Clinical Policy: Siltuximab (Sylvant)

Reference Number: LA.PHAR.329
Effective Date:
Last Review Date: 03.21 — **Coding Implications**
Line of Business: Medicaid — **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

Prior authorization is required. 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 ≥ 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. Other diagnoses/indications
1. **Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): 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. Other diagnoses/indications (must meet 1 or 2):
1. **Currently receiving medication via Louisiana Healthcare Connections benefit and documentation supports positive response to therapy.**
   Approval duration: Duration of request or 6 months (whichever is less); or
2. **Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): 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

CD: Castleman's disease
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.sylvant.com/files/important-product-info.pdf. Accessed October 13, 2020.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.nccn.org. Accessed October 13, 2020.
3. B-Cell Lymphomas Version 4.2020. National Comprehensive Cancer Network Guidelines. Available at www.nccn.org. Accessed October 13, 2020.

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
Converted corporate to local policy	03.2021

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.

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.

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.

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