March 1, 2017, to March 5, 2018. No new studies were found that would require changes to policy. Toxicities of TNF inhibitors section revised to exclude non-IBD disease states.

2019 Update

A literature search was conducted from March 1, 2018, to May 31, 2019. No new studies were found that would require changes to policy.

2021 Update

Reviewed prescribing information for all drugs. No new evidence was identified that would require changes to drugs listed in this policy. Updated initial authorization duration for Stelara (ustekinumab) IV to 30-days to match policy criteria.

References


31. Strand V, Keininger DL, Tahiri-Fitzgerald E. Certolizumab pegol results in clinically meaningful improvements in physical function and health-related quality of life in patients with active rheumatoid arthritis despite treatment with methotrexate. Presented at: American College of Rheumatology; November 7-11, 2007; Boston, MA.


<table>
<thead>
<tr>
<th>Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/01/16</td>
<td>Interim review, approved October 11, 2016. Clarified age criteria language indicating that site of service review is applicable to only those age 13 and older; drug criteria review applies to all ages. Inclusion of Stelara with its new indication for use in Crohn’s disease (along with the description and clinical trials information).</td>
</tr>
<tr>
<td>12/01/16</td>
<td>Interim review, approved November 8, 2016. Clarification added regarding Inflectra’s covered indications: not approved for pediatric UC.</td>
</tr>
<tr>
<td>03/14/17</td>
<td>Annual review, changes to become effective April 1, 2017. Added administration route to each drug, as well as included a statement on the status of IV agents being processed exclusively through the medical benefit.</td>
</tr>
<tr>
<td>03/22/17</td>
<td>Interim update. Cimzia in the setting of Crohn’s disease now has an extra step that requires a trial and failure of either Humira or Stelara. Effective April 1, 2017.</td>
</tr>
<tr>
<td>04/10/17</td>
<td>Interim update. Policy section updated with infliximab (Remicade) IV and vedolizumab (Entyvio) moving to first-line agents, considered medically necessary as when criteria are met.</td>
</tr>
<tr>
<td>05/05/17</td>
<td>Minor update; added hyperlinks and step therapy graphs.</td>
</tr>
<tr>
<td>07/01/17</td>
<td>Interim review, approved June 13, 2017. Added coverage criteria for Renflexis (infliximab-abda). Added adalimumab step to Stelara SC.</td>
</tr>
<tr>
<td>07/14/17</td>
<td>Coding updated, added HCPCS code Q9989 (new code effective 7/1/17).</td>
</tr>
<tr>
<td>11/01/17</td>
<td>Interim Review, approved October 3, 2017. Clarified site of service exception criterion related to access: There is no outpatient infusion center within 50 miles of the patient’s home and there is no contracted home infusion agency that will travel to their home, or a hospital is the only place that offers infusions of this drug.</td>
</tr>
<tr>
<td>01/01/18</td>
<td>Coding update; added HCPCS code J3358 (new code effective 1/1/18).</td>
</tr>
<tr>
<td>02/14/18</td>
<td>Interim Review, approved February 6, 2018. Stelara has been moved from second line agent to first line agent for Crohn’s Disease with removal of mandatory step through Humira in criteria. Approved February 13, 2018, to update hospital-based outpatient coverage from 30 days to 90 days.</td>
</tr>
<tr>
<td>04/01/18</td>
<td>Coding update: added new HCPCS codes QS103 and QS104 (effective 4/1/18), noted that QS102 terminated 4/1/18.</td>
</tr>
<tr>
<td>05/01/18</td>
<td>Annual Review, approved April 18, 2018. A literature search was conducted from 3/1/2017 to 3/5/2018. No new studies were found that would require changes to policy. Toxicities of TNF inhibitors section revised to exclude non-IBD disease states.</td>
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<tr>
<td>06/01/18</td>
<td>Added suppositories as one of the options for corticosteroid and mesalamine products for ulcerative colitis. Dosing table was removed.</td>
</tr>
<tr>
<td>08/01/18</td>
<td>Interim Review approved July 13, 2018. Added criteria and references for tofacitinib to treat ulcerative colitis.</td>
</tr>
<tr>
<td>11/01/18</td>
<td>Minor update, the Site of Service criteria was updated for clarity.</td>
</tr>
<tr>
<td>01/01/19</td>
<td>Interim Review, approved December 13, 2018. Clarified criteria for Humira under the ulcerative colitis section.</td>
</tr>
<tr>
<td>02/01/19</td>
<td>Interim Review, approved January 8, 2019. Added tofacitinib to first-line treatment for ulcerative colitis.</td>
</tr>
<tr>
<td>03/01/19</td>
<td>Coding update: removed HCPCS code Q5102. Also added link to future version of policy that becomes effective June 9, 2019.</td>
</tr>
<tr>
<td>06/21/19</td>
<td>Revised the effective date of the updated policy from July 1, 2019, to July 31, 2019.</td>
</tr>
<tr>
<td>07/01/19</td>
<td>Annual Review, approved June 20, 2019. No changes to policy coverage criteria.</td>
</tr>
<tr>
<td>07/18/19</td>
<td>Removed link and note regarding updated policy.</td>
</tr>
<tr>
<td>09/01/19</td>
<td>Interim Review, approved August 22, 2019. Updated criteria for Cimzia.</td>
</tr>
<tr>
<td>11/01/19</td>
<td>Interim Review, approved October 8, 2019. Updated criteria for Xeljanz and Simponi SC when used for ulcerative colitis.</td>
</tr>
<tr>
<td>02/01/20</td>
<td>Interim Review, approved January 23, 2020. Added Xeljanz XR for UC with Xeljanz. Added Avsola (infliximab-axxq) to same status as Inflectra and Renflexis and removed note for non-indication for pediatric UC, now have indication per PI for all 3 agents. Added investigational table next to not medically necessary table for clarity and changed not medically necessary language. Added HCPCS code J3590 to report Avsola only.</td>
</tr>
<tr>
<td>07/01/20</td>
<td>Interim Review, approved June 18, 2020. Added Avsola as drug subject to site of service review. Changes to Avsola for site of service review are effective for dates of service on or after October 2, 2020, following 90-day provider notification. Effective July 1, 2020: Updated the Investigational table to include quantities that exceed the FDA labeled dosing for condition. Updated Stelara criteria for IV dosage form to a one-time induction dose. Removed J3590 and added Q5121 for Avsola.</td>
</tr>
<tr>
<td>10/01/20</td>
<td>Annual Review, approved September 8, 2020, effective January 1, 2021. Updated coverage criteria for Tysabri (natalizumab) adding trial and treatment failure with one prior agent. Added site of service review for Tysabri (natalizumab) for dates of service on or after January 1, 2021.</td>
</tr>
<tr>
<td>Date</td>
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<tr>
<td>01/01/21</td>
<td>Interim Review, approved December 8, 2020. Updated Stelara (ustekinumab) coverage criteria from second-line to first-line therapy for the treatment of ulcerative colitis. For Crohn’s disease medications updated the coverage criteria for Avsola, Cimzia, Entyvio, Humira, Inflectra, Remicade, Renflexis, Stelara, and Tysabri to require adequate trial and treatment failure with one corticosteroid or one other agent for Crohn’s disease. For ulcerative colitis medications updated the coverage criteria for Avsola, Entyvio, Humira, Inflectra, Remicade, Renflexis, Simponi, and Stelara to require adequate trial and treatment failure with one systemic agent. Added HCPCS code J3590 for Simponi®.</td>
</tr>
<tr>
<td>05/01/21</td>
<td>Annual Review, approved April 22, 2021. Updated initial authorization duration for Stelara (ustekinumab) IV to 30-days.</td>
</tr>
<tr>
<td>08/01/21</td>
<td>Interim Review, approved July 13, 2021. Added coverage criteria for Zeposia (ozanimod) for the treatment of ulcerative colitis.</td>
</tr>
<tr>
<td>01/01/22</td>
<td>Interim Review, approved December 21, 2021. Changed the re-authorization duration from 1-year to 3 years.</td>
</tr>
</tbody>
</table>

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2022 Premera All Rights Reserved.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.
Discrimination is Against the Law

Premera Blue Cross complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Premera:
• Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  • Qualified sign language interpreters
  • Written information in other formats (large print, audio, accessible electronic formats, other formats)
• Provides free language services to people whose primary language is not English, such as:
  • Qualified interpreters
  • Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Civil Rights Coordinator - Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5592. TTY 800-842-5357
Email AppealsDepartmentInquiries@Premera.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost.

Call 800-722-1471 (TTY: 800-842-5357).

Arabic (Arabic):

يوجد في هذا الإشعار معلومات هامة. قد يوجد في هذا الإشعار معلومات مهمة لمصلحة طبيك أو الطبيبة في هذا الإشعار. قد تحتاج للاطلاع على توضيحات هذه المعلومات. تعتبر هذه المعلومات وضعت بموجب قانون Premera Blue Cross. في هذه المعلومات، يمكن أن تكون هناك ترتيبات مالية، أو تقديم خدمات في فن للكشف، قبل كلفة الخدمات على هذه المعلومات. ستكونIK 800-722-1471 (TTY: 800-842-5357).

Chinese (Chinese):

本通知有重要的訊息。本通知可能有關於您透過 Premera Blue Cross 提交的申請或保險的重要訊息。本通知內可能有重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 800-722-1471 (TTY: 800-842-5357).

Oromo (Cushite):


Français (French):


Kreyòl ayisyen (Creole):


Deutsche (German):


Hmoob (Hmong):

Tsaab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb. Tjex daum tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog kog daim ntawv thov kov keb pa los yog kog qhov kov keb pa los ntawm Premera Blue Cross. Tjex daum cov hnub tseem ceeb uas sau rau hauv daim ntawm no. Tjex daum kog kuv jayu uaa qee yam uas pek bom kog kuv tsab pu dhaa cov caj nyong uas teev tsab rau hauv daim ntawm no maw gaj koj kuv jayu uaa baas cov keb pa los kuv bom caij caj nyong uas saaw hauv daim ntawm thov keb pa los yog kog qhov kov keb pa. Tjex daum cov kouv jayu uaa qee yam uas pek bom kog kuv tsab pu dhaa cov caj nyong uas teev tsab rau hauv daim ntawm no maw gaj koj kuv jayu uaa baas cov keb pa los kuv bom caij caj nyong uas saaw hauv daim ntawm thov keb pa los yog kog qhov kov keb pa.

Illoko (Illocano):

Daytowy a pakdaar ket naglaon iti Napateg nga Impormasion. Daytowy a pakdaar mabalin nga adda ket naglaon iti napateg nga impormasion mapianggep iti aplisayonono yowo coverage babaen iti Premera Blue Cross. Daytowy ket mabalin dagiti importante a petsa iti daytowy a pakdaar. Mabalin nga adda rumbeng nga aramideny ngi addang sabbay dagiti partikular a nitading nga adda aldaw tapo napagtagaliadayo ti coverage iti salun-ayyo yowo tulong kadagiti gastos. Adda karbangomo a mangala iti daytowy nga impormasion ken tulong iti bukodyo a pasagsao nga awan ti bayadanyo. Tumawag ti numero nga oswa 800-722-1471 (TTY: 800-842-5357).

Italiano (Italian):

Esta notificación puede contener información importante privada que podría afectar su derecho a la privacidad. Si desea obtener más información sobre cómo proteger su privacidad, lo invitamos a leer la sección "Información sobre la privacidad" en la página web de Premera Blue Cross.

es (Portuguese):
Este aviso poderá conter informações importantes privadas que possam afetar os direitos de privacidade. Se deseja obter mais informações sobre como proteger sua privacidade, nos aconselhamos a ler a seção "Informações sobre a privacidade" no site da Premera Blue Cross.

vi (Vietnamese):
Thông báo này có thể chứa thông tin quan trọng về quyền của bạn. Nếu bạn muốn biết thêm thông tin về quyền riêng tư, xin vui lòng xem phần "Thông tin về quyền riêng tư" trên trang web của Premera Blue Cross.