Actemra (tocilizumab)

NOTICE

This policy contains information which is clinical in nature. The policy is not medical advice. The information in this policy is used by Wellmark to make determinations whether medical treatment is covered under the terms of a Wellmark member's health benefit plan. Physicians and other health care providers are responsible for medical advice and treatment. If you have specific health care needs, you should consult an appropriate health care professional. If you would like to request an accessible version of this document, please contact customer service at 800-524-9242.

BENEFIT APPLICATION

Benefit determinations are based on the applicable contract language in effect at the time the services were rendered. Exclusions, limitations or exceptions may apply. Benefits may vary based on contract, and individual member benefits must be verified. Wellmark determines medical necessity only if the benefit exists and no contract exclusions are applicable. This medical policy may not apply to FEP. Benefits are determined by the Federal Employee Program.

DESCRIPTION

The intent of the Actemra drug policy is to ensure appropriate selection of patients for therapy based on product labeling, clinical guidelines and clinical studies while steering utilization to the most cost-effective medication within the therapeutic class. For this program, Cosentyx, Enbrel, Humira, Otezla, Rinvoq, Skyrizi, Stelara, Tremfya, and Xeljanz/Xeljanz XR/Xeljanz Oral Solution are the preferred products and will apply to members requesting treatment with subcutaneous Actemra for an indication that is FDA-approved for the preferred product. The criteria will require the use of two of the health plan's preferred products before the use of non-preferred products unless there are clinical circumstances that exclude the use of all the preferred products, the patient is currently receiving treatment with the non-preferred drug and experience a positive therapeutic outcome, or there is only one preferred product for an indication. Additionally for this program, infliximab biosimilars (Avsola, Inflectra, Renflexis), Entyvio, Ilumya, Stelara IV, and Simponi Aria are the preferred products and will apply to members requesting treatment with intravenous Actemra for an indication that is FDA-approved for the preferred product. Coverage for targeted products is provided based on clinical circumstances that would exclude the use of the preferred product and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made.

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. Adult patients with moderately to severely active rheumatoid arthritis who have had an inadequate response to one or more disease-modifying antirheumatic drugs (DMARDs).
2. Patients 2 years of age and older with active polyarticular juvenile idiopathic arthritis
3. Patients 2 years of age and older with active systemic juvenile idiopathic arthritis

4. Adult patients with giant cell arteritis
5. Adult patients with systemic sclerosis-associated interstitial lung disease (SSc-ILD) for slowing the rate of decline in pulmonary function.
6. 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.

Compendial Uses

1. Unicentric Castleman's disease
2. Multicentric Castleman's disease
3. Oligoarticular juvenile idiopathic arthritis
4. Refractory/severe immunotherapy-related inflammatory arthritis not responding to corticosteroids and anti-inflammatory agents
5. Acute graft versus host disease
6. Cytokine release syndrome (other than severe or life-threatening CAR T cell-induced CRS)

POLICY

Required Documentation

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

A) Rheumatoid arthritis (RA)
   1. Initial requests:
      i. Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.
      ii. Laboratory results, chart notes, or medical record documentation of biomarker testing (i.e., rheumatoid factor [RF], anti-cyclic citrullinated peptide [anti-CCP], and C-reactive protein [CRP] and/or erythrocyte sedimentation rate [ESR]) (if applicable).
   2. Continuation requests: Chart notes or medical record documentation supporting positive clinical response.

B) Articular juvenile idiopathic arthritis or systemic juvenile idiopathic arthritis (sJIA):
   1. Initial requests: Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.
   2. Continuation requests: Chart notes or medical record documentation supporting positive clinical response.

C) Cytokine release syndrome, immunotherapy-related inflammatory arthritis, and graft versus host disease:
   1. For initial requests: Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.

D) Giant cell arteritis (GCA):
   1. For continuation requests: Chart notes or medical record documentation supporting positive clinical response.

E) Systemic sclerosis-associated interstitial lung disease (SSc-ILD):
   1. For initial requests: Result of a chest high-resolution computed tomography (HRCT) study.

Must meet BOTH the Preferred Drug Plan Design and Criteria for Initial Approval/Continuation of Therapy when both are applicable.

Preferred Drug Plan Design for subcutaneous Actemra requests

A) Rheumatoid Arthritis

1. Criteria for initial approval for rheumatoid arthritis will only apply when at least ONE of the following criteria are met:
    a) Member has had an inadequate response to treatment or intolerable adverse event with at least TWO of the preferred products (Enbrel, Humira, Rinvoq, and Xeljanz/Xeljanz XR)
    b) Member has a clinical reason to avoid Enbrel and Humira (See Appendix A) AND has had an inadequate response to treatment or intolerable adverse event with the preferred products, Rinvoq AND Xeljanz or Xeljanz XR
    c) Member is currently receiving treatment with the requested product through insurance (excludes obtainment as samples or via manufacturer's patient assistance programs) and experiencing a positive therapeutic outcome

B) Polyarticular juvenile idiopathic arthritis

1. Criteria for initial approval on polyarticular juvenile idiopathic arthritis will only apply when at least ONE of the following criteria are met:
    a) Member has had an inadequate response to treatment or intolerable adverse event with at least TWO of the preferred products (Humira, Enbrel, and Xeljanz/Xeljanz Oral Solution)
    b) Member has a clinical reason to avoid Enbrel and Humira (See Appendix A) AND has had an inadequate response to treatment or intolerable adverse event with the preferred product Xeljanz or Xeljanz Oral Solution
    c) Member is currently receiving treatment with the requested product through insurance (excludes obtainment as samples or via manufacturer's patient assistance programs) and experiencing a positive therapeutic outcome

<u>Preferred Drug Plan Design for intravenous Actemra requests</u>

A) Rheumatoid Arthritis

1. Criteria for initial approval on rheumatoid arthritis will only apply when at least ONE of the following criteria are met:
    a) Member has a documented inadequate response or intolerable adverse event with each of the following:
        a. Infliximab biosimilar (Avsola, Inflectra, Renflexis)
        b. Simponi Aria
    b) Member has a documented clinical reason to avoid TNF inhibitors (See Appendix A)
    c) Member is currently receiving treatment with the requested product through insurance (excludes obtainment as samples or via manufacturer's patient assistance programs) and experiencing a positive therapeutic outcome

B) Polyarticular juvenile idiopathic arthritis

1. Criteria for initial approval on polyarticular juvenile idiopathic arthritis will only apply when at least ONE of the following criteria are met:
    a) Member has a documented inadequate response or intolerable adverse event to Simponi Aria
    b) Member has a documented clinical reason to avoid TNF inhibitors (See Appendix A)
    c) Member is currently receiving treatment with the requested product through insurance (excludes obtainment as samples or via manufacturer's patient assistance programs) and experiencing a positive therapeutic outcome

Note: Submission of chart notes detailing the outcomes of treatment, intolerable adverse event(s) experienced, contraindication(s), or exclusion(s) to treatment with preferred product(s) is required (where applicable).

<u>Criteria for Initial Approval</u>

A) Moderately to severely active rheumatoid arthritis (RA)

1. Authorization of 12 months may be granted for members who have previously received a biologic or targeted synthetic DMARD (e.g., Rinvoq, Xeljanz) indicated for moderately to severely active rheumatoid arthritis.
2. Authorization of 12 months may be granted for treatment of moderately to severely active RA when any of the following criteria is met:
    a). Member meets either of the following criteria:
        a. Member has been tested for either of the following biomarkers and the test was positive:
            i. Rheumatoid factor (RF)
            ii. Anti-cyclic citrullinated peptide (anti-CCP)
        b. Member has been tested for ALL of the following biomarkers:
            i. RF
            ii. Anti-CCP
            iii. C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR)
    b). Member meets any of the following criteria:
        a. Member has experienced an inadequate response to at least a 3-month trial of methotrexate despite adequate dosing (i.e., titrated toat least 15 mg/week).
        b. Member has an intolerance or contraindication to methotrexate (see Appendix B).
        c. Member has experienced an inadequate response to an alternative DMARD (e.g., leflunomide, hydroxychloroquine, sulfasalazine)

B) Active articular juvenile idiopathic arthritis

1. Authorization of 12 months may be granted for members who have previously received a biologic or targeted synthetic DMARD indicated for active articular juvenile idiopathic arthritis.
2. Authorization of 12 months may be granted for the treatment of active articular juvenile idiopathic arthritis when any of the following criteria are met:
    a). The member had an inadequate response to methotrexate or another non-biologic DMARD administered at an adequate dose and duration.
    b). The member has risk factors (See Appendix C) and the member also meets one of the following:
        i. High-risk joints are involved (e.g., cervical spine, wrist, or hip).
        ii. High disease activity
        iii. Are judged to be at high risk for disabling joint disease.

C) Active Systemic Juvenile Idiopathic Arthritis (sJIA)

1. Authorization of 12 months may be granted for members who have previously received a biologic indicated for active systemic juvenile idiopathic arthritis.
2. Authorization of 12 months may be granted for the treatment of active sJIA when any of the following criteria is met:
    a). Member has an inadequate response to at least a 1-month trial of NSAIDs.
    b). Member has an inadequate response to at least a 2-week trial of corticosteroids.
    c). Member has an inadequate response to at least a 3-month trial of methotrexate or leflunomide.

D) Giant Cell Arteritis

1. Authorization of 12 months may be granted for the treatment of giant cell arteritis when the patient's diagnosis was confirmed by the following:
    a). Temporal artery biopsy or cross-sectional imaging; or
    b). Acute-phase reactant elevation (i.e., high erythrocyte sedimentation rate [ESR] and/or high serum C-reactive protein [CRP])

E) Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD)

Authorization of 12 months may be granted for treatment of sclerosis-associated interstitial lung disease when the diagnosis was confirmed by a high-resolution computed tomography (HRCT) study of the chest.

F) Cytokine release syndrome

1. Authorization of 1 month may be granted for the treatment of chimeric antigen receptor (CAR) T cell-induced cytokine release syndrome (CRS).
2. Authorization of 1 month may be granted for treatment of cytokine release syndrome in members with refractory CRS related to blinatumomab therapy.

G) Unicentric Castleman's Disease

1. Authorization of 12 months may be granted for treatment of unicentric Castleman's disease when all of the following are met:
   a). The member is HIV-negative
   b). The member is human herpes virus-8-negative
   c). The requested drug will be used as monotherapy.
   d). The requested drug is being used as second-line therapy for relapsed/refractory disease.

H) Multicentric Castleman's Disease

1. Authorization of 12 months may be granted for treatment of multicentric Castleman's disease when both of the following are met:
   a). The requested drug will be used as monotherapy.
   b). The requested drug is being used as second-line therapy for relapsed/refractory or progressive disease.

I) Immunotherapy-related Inflammatory Arthritis

Authorization of 12 months may be granted for treatment of severe/refractory immunotherapy-related inflammatory arthritis that is not responding to corticosteroids and anti-inflammatory agents

J) Acute graft versus host disease

1. Authorization of 12 months may be granted for treatment of acute graft versus host disease when either of the following criteria is met:
   a) Member has experienced an inadequate response to systemic corticosteroids; or
   b) Member has an intolerance or contraindication to corticosteroids.

<u>Continuation of Therapy</u>

A. Moderately to severely active RA

Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for moderately to severely active RA and who achieve or maintain a positive clinical response as evidenced by disease activity improvement of at least 20% from baseline in tender joint count, swollen joint count, pain, or disability.

B. Active articular juvenile idiopathic arthritis

Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for active articular juvenile idiopathic arthritis and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:

1. Number of joints with active arthritis (e.g., swelling, pain, limitation of motion)
2. Number of joints with limitation of movement
3. Functional ability

C. Active Systemic Juvenile Idiopathic Arthritis (sJIA)

Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for active sJIA and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:

1. Number of joints with active arthritis (e.g., swelling, pain, limitation of motion)
2. Number of joints with limitation of movement
3. Functional ability
4. Systemic symptoms (e.g., fevers, evanescent skin rashes)

D. Giant Cell Arteritis (GCA)

Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for GCA and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:

1. Headaches
2. Scalp tenderness
3. Tenderness and/or thickening of superficial temporal arteries
4. Constitutional symptoms (e.g., weight loss, fever, fatigue, night sweats)
5. Jaw and/or tongue claudication
6. Acute visual symptoms (e.g., amaurosis fugax, acute visual loss, diplopia)
7. Symptoms of polymyalgia rheumatica (e.g., shoulder and/or hip girdle pain)
8. Limb claudication

E. Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD)

Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for SSc-ILD when the member is currently receiving treatment with Actemra, excluding when Actemra is obtained as samples or via manufacturer's patient assistance programs.

F. Cytokine release syndrome, immunotherapy-related inflammatory arthritis, and graft versus host disease

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

All other diagnoses

Authorization of 12 months may be granted for continued treatment in members who are using Actemra for an indication outlined in Criteria for Initial Approval when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

Other

For all indications: Member has had a documented negative TB test (which can include a tuberculosis skin test [PPD], an interferon-release assay [IGRA], or a chest x-ray)* within 6 months of initiating therapy for persons who are naïve to biologic DMARDs or targeted synthetic DMARDs associated with an increased risk of TB.

* If the screening testing for TB is positive, there must be further testing to confirm there is no active disease. Do not administer the requested medication to members with active TB infection. If there is latent disease, TB treatment must be started before initiation of the requested medication.

For all indications: Member cannot use the requested medication concomitantly with any other biologic DMARD or targeted synthetic DMARD.

Actemra is considered **not medically necessary** for members who do not meet the criteria set forth above.

Dosage and Administration

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Quantity Limits

Trade Name	Generic Name	Quantity Limit
Actemra®	Tocilizumab IV	40 mL(800 mg) per 28 days
Actemra®	Tocilizumab SC	Up to 4 syringes/auto-injectors per 28 days

Appendix

Appendix A: Clinical reasons to avoid TNF-inhibitors

1. History of demyelinating disorder
2. History of congestive heart failure
3. History of hepatitis B infection
4. Autoantibody formation/lupus-like syndrome
5. Risk of lymphoma

Note: Primary failure to respond to a TNF-inhibitor does not preclude successful response to a different TNF-inhibitor per 2019 AAD-NPF guidelines and therefore is not consider a clinical reason to avoid TNF-inhibitors.

Appendix B: Examples of Contraindications to Methotrexate

1. Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease
2. Breastfeeding
3. Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
4. Elevated liver transaminases
5. History of intolerance or adverse event
6. Hypersensitivity
7. Interstitial pneumonitis or clinically significant pulmonary fibrosis
8. Myelodysplasia
9. Pregnancy or currently planning pregnancy
10. Renal impairment
11. Significant drug interaction

Appendix C: Risk factors for articular juvenile idiopathic arthritis

1. Positive rheumatoid factor
2. Positive anti-cyclic citrullinated peptide antibodies
3. Pre-existing joint damage

PROCEDURES AND BILLING CODES

To report provider services, use appropriate CPT* codes, Alpha Numeric (HCPCS level 2) codes, Revenue codes, and/or ICD diagnostic codes.

- J3262 Injection, tocilizumab, 1 mg

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*Some content reprinted from CVSHealth

POLICY HISTORY

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