Clinical Policy: Siltuximab (Sylvant)

Reference Number: CP.PHAR.329
Effective Date: 03.01.17
Last Review Date: 02.22
Line of Business: HIM, Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Siltuximab (Sylvant®) is an interleukin-6 (IL-6) antagonist.

FDA Approved Indication(s)

Sylvant is indicated for the treatment of patients with multicentric Castleman's disease (MCD) who are human immunodeficiency virus (HIV) negative and human herpesvirus-8 (HHV-8) negative.

Limitation(s) of use: Sylvant was not studied in patients with MCD who are HIV positive or HHV-8 positive because Sylvant did not bind to virally produced IL-6 in a nonclinical study.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Sylvant is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Castleman's Disease (must meet all)**:**

1. Diagnosis of Castleman's disease (CD) (a B-cell lymphoma subtype) confirmed by biopsy of involved tissue (usually a lymph node);
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Sylvant is prescribed in one of the following ways (a or b):
   a. As single-agent therapy for MCD;
   b. As single-agent therapy for relapsed or refractory unicentric CD (UCD) (off-label);
5. Documented negative tests for human immunodeficiency virus (HIV) and human herpesvirus-8 (HHV-8);
6. Request meets one of the following (a or b):*
   a. Dose does not exceed 11 mg/kg every 3 weeks.
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration: 6 months

B. Cytokine Release Syndrome (off-label) (must meet all):
1. Member has a scheduled chimeric antigen receptor (CAR) T cell therapy (e.g., Kymriah™, Yescarta™, Abecma®, Tecartus®, Breyanzi®);
2. Sylvant is prescribed in one of the following ways (a or b):
   a. For the management of grade 4 CRS that is refractory to high-dose corticosteroids and anti-IL-6 therapy;
   b. As a replacement for the second dose of Actemra® when supplies are limited or unavailable for CRS or immunotherapy related neurotoxicity;
3. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: Up to 4 doses total

C. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: HIM.PA.33 for health insurance marketplace and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: HIM.PA.103 for health insurance marketplace and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: HIM.PA.154 for health insurance marketplace and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Castleman's Disease (must meet all)**:**
1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Sylvant for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed 11 mg/kg every 3 weeks;
   b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

   **Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration: 12 months

B. Cytokine Release Syndrome (off-label) (must meet all):
1. Documentation supports that member is currently receiving Sylvant for CAR T cell-induced CRS and member has not yet received 4 doses total;
2. Member is responding positively to therapy;

3. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: Up to 4 doses total

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: HIM.PA.33 for health insurance marketplace and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: HIM.PA.103 for health insurance marketplace and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: HIM.PA.154 for health insurance marketplace and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – HIM.PA.154 for health insurance marketplace and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CAR: chimeric antigen receptor
CD: Castleman's disease
CRS: cytokine release syndrome
FDA: Food and Drug Administration
HHV-8: negative and human hperesvirus-8
HIV: human immunodeficiency virus
MCD: multicentric Castleman's disease
UCD: unicentric Castleman's disease

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): severe hypersensitivity reaction to siltuximab or any of the excipients in Sylvant
- Boxed warning(s): none reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
CD	11 mg/kg over 1 hour IV every 3 weeks	11 mg/kg

VI. Product Availability

Lyophilized powder in a single-use vial: 100 mg and 400 mg

VII. References

1. Sylvant Prescribing Information. Horsham, PA: Janssen Biotech, Inc.; December 2019. Available at https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/125496s018lbl.pdf. Accessed September 29, 2021.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.nccn.org. Accessed September 29, 2021.
3. B-Cell Lymphomas Version 5.2021. National Comprehensive Cancer Network Guidelines. Available at https://www.nccn.org/professionals/physician_gls/pdf/b-cell.pdf. Accessed September 29, 2021.
4. Management of Immunotherapy-Related Toxicities Version 4.2021. National Comprehensive Cancer Network Guidelines. Available at https://www.nccn.org/professionals/physician_gls/pdf/immunotherapy.pdf. Accessed September 29, 2021.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J2860	Injection, siltuximab, 10 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q18 annual review: No significant changes; References reviewed and updated.	11.20.17	02.18
1Q 2019 annual review: added prescriber requirement; allowed COC for continued approval; added option for off-label dosing as supported by guidelines or literature; references reviewed and updated.	11.20.18	02.19
1Q 2020 annual review: added HIM line of business; references reviewed and updated.	11.08.19	02.20
1Q 2021 annual review: lab parameters removed from criteria sets given they do not represent a treatment contraindication; no significant changes; references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.	10.13.20	02.21
1Q 2022 annual review: added criteria set for NCCN compendium supported use for CRS associated with CAR or autologous T cell therapy; references reviewed and updated.	09.29.21	02.22
Template changes applied to other diagnoses/indications.	09.21.22	

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.