# Clinical Policy: Anakinra (Kineret)

Reference Number: PA.CP.PHAR.244
Effective Date: 01/18
Last Review Date: 04/19 Revision Log

**Description**
Anakinra (Kineret®) is an interleukin-1 (IL-1) receptor antagonist.

**FDA Approved Indication(s)**
Kineret is indicated for the treatment of:

- Rheumatoid arthritis (RA) for the reduction in signs and symptoms and slowing the progression of structural damage in moderately to severely active RA, in patients 18 years of age or older who have failed 1 or more disease modifying antirheumatic drugs (DMARDs)
- Cryopyrin-associated periodic syndromes (CAPS): Treatment of neonatal-onset multisystem inflammatory disease (NOMID).

**Policy/Criteria**
*Provider must submit documentation (which may include office chart notes and lab results) supporting that member has met all approval criteria*

It is the policy of Pennsylvania Health and Wellness® that Kineret is **medically necessary** when the following criteria are met:

**I. Initial Approval Criteria**

**A. Rheumatoid Arthritis** (must meet all)**:**

1. Diagnosis of RA;
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 methotrexate (MTX) for ≥ 3 consecutive months 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 DMARD (e.g., sulfasalazine, leflunomide, hydroxychloroquine) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
5. Failure of etanercept *(Enbrel is preferred)* and adalimumab *(Humira is preferred)*each used for ≥ 3 consecutive months, unless contraindicated or clinically significant adverse effects are experienced, or member is currently receiving Kineret; **Prior authorization is required for etanercept and adalimumab*
6. Dose does not exceed 100 mg daily.

**Approval duration: 6 months**

**B. Cryopyrin-Associated Periodic Syndromes** (must meet all)**:**

1. Diagnosis of neonatal-onset multisystem inflammatory disease (NOMID);
2. Prescribed by or in consultation with a rheumatologist;
3. Dose does not exceed 8 mg/kg per day.

**Approval duration: 6 months**

**C. Other diagnoses/indications**

1. Refer to PA.CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

## II. Continued Therapy

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

1. Currently receiving medication via Pennsylvania Health and Wellness benefit or member has previously met initial approval criteria or Continuity of Care policy applies;
2. Member is responding positively to therapy (examples: sign/symptom reduction, no disease progression, no significant toxicity);
3. If request is for a dose increase, new dose does not exceed:
   a. For RA: 100 mg per day;
   b. For NOMID: 8mg/kg per day.

**Approval duration: 12 months**

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

1. Currently receiving medication via Pennsylvania Health and Wellness benefit and documentation supports positive response to therapy.

**Approval duration: Duration of request or 12 months (whichever is less)**; or

2. Refer to PA.CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

## 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 – PA.CP.PMN.53 or evidence of coverage documents.

## IV. Appendices/General Information

*Appendix A: Abbreviation/Acronym Key*

CAPS: cryopyrin-associated periodic syndromes
DMARD: disease-modifying antirheumatic drug
FDA: Food and Drug Administration
IL-1: interleukin-1
MTX: methotrexate
NOMID: neonatal-onset multisystem inflammatory disease
RA: rheumatoid arthritis

*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**<br>1 mg/kg/day PO QD or divided BID | 2.5 mg/kg/day |
| Cuprimine® (d-penicillamine) | **RA***<br>Initial dose:<br>125 or 250 mg PO QD<br>Maintenance dose:<br>500 – 750 mg/day PO QD | 1,500 mg/day |
| cyclosporine (Sandimmune®, Neoral®) | **RA**<br>2.5 – 4 mg/kg/day PO divided BID | 4 mg/kg/day |
| hydroxychloroquine (Plaquenil®) | **RA***<br>Initial dose:<br>400 – 600 mg/day PO QD<br>Maintenance dose:<br>200 – 400 mg/day PO QD | 600 mg/day |
| leflunomide (Arava®) | **RA**<br>100 mg PO QD for 3 days, then 20 mg PO QD | 20 mg/day |
| methotrexate (Rheumatrex®) | **RA**<br>7.5 mg/week PO, SC, or IM or 2.5 mg PO Q12 hr for 3 doses/week | 30 mg/week |
| Ridaura® (auranofin) | **RA**<br>6 mg PO QD or 3 mg PO BID | 9 mg/day (3 mg TID) |
| sulfasalazine (Azulfidine®) | **RA**<br>2 g/day PO in divided doses | 3 g/day |
| Enbrel® (etanercept) | **RA**<br>25 mg SC twice weekly or 50 mg SC once weekly | 50 mg/week |
| Humira® (adalimumab) | **RA**<br>40 mg SC every other week (may increase to once weekly) | 40 mg/week |

*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 *E. coli*-derived proteins, Kineret, or any components of the product
- Boxed warning(s): none reported

*Appendix D: General Information*

- Definition of MTX or DMARD Failure

- 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

## V. Dosage and Administration

| | | |
|---|---|---|
| RA | 100 mg SC QD | 100 mg/day |
| NOMID | Initial dose:<br>1 – 2 mg/kg SC QD or divided BID<br>Maintenance dose:<br>8 mg/kg SC QD or divided BID | 8 mg/kg/day |

## VI. Product Availability

Single-use prefilled syringe: 100 mg/0.67 mL

## VII. References

1. Kineret Prescribing Information. Stockholm, Sweden: Swedish Orphan Biovitrum AB; June 2018. Available at: http://www.kineretrx.com/pdf/Full-Prescribing-Information-English.pdf. Accessed February 26, 2019.
2. Smolen JS, Landewé R, Breedveld FC, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2013 update. Ann Rheum Dis. 2014; 73: 492-509.
3. Singh JA, Furst DE, Bharat A, et al. 2012 update of the 2008 American College of Rheumatology recommendations for the use of disease-modifying antirheumatic drugs and biologic agents in the treatment of rheumatoid arthritis. Arthritis Care Res. 2012; 64(5): 625-639.
4. 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.

## 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 |
|---|---|
| N/A | |

| Reviews, Revisions, and Approvals | Date | Approval Date |
|---|---|---|
| 2Q 2018 annual review: removed TB testing requirement from all indications; references reviewed and updated. | 2.27.18 | |
| 2Q 2019 annual review: references reviewed and updated. | 04.17.19 | |