



STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES



Office of Pharmacy Service
Prior Authorization Criteria

Remicade® (infliximab)
[Prior Authorization Request Form](#)

Effective 10/01/2017

REMICADE is a tumor necrosis factor (TNF) blocker indicated for:

- Crohn's Disease
- Pediatric Crohn's Disease
- Ulcerative Colitis
- Pediatric Ulcerative Colitis
- Rheumatoid Arthritis (in combination with methotrexate)
- Ankylosing Spondylitis
- Psoriatic Arthritis
- Plaque Psoriasis

Prior authorization requests for Remicade may be approved if the following criteria are met:

1. Patient must be at least 6 years of age; **AND**
2. Request must be for an FDA-approved age and indication; **AND**
3. Request must be made by, or in consultation with, an appropriate specialist; **AND**
4. Patient must have records indicating unsatisfactory clinical results after 90 day trials of Humira, Enbrel and Cosentyx for all FDA-approved indications held in common by these medications. All prior authorization criteria that apply to Humira, Enbrel and Cosentyx must also be satisfied before Remicade will be approved.

References

- 1.) Lexi-Comp drug monograph for Remicade (Reviewed 7/06/2017)
- 2.) Remicade Package Insert (updated 10/2015)
- 3.) UpToDate clinical monograph (reviewed 7/6/2017)