Reference number(s)
3499-A

SPECIALTY GUIDELINE MANAGEMENT

REDITREX (methotrexate injection)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications[1]

A. Rheumatoid Arthritis (RA) including Polyarticular Juvenile Idiopathic Arthritis (pJIA)
RediTrex is indicated in the management of selected adults with severe, active rheumatoid arthritis (RA) or children with active polyarticular juvenile idiopathic arthritis (pJIA), who have had an insufficient therapeutic response to, or are intolerant of, an adequate trial of first-line therapy including full dose non-steroidal anti-inflammatory agents (NSAIDs).

B. Psoriasis
RediTrex is indicated in adults for the symptomatic control of severe, recalcitrant, disabling psoriasis that is not adequately responsive to other forms of therapy, but only when the diagnosis has been established, as by biopsy and/or after dermatologic consultations. It is important to ensure that a psoriasis "flare" is not due to an undiagnosed concomitant disease affecting immune responses.

Limitations of use:
RediTrex is not indicated for the treatment of neoplastic diseases

All other indications are considered experimental/investigational and not medically necessary.

II. DOCUMENTATION

Submission of the following information is necessary to initiate the prior authorization review:

A. Chart notes, medical record documentation, or claims history supporting previous use of generic oral methotrexate and inadequate response or intolerance to therapy.
B. Chart notes or medical record documentation of member's inability to prepare and administer generic injectable methotrexate.

III. CRITERIA FOR INITIAL APPROVAL

Authorization of 12 months may be granted for treatment of rheumatoid arthritis (RA), polyarticular juvenile idiopathic arthritis (pJIA), or psoriasis when BOTH of the following criteria are met:

A. Member has tried and had an inadequate response or intolerance to generic oral methotrexate.
B. Member has inability to prepare and administer generic injectable methotrexate.

IV. CONTINUATION OF THERAPY

Authorization of 12 months may be granted for all members (including new members) who meet ALL initial authorization criteria and achieve or maintain positive clinical response after at least 3 months of therapy with RediTrex as evidenced by low disease activity or improvement in signs and symptoms of the condition.

V. REFERENCES

1. RediTrex [package insert]. Nashville, TN: Cumberland Pharmaceuticals, Inc; August 2020.