

Infliximab (for Ohio Only)

Policy Number: CSOH2025D0004.B

Effective Date: March 1, 2025

[Instructions for Use](#)

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Related Policy

- [Maximum Dosage and Frequency \(for Ohio Only\)](#)

Application

This Medical Benefit Drug Policy only applies to the state of Ohio. Any requests for services that are stated as unproven or services for which there is a coverage or quantity limit will be evaluated for medical necessity using Ohio Administrative Code 5160-1-01.

Coverage Rationale

This policy refers to the following infliximab products:

- Avsola® (infliximab-axxq)
- Inflectra® (infliximab-dyyb)
- Remicade® (infliximab)
- Renflexis® (infliximab-abda)

Avsola, Inflectra, Remicade, and Renflexis are considered medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the [Ohio Department of Medicaid Unified Preferred Drug List Criteria](#).

Policy History/Revision Information

Date	Summary of Changes
04/01/2025	<ul style="list-style-type: none"> Updated reference link to the <i>Ohio Department of Medicaid Unified Preferred Drug List Criteria</i> (no change to policy guidelines)
03/01/2025	<p>Title Change</p> <ul style="list-style-type: none"> Previously titled <i>Infliximab (Avsola®, Inflectra®, Remicade®, & Renflexis®) (for Ohio Only)</i> <p>Coverage Rationale</p> <ul style="list-style-type: none"> Added language to indicate Avsola, Inflectra, Remicade, and Renflexis are considered medically necessary in certain circumstances; for medical necessity clinical coverage criteria for non-oncology indications, refer to the <i>Ohio Department of Medicaid Unified Preferred Drug List Criteria</i> Removed language indicating Infliximab is proven and medically necessary for the treatment of certain conditions outlined within the InterQual® criteria; for medical necessity clinical coverage criteria for non-oncology indications, refer to the current release of the InterQual® CP: Specialty Rx Non-Oncology: <ul style="list-style-type: none"> ○ Infliximab (Remicade) ○ Infliximab-abda (Renflexis) ○ Infliximab-axxq (Avsola) ○ Infliximab-dyyb (Inflectra)

Date	Summary of Changes
	Supporting Information <ul style="list-style-type: none">Removed <i>Applicable Codes</i> sectionArchived previous policy version CSOH2024D0004.A

Instructions for Use

This Medical Benefit Drug Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state (Ohio Administrative Code [OAC]), or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state (OAC), or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state (OAC), or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state (OAC), or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Benefit Drug Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Benefit Drug Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.