Clinical Policy: Tocilizumab (Actemra)

Reference Number: CP.PHAR.263
Effective Date: 07.01.16
Last Review Date: 05.21
Line of Business: Medicaid

Coding Implications
Revision Log

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

Description

Tocilizumab (Actemra®) is an interleukin 6 (IL-6) receptor antagonist.

FDA Approved Indication(s)

Actemra is indicated for the treatment of:

- Adult patients with moderately to severely active rheumatoid arthritis (RA) who have had an inadequate response to one or more Disease-Modifying Anti-Rheumatic Drugs (DMARDs)
- Adult patients with giant cell arteritis (GCA)
- Slowing the rate of decline in pulmonary function in adult patients with systemic sclerosis-associated interstitial lung disease (SSc-ILD)
- Patients 2 years of age and older with active polyarticular juvenile idiopathic arthritis (PJIA)
- Patients 2 years of age and older with active systemic juvenile idiopathic arthritis (SJIA)
- Adults and pediatric patients 2 years of age and older with chimeric antigen receptor (CAR) T cell-induced severe or life-threatening cytokine release syndrome (CRS)

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 Actemra is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Cytokine Release Syndrome (must meet all):

1. Request is for IV formulation;
2. Age ≥ 2 years;
3. Member meets one of the following (a or b):
   a. Member has a scheduled CAR T cell therapy (e.g., Kymriah™, Yescarta™);
   b. Member has developed refractory (i.e., inadequate response to steroids, vasopressors) CRS related to blinatumomab therapy;
4. Request meets one of the following (a or b):*
   a. Dose does not exceed 800 mg per infusion for up to 4 total doses;
   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: Up to 4 doses total

B. Giant Cell Arteritis (must meet all)**:**
1. Diagnosis of GCA;
2. Request is for SC formulation;
3. Prescribed by or in consultation with a rheumatologist;
4. Age ≥ 18 years;
5. Failure of a ≥ 3 consecutive month trial of a systemic corticosteroid at up to maximally tolerated doses in conjunction with MTX or azathioprine, unless contraindicated or clinically significant adverse effects are experienced;
6. Dose does not exceed 162 mg every week.

Approval duration: 6 months

C. Polyarticular Juvenile Idiopathic Arthritis (must meet all)**:**
1. Diagnosis of PJIA as evidenced by ≥ 5 joints with active arthritis;
2. Prescribed by or in consultation with a rheumatologist;
3. Age ≥ 2 years;
4. Documented baseline 10-joint clinical juvenile arthritis disease activity score (cJADAS-10) (*see Appendix I*);
5. Member meets one of the following (a, b, c, or d):
   a. Failure of a ≥ 3 consecutive month trial of MTX at up to maximally indicated doses;
   b. If intolerance or contraindication to MTX (*see Appendix D*), failure of a ≥ 3 consecutive month trial of leflunomide or sulfasalazine at up to maximally indicated doses, unless clinically significant adverse effects are experienced or both are contraindicated;
   c. For sacroiliitis/axial spine involvement (i.e., spine, hip), failure of a ≥ 4 week trial of an NSAID at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
   d. Documented presence of high disease activity as evidenced by a cJADAS-10 > 8.5 (*see Appendix I*);
6. Failure of both of the following, each used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or both are contraindicated: Enbrel®, Xeljanz®;
   **Prior authorization may be required for Enbrel and Xeljanz*
7. Dose does not exceed one of the following (*see Appendix E for dose rounding guidelines*) (a or b):
   a. Weight < 30 kg: 10 mg/kg IV every 4 weeks or 162 mg SC every 3 weeks;
   b. Weight ≥ 30 kg: 8 mg/kg IV every 4 weeks or 162 mg SC every 2 weeks.

Approval duration: 6 months

D. Rheumatoid Arthritis (must meet all)**:**
1. Diagnosis of RA per American College of Rheumatology (ACR) criteria (*see Appendix F*);
2. Prescribed by or in consultation with a rheumatologist;
3. Age ≥ 18 years;
4. Member meets one of the following (a or b):

a. Failure of a ≥ 3 consecutive month trial of methotrexate (MTX) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
b. If intolerance or contraindication to MTX (*see Appendix D*), failure of a ≥ 3 consecutive month trial of at least ONE conventional DMARD (e.g., sulfasalazine, leflunomide, hydroxychloroquine) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;

5. Failure of at least TWO of the following, each used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or all are contraindicated: Enbrel, Kevzara®, Xeljanz/Xeljanz XR;
   **Prior authorization may be required for Enbrel, Kevzara, and Xeljanz/Xeljanz XR*
6. Documentation of one of the following baseline assessment scores (a or b):
   a. Clinical disease activity index (CDAI) score (*see Appendix G*);
   b. Routine assessment of patient index data 3 (RAPID3) score (*see Appendix H);*
7. Dose does not exceed one of the following (a or b):
   a. IV: 800 mg every 4 weeks;
   b. SC: 162 mg every week.

Approval duration: 6 months

E. Systemic Juvenile Idiopathic Arthritis (must meet all)**:**
1. Diagnosis of SJIA;
2. Prescribed by or in consultation with a dermatologist, rheumatologist, or gastroenterologist;
3. Age ≥ 2 years;
4. Member meets one of the following (a or b):
   a. Failure of a ≥ 3 consecutive month trial of MTX or leflunomide at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
   b. Failure of a ≥ 2-week trial of a systemic corticosteroid at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
5. Dose does not exceed one of the following (a or b):
   a. IV (*see Appendix E for dose rounding guidelines*):
      i. Weight < 30 kg: 12 mg/kg every 2 weeks;
      ii. Weight ≥ 30 kg: 8 mg/kg every 2 weeks;
   b. SC:
      i. Weight < 30 kg: 162 mg every 2 weeks;
      ii. Weight ≥ 30 kg: 162 mg every week.

Approval duration: 6 months

F. Systemic Sclerosis –Associated Interstitial Lung Disease (must meet all):
1. Diagnosis of SSc-ILD;
2. Request is for SC formulation;
3. Prescribed by or in consultation with a pulmonologist;
4. Member meets both of the following (a and b):

a. Pulmonary fibrosis on high-resolution computed tomography (HRCT);
b. Additional signs of SSc are identified (*see Appendix J)*;

5. Failure of a ≥ 3 consecutive month trial of cyclophosphamide or mycophenolate mofetil, at up to maximally indicated doses, unless both are contraindicated or clinically significant adverse effects are experienced;
6. Dose does not exceed 162 mg every week.

Approval duration: 6 months

G. Castleman's Disease (off-label) (must meet all)**:**

1. Diagnosis of Castleman's disease;
2. Disease is relapsed/refractory or progressive;
3. Member is human immunodeficiency virus (HIV)-negative and human herpesvirus 8 (HHV-8)-negative;
4. Prescribed as second-line therapy as a single agent;
5. Request meets one of the following (a or b):*
   a. Dose does not exceed 8 mg/kg per infusion every 2 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

H. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Documentation supports that member is currently receiving Actemra IV for CAR T cell-induced CRS and member has not yet received 4 doses total;
2. Member meets one of the following (a, b, or c):
   a. For RA: member is responding positively to therapy as evidenced by one of the following (i or ii):
      i. A decrease in CDAI (*see Appendix G*) or RAPID3 (*see Appendix H*) score from baseline;
      ii. Medical justification stating inability to conduct CDAI re-assessment, and submission of RAPID3 score associated with disease severity that is similar to initial CDAI assessment or improved;
   b. For pJIA, member is responding positively to therapy as evidenced by a decrease in cJADAS-10 from baseline (*see Appendix I*);
   c. For all other indications: member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed one of the following (a, b, c, d, e, f):

a. CRS: 800 mg per infusion for up to 4 doses total, or dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*);
b. PJIA (*see Appendix E for dose rounding guidelines*) (i or ii):
   i. Weight < 30 kg: 10 mg/kg IV every 4 weeks or 162 mg SC every 3 weeks;
   ii. Weight ≥ 30 kg: 8 mg/kg IV every 4 weeks or 162 mg SC every 2 weeks;
c. RA (i or ii):
   i. IV: 800 mg every 4 weeks;
   ii. SC: 162 mg every week;
d. GCA, SSc-ILD: 162 mg SC every week;
e. SJIA (*see Appendix E for dose rounding guidelines*): (i or ii):
   i. Weight < 30 kg: 12 mg/kg IV every 2 weeks 162 mg SC 2 every week;
   ii. Weight ≥ 30 kg: 8 mg/kg IV every 2 weeks or 162 mg SC every week;
f. Castleman's Disease (i or ii):*
   i. Dose does not exceed 8 mg/kg per infusion every 2 weeks;
   ii. 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:
CRS: Up to 4 doses total
All other indications: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via Centene 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 for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): 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 – CP.PMN.53 for Medicaid or evidence of coverage documents;

B. Combination use of biological disease-modifying antirheumatic drugs (bDMARDs), including any tumor necrosis factor (TNF) antagonists [Cimzia®, Enbrel®, Simponi®, Avsola™, Inflectra™, Remicade®, Renflexis™], interleukin agents [Arcalyst® (IL-1 blocker), Ilaris® (IL-1 blocker), Kineret® (IL-1RA), Actemra® (IL-6RA), Kevzara® (IL-6RA), Stelara® (IL-12/23 inhibitor), Cosentyx® (IL-17A inhibitor), Taltz® (IL-17A inhibitor), Siliq™ (IL-17RA), Ilumya™ (IL-23 inhibitor), Skyrizi™ (IL-23 inhibitor), Tremfya® (IL-23 inhibitor)], janus kinase inhibitors (JAKi) [Xeljanz®/Xeljanz® XR, Rinvoq™], anti-CD20 monoclonal antibodies [Rituxan®, Riabni™, Ruxience™, Truxima®, and Rituxan Hycela®], selective co-stimulation modulators [Orencia®], or integrin receptor antagonists [Entyvio®] because of the possibility of increased immunosuppression, neutropenia and increased risk of infection.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CAR: chimeric antigen receptor
CDAI: clinical disease activity index
cJADAS: clinica juvenile arthritis disease activity score
CRS: cytokine release syndrome
DMARDs: disease-modifying anti-rheumatic drugs
FDA: Food and Drug Administration
GCA: giant cell arteritis
GI: gastrointestinal
HHV-8: human herpesvirus 8
HIV: human immunodeficiency virus
IL-6: interleukin 6
MTX: methotrexate
PJIA: polyarticular juvenile idiopathic arthritis
RA: rheumatoid arthritis
RAPID3: routine assessment of patient index data 3
SJIA: systemic juvenile idiopathic arthritis
SSc-ILD: systemic sclerosis-associated interstitial lung disease

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
azathioprine (Azasan®, Imuran®)	**RA** 1 mg/kg/day PO QD or divided BID **GCA*** 1.5 – 2 mg/kg/day PO	2.5 mg/kg/day
corticosteroids	**GCA*, SJIA*** Various	Various
Cuprimine® (d-penicillamine)	**RA*** Initial dose: 125 or 250 mg PO QD Maintenance dose: 500 – 750 mg/day PO QD	1,500 mg/day
Cyclophosphamide (Cytoxan®, Neosar®)	**SSc-ILD*** PO: 1 – 2 mg/kg/day IV: 600 mg/m^2/month	PO: 2 mg/kg/day IV: 600 mg/m^2/month
cyclosporine (Sandimmune®, Neoral®)	**RA** 2.5 – 4 mg/kg/day PO divided BID	4 mg/kg/day
hydroxychloroquine (Plaquenil®)	**RA*** Initial dose: 400 – 600 mg/day PO QD Maintenance dose: 200 – 400 mg/day PO QD	600 mg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
leflunomide (Arava®)	**PJIA*** Weight < 20 kg: 10 mg every other day Weight 20 - 40 kg: 10 mg/day Weight > 40 kg: 20 mg/day **RA** 100 mg PO QD for 3 days, then 20 mg PO QD **SJIA*** 100 mg PO every other day for 2 days, then 10 mg every other day	PJIA, RA: 20 mg/day SJIA: 10 mg every other day
methotrexate (Rheumatrex®)	**GCA*** 20 – 25 mg/week PO **PJIA*** 10 – 20 mg/m^2/week PO, SC, or IM **RA** 7.5 mg/week PO, SC, or IM or 2.5 mg PO Q12 hr for 3 doses/week **SJIA*** 0.5-1 mg/kg/week PO	30 mg/week
mycophenolate mofetil (CellCept®)	**SSc-ILD*** PO: 1 – 3 g/day	3 g/day
Ridaura® (auranofin)	**RA** 6 mg PO QD or 3 mg PO BID	9 mg/day (3 mg TID)
sulfasalazine (Azulfidine®)	**PJIA*** 30-50 mg/kg/day PO divided BID **RA** 2 g/day PO in divided doses	PJIA: 2 g/day RA: 3 g/day
Enbrel® (etanercept)	**PJIA** Weight < 63 kg: 0.8 mg/kg SC once weekly Weight ≥ 63 kg: 50 mg SC once weekly **RA** 25 mg SC twice weekly or 50 mg SC once weekly	50 mg/week
Kevzara® (sarilumab)	**RA** 200 mg SC once every two weeks	200 mg/2 weeks

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Xeljanz® (tofacitinib)	**PJIA** • 10 kg ≤ body weight < 20 kg: 3.2 mg (3.2 mL oral solution) PO BID • 20 kg ≤ body weight < 40 kg: 4 mg (4 mL oral solution) PO BID • Body weight ≥ 40 kg: 5 mg PO BID **RA** 5 mg PO BID	10 mg/day
Xeljanz XR® (tofacitinib extended-release)	**RA** 11 mg PO QD	11 mg/day

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.
**Off-label*

Appendix C: Contraindications/Boxed Warnings
- Contraindication(s): known hypersensitivity to Actemra
- Boxed warning(s): risk of serious infections

Appendix D: General Information
- Definition of failure of MTX or DMARDs
  - Child-bearing age is not considered a contraindication for use of MTX. Each drug has risks in pregnancy. An educated patient and family planning would allow use of MTX in patients who have no intention of immediate pregnancy.
  - Social use of alcohol is not considered a contraindication for use of MTX. MTX may only be contraindicated if patients choose to drink over 14 units of alcohol per week. However, excessive alcohol drinking can lead to worsening of the condition, so patients who are serious about clinical response to therapy should refrain from excessive alcohol consumption.
- Examples of positive response to therapy may include, but are not limited to:
  - Reduction in joint pain/swelling/tenderness
  - Improvement in ESR/CRP levels
  - Improvements in activities of daily living

Appendix E: Dose Rounding Guidelines for PJIA and SJIA

Weight-based Dose Range	Vial Quantity Recommendation
≤ 83.99 mg	1 vial of 80 mg/4 mL
84 to 209.99 mg	1 vial of 200 mg/10 mL
210 to 419.99 mg	1 vial of 400 mg/20 mL
420 to 503.99 mg	1 vial of 80 mg/4 mL and 1 vial 400 mg/20 mL
504 to 629.99 mg	1 vial of 200 mg/10 mL and 1 vial 400 mg/20 mL
630 to 839.99 mg	2 vials 400 mg/20 mL
840 to 923.99 mg	1 vial of 80 mg/4 mL and 2 vials 400 mg/20 mL
924 to 1,049.99 mg	1 vial of 200 mg/10 mL and 2 vials 400 mg/20 mL
1050 to 1,259.99 mg	3 vials 400 mg/20 mL

Appendix F: The 2010 ACR Classification Criteria for RA

Add score of categories A through D; a score of ≥ 6 out of 10 is needed for classification of a patient as having definite RA.

A	**Joint involvement**	Score
	1 large joint	0
	2-10 large joints	1
	1-3 small joints (with or without involvement of large joints)	2
	4-10 small joints (with or without involvement of large joints)	3
	> 10 joints (at least one small joint)	5
B	**Serology (at least one test result is needed for classification)**	
	Negative rheumatoid factor (RF) *and* negative anti-citrullinated protein antibody (ACPA)	0
	Low positive RF *or* low positive ACPA * *Low: < 3 x upper limit of normal*	2
	High positive RF *or* high positive ACPA * *High: ≥ 3 x upper limit of normal*	3
C	**Acute phase reactants (at least one test result is needed for classification)**	
	Normal C-reactive protein (CRP) and normal erythrocyte sedimentation rate (ESR)	0
	Abnormal CRP or abnormal ESR	1
D	**Duration of symptoms**	
	< 6 weeks	0
	≥ 6 weeks	1

Appendix G: Clinical Disease Activity Index (CDAI) Score

The Clinical Disease Activity Index (CDAI) is a composite index for assessing disease activity in RA. CDAI is based on the simple summation of the count of swollen/tender joint count of 28 joints along with patient and physician global assessment on VAS (0–10 cm) Scale for estimating disease activity. The CDAI score ranges from 0 to 76.

CDAI Score	Disease state interpretation
≤ 2.8	Remission
> 2.8 to ≤ 10	Low disease activity
> 10 to ≤ 22	Moderate disease activity
> 22	High disease activity

Appendix H: Routine Assessment of Patient Index Data 3 (RAPID3) Score
The Routine Assessment of Patient Index Data 3 (RAPID3) is a pooled index of the three patient-reported ACR core data set measures: function, pain, and patient global estimate of status. Each of the individual measures is scored 0 – 10, and the maximum achievable score is 30.

RAPID3 Score	Disease state interpretation
≤ 3	Remission
3.1 to 6	Low disease activity
6.1 to 12	Moderate disease activity
> 12	High disease activity

Appendix I: Clinical Juvenile Arthritis Disease Activity Score based on 10 joints (cJADAS-10)
The cJADAS10 is a continuous disease activity score specific to JIA and consisting of the following three parameters totaling a maximum of 30 points:

- Physician's global assessment of disease activity measured on a 0-10 visual analog scale (VAS), where 0 = no activity and 10 = maximum activity;
- Parent global assessment of well-being measured on a 0-10 VAS, where 0 = very well and 10 = very poor;
- Count of joints with active disease to a maximum count of 10 active joints*

**ACR definition of active joint: presence of swelling (not due to currently inactive synovitis or to bony enlargement) or, if swelling is not present, limitation of motion accompanied by pain, tenderness, or both*

cJADAS-10	Disease state interpretation
≤ 1	Inactive disease
1.1 to 2.5	Low disease activity
2.51 to 8.5	Moderate disease activity
> 8.5	High disease activity

Appendix J: American College of Rheumatology (ACR) 2013 SSc Classification Criteria
While the majority of patients with SSc experience skin thickening and variable involvement of internal organs, there is no one confirmatory test for SSc. Similar to the IPF guidelines above, ACR lists HRCT as a diagnostic method for determining pulmonary fibrosis in SSc-ILD. The other diagnostic parameters below are drawn from ACR's scoring system purposed for clinical trials. While informative, ACR cautions that the scoring system parameters are not all inclusive of the myriad of SSc manifestations that may occur across musculoskeletal, cardiovascular, renal, neuromuscular and genitourinary systems.

Examples of SSc skin/internal organ manifestations and associated laboratory tests:

- Skin thickening of the fingers
- Fingertip lesions
- Telangiectasia
- Abnormal nailfold capillaries
- Raynaud's phenomenon
- SSc-ILD
- Pulmonary arterial hypertension
- SSc-related autoantibodies

- Anticentromere
- Anti-topoisomerase I (anti-Scl-70)
- Anti-RNA polymerase III

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
CRS	Weight < 30 kg: 12 mg/kg IV per infusion Weight ≥ 30 kg: 8 mg/kg IV per infusion If no clinical improvement in the signs and symptoms of CRS occurs after the first dose, up to 3 additional doses of Actemra may be administered. The interval between consecutive doses should be at least 8 hours.	IV: 800 mg/infusion, up to 4 doses
GCA	162 mg SC every week (every other week may be given based on clinical considerations)	SC: 162 mg every week
PJIA	• Weight < 30 kg: 10 mg/kg IV every 4 weeks or 162 mg SC every 3 weeks • Weight ≥ 30 kg: 8 mg/kg IV every 4 weeks or 162 mg SC every 2 weeks *See Appendix E for dose rounding guidelines*	IV: 10 mg/kg every 4 weeks SC: 162 mg every 2 weeks
RA	IV: 4 mg/kg every 4 weeks followed by an increase to 8 mg/kg every 4 weeks based on clinical response SC: Weight < 100 kg: 162 mg SC every other week, followed by an increase to every week based on clinical response Weight ≥ 100 kg: 162 mg SC every week	IV: 800 mg every 4 weeks SC: 162 mg every week
SJIA	IV: Weight < 30 kg: 12 mg/kg IV every 2 weeks Weight ≥ 30 kg: 8 mg/kg IV every 2 weeks *See Appendix E for dose rounding guidelines* SC: Weight < 30 kg: 162 mg SC every 2 weeks Weight ≥ 30 kg: 162 mg SC every week	IV: 12 mg/kg every 2 weeks SC: 162 mg every week
SSc-ILD	162 mg SC once weekly	SC: 162 mg every week

VI. Product Availability

- Single-use vial: 80 mg/4 mL, 200 mg/10 mL, 400 mg/20 mL
- Single-dose prefilled syringe: 162 mg/0.9 mL
- Single-dose prefilled autoinjector: 162 mg/0.9 mL

VII. References

1. Actemra Prescribing Information. South San Francisco, CA: Genentech; March 2021. Available at: https://www.actemra.com/. Accessed March 18, 2021.
2. Actemra. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed January 15, 2021.
3. European League Against Rheumatism. EULAR recommendations for the management of large vessel vasculitis. *Ann Rheum Dis.* 2009;68:318–323.
4. Ringold, S., Weiss, P. F., Beukelman, T., DeWitt, E. M., Ilowite, N. T., Kimura, Y., Laxer, R. M., Lovell, D. J., Nigrovic, P. A., Robinson, A. B. and Vehe, R. K. (2013), 2013 Update of the 2011 American College of Rheumatology Recommendations for the Treatment of Juvenile Idiopathic Arthritis: Recommendations for the Medical Therapy of Children With Systemic Juvenile Idiopathic Arthritis and Tuberculosis Screening Among Children Receiving Biologic Medications. *Arthritis & Rheumatism*. 65: 2499–2512.
5. Singh JA, Saag KG, Bridges SL, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Rheumatology*. 2016; 68(1):1-26.
6. Kowal-Bielecka O, Fransen J, Avouac J, et al. Update of EULAR recommendations for the treatment of systemic sclerosis. *Annals of the Rheumatic Diseases*. 2017;76:1327-1339.
7. Kapriniotis K, Lampridis S, Mitsos S, et al. Biologic agents in the treatment of multicentric Castleman Disease. *Turk Thorac J.* 2018; 19(4):220-5. DOI: 10.5152/TurkThoracJ.2018.18066.
8. Cottin V and Brown K. Interstitial lung disease associated with systemic sclerosis (SSc-ILD). *Respiratory Research.* 2019; 20(13). doi: 10.1186/s12931-019-0980-7.
9. Khanna D, Lin CJF, Furst DE, et al. Tocilizumab in systemic sclerosis: a randomized, double-blind, placebo-controlled, phase 3 trial. *Lancet*. 2020; 8(10:963-974. doi: 10.1016/S2213-2600(20)30318-0.
10. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2021. Available at: https://www.clinicalpharmacology-ip.com/.

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
J3262	Injection, tocilizumab, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy converted to new template. Added criteria for new FDA indication Giant Cell Arteritis. Revised criteria for confirmation of RA diagnosis per 2010 ACR Criteria. Removed safety requirements per updated CPAC Safety Precaution in PA Policies approach.	07.17	07.17
SJIA: Removed requirement for trial/failure of NSAID as it not a first line therapy recommended by the SJIA guidelines.	08.17.17	11.17

Reviews, Revisions, and Approvals	Date	P&T Approval Date
GCA: Added age requirement as safety and efficacy have not been established in pediatric populations.		
Added criteria for new indication of cytokine release syndrome	09.26.17	11.17
Corrected continued approval duration for "all other indications" from "6 months or member's renewal date, whichever is longer" to 12 months	11.30.17	
2Q 2018 annual review: policies combined for HIM and Medicaid lines of business; HIM: removed specific diagnosis requirements for RA, removed trial and failure of NSAIDs for SJIA as it is not first line; Medicaid and HIM: modified trial and failure for RA to at least one conventional DMARD, modified requirement of corticosteroid trial to be 3 consecutive months for GCS, removed TB testing for all indications, added dermatologist and GI specialist as prescriber specialists for SJIA; added age requirement for CRS; added weight-based max dosing requirements for PJIA and SJIA; references reviewed and updated.	02.27.18	05.18
No significant changes: newly FDA-approved subcutaneous dosing for PJIA added.	07.16.18	
4Q 2018 annual review: removed "request is for IV formulation" for SJIA and PJIA per labeling update; references reviewed and updated.	09.04.18	11.18
2Q 2019 annual review: no significant changes; revised GI specialist to gastroenterologist for specialist requirement for SJIA; added autoinjector formulation; added HIM-Medical Benefit option for autoinjector formulation; references reviewed and updated.	02.26.19	05.19
Removed HIM line of business; updated preferred redirections based on SDC recommendation and prior clinical guidance: for PJIA, removed redirection to adalimumab and added redirection to Enbrel; for RA, removed redirection to adalimumab, added redirection to 2 of 3: Enbrel, Kevzara, and Xeljanz/Xeljanz XR; added subcutaneous dosing for SJIA in the continuation criteria.	12.13.19	
2Q 2020 annual review: for RA, added specific diagnostic criteria for definite RA, baseline CDAI score requirement, and decrease in CDAI score as positive response to therapy; allowed refractory CRS related to blinatumomab therapy per NCCN; added off-label use criteria for Castlemna's disease per NCCN; added dose rounding guidelines for IV weight-based dosing for PJIA and SJIA; references reviewed and updated.	04.23.20	05.20
Revised typo in Appendix E from "normal ESR" to "abnormal ESR" for a point gained for ACR Classification Criteria.	11.22.20	
Updated pJIA criteria to require diagnosis as evidenced by ≥ 5 joints, cJADAS assessment, and rediretion to Enbrel and Xeljanz per SDC. Additionally, updated criteria to allow tiered redirection or bypass of MTX in the event of sacroiliitis or high disease activity.	11.24.20	02.21

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Added criteria for RAPID3 assessment for RA given limited in-person visits during COVID-19 pandemic, updated appendices.		
2Q 2021 annual review: added combination of bDMARDs under Section III; updated CDAI table with ">" to prevent overlap in classification of severity; references reviewed and updated. RT4: added criteria for new FDA indication, SSc-ILD.	02.23.21	05.21

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.