

Clinical Policy: Siltuximab (Sylvant)

Reference Number: LA.PHAR.329

Effective Date: 11.04.23

Last Review Date: ~~03.03.2024~~ 17.25

Line of Business: Medicaid

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

****Please note: This policy is for medical benefit****

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 Louisiana Healthcare Connections 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 \geq 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~~ surgically unresectable/ or if incomplete resection unicentric CD (UCD) (off-label);
5. Documented negative tests for HIV and 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~~ 12 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[®], Carvykti[®]);
2. Sylvant is prescribed in one of the following ways (a, b, or bc):
 - a. For the management of grade 4 cytokine release syndrome (CRS) that is refractory to high-dose corticosteroids and anti-IL-6 therapy;
 - b. As a replacement for the second dose of Actemra[®], Avtozma[®], Tofidence[™], or Tyenne[®] when supplies are limited or unavailable for CRS ~~or immunotherapy related neurotoxicity~~;
 - c. ~~Dose~~In addition to tocilizumab, and one of the following (i or ii):
 - i. For grade 2 CRS, symptoms persists for > 24 hours;
 - ii. For grade 3-4 CRS, symptoms persist despite combination therapy with tocilizumab and corticosteroids;
3. Dose is within FDA maximum limit for any FDA-approved indication or 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.*

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Approval duration: Up to 4 doses total

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C. Kaposi-sarcoma associated herpesvirus (KSHV)-Associated Inflammatory Cytokine Syndrome (KICS) (off-label) (must meet all):

1. Diagnosis of refractory or progressive KICS;
2. Prescribed by or in consultation with an oncologist;
3. Sylvant is prescribed in addition to current Kaposi sarcoma-directed systemic therapies (e.g., doxorubicin with rituximab, paclitaxel, sirolimus);
4. Dose is within FDA maximum limit for any FDA-approved indication or 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.*

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Approval duration: 12 months

C.D. 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 LA.PMN.255
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: LA.PMN.53 for Medicaid.~~

II. Continued Therapy

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

1. Currently receiving medication via Louisiana Healthcare Connections 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~~If request is for a dose increase, new dose is within FDA maximum limit for any FDA-approved indication or 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: Up to 4 doses total

C. Kaposi-sarcoma associated herpesvirus (KSHV)-Associated Inflammatory Cytokine Syndrome (KICS) (off-label) (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. Documentation supports that member is currently receiving Sylvant in addition to current Kaposi sarcoma-directed systemic therapies;
- 4. If request is for a dose increase, new dose is within FDA maximum limit for any FDA-approved indication or 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.D. 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 LA.PMN.255
- 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~~-LA.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 policy – LA.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

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CRS: cytokine release syndrome
FDA: Food and Drug Administration
HHV-8: negative and human
herpesvirus-8
HIV: human immunodeficiency virus

KICS: KSHV-associated inflammatory
cytokine syndrome
KSHV: Kaposi-sarcoma associated
herpesvirus
MCD: multicentric Castleman's disease
UCD: unicentric Castleman's disease

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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~~; ~~June 2024~~. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/125496s0181bl.pdf. Accessed ~~October 25, 2024~~; ~~November 6, 2025~~.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: www.nccn.org. Accessed; November ~~4, 2024~~; ~~2025~~.
3. ~~Castleman Disease Version 1.2024~~. National Comprehensive Cancer Network ~~Guidelines~~. ~~Castleman Disease Version 1.2026~~. Available at: https://www.nccn.org/professionals/physician_gls/pdf/castleman.pdf. Accessed; November ~~4, 2024~~; ~~2025~~.
4. ~~National Comprehensive Cancer Network~~. Management of ~~Immunotherapy~~ ~~CAR T-Cell and Lymphocyte Engager-Related Toxicities Version 2.2024~~. ~~National Comprehensive Cancer Network Guidelines.2026~~. Available at: https://www.nccn.org/professionals/physician_gls/pdf/immunotherapycellular_tox.pdf. Accessed; November ~~4, 2024~~; ~~2025~~.
- 4.5. ~~National Comprehensive Cancer Network~~. ~~Kaposi Sarcoma Version 2.2026~~. Available at: https://www.nccn.org/professionals/physician_gls/pdf/kaposi.pdf. Accessed: November ~~24, 2025~~.

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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-

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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	LDH Approval Date
Converted corporate to local policy.	06.19.23	10.05.23
Annual review: in CRS initial criteria, added Sylvant may be used to replace the second dose of Actemra OR Tofidence per NCCN; references reviewed and updated.	04.30.24	08.20.24
Added that Sylvant may be used to replace the second dose of Tyenne per NCCN; added Carvykti as an additional example of a CAR-T therapy; references reviewed and updated.	04.17.25	<u>07.14.25</u>
<u>Annual review: extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; in CRS initial criteria, added Avtozma may be used to replace the second dose of Tyenne per NCCN; for off-label UCD, revised usage from “relapsed or refractory” to “surgically unresectable/or if incomplete resection” per NCCN; for off-label CRS, removed option as replacement for second dose for immunotherapy related neurotoxicity and added option for usage in addition to toclizumab for grade 2-4 CRS per NCCN; added off-label indication for KICS per NCCN; references reviewed and updated.</u>	<u>03.03.26</u>	

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. LHCC 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.

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 LHCC administrative policies and procedures.

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This clinical policy is effective as of the date determined by LHCC. 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. LHCC 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.

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