

Clinical Policy: Siltuximab (Sylvant)

Reference Number: PA.CP.PHAR.329

Effective Date: 01/2018

Last Review Date: 01/2026

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 PA Health & Wellness[®] 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 or hematologist;
3. Age \geq 18 years;
4. Sylvant is prescribed in one of the following ways (a, b or c):
 - a. As single-agent therapy for MCD;
 - b. As single-agent therapy for surgically unresectable/or if incomplete resection unicentric CD (UCD) (off-label);
 - c. Other NCCN recommendations listed as category 1, 2A, or 2B;
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*).

Approval duration: 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-d):
 - 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;
 - c. 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;
 - d. Other NCCN recommendations listed as category 1, 2A, or 2B;
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*).

Approval duration: Up to 4 doses total

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*).

Approval duration: 12 months

D. Other diagnoses/indications: Refer to PA.CP.PMN.53

II. Continued Approval

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

1. Currently receiving medication via PA Health & Wellness benefit or member has previously met all initial approval criteria; or the Continuity of Care policy (PA.PHARM.01) applies;
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*).

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. 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*).

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 PA Health & Wellness benefit or member has previously met all initial approval criteria; or the Continuity of Care policy (PA.PHARM.01) applies;
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*).

Approval duration: 12 months

D. Other diagnoses/indications (must meet 1 or 2):

1. Currently receiving medication via PA Health & Wellness benefit and documentation supports positive response to therapy; or the Continuity of Care policy (PA.PHARM.01) applies;
Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to PA.CP.PMN.53

III. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CAR: chimeric antigen receptor	KICS: KSHV-associated inflammatory cytokine syndrome
CD: Castleman’s disease	KSHV: Kaposi-sarcoma associated herpesvirus
CRS: cytokine release syndrome	MCD: multicentric Castleman’s disease
FDA: Food and Drug Administration	UCD: unicentric Castleman’s disease
HHV-8: negative and human herpesvirus-8	
HIV: human immunodeficiency virus	

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

IV. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
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Castleman's disease	11 mg/kg over 1 hour IV every 3 weeks	11 mg/kg
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V. Product Availability

Lyophilized powder in a single-use vial: 100 mg and 400 mg

VI. References

1. Sylvant Prescribing Information. Horsham, PA: Janssen Biotech, Inc.; June 2024. Available at https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/125496s0181bl.pdf, Accessed November 6, 2025.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.nccn.org. Accessed November 26, 2025.
3. National Comprehensive Cancer Network. Castleman Disease Version 1.2026. National Comprehensive Cancer Network Guidelines. Available at https://www.nccn.org/professionals/physician_gls/pdf/castleman.pdf. Accessed November 24, 2025.
4. National Comprehensive Cancer Network. Management of CAR T-Cell and Lymphocyte Engager-Related Toxicities Version 2.2026. Available at: https://www.nccn.org/professionals/physician_gls/pdf/cellular_tox.pdf. Accessed: November 24, 2025.
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.

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
Age added. Dose parameters delineated. References reviewed and updated.	02/2018
1Q 2019 annual review: added prescriber requirement; allowed COC for continued approval; added option for off-label dosing as supported by guidelines or literature; references reviewed and updated.	01/2019
1Q 2020 annual review: references reviewed and updated.	01/2020
1Q 2021 annual review: lab parameters removed from criteria sets given they do not represent a treatment contraindication; no significant changes; references reviewed and updated.	01/2021

Reviews, Revisions, and Approvals	Date
1Q 2022 annual review: added criteria set for NCCN compendium supported use for CRS associated with CAR or autologous T cell therapy; references reviewed and updated.	01/2022
1Q 2023 annual review: no significant changes; references reviewed and updated.	01/2023
1Q 2024 annual review: in CRS initial criteria, added Sylant may be used to replace the second dose of Actemra OR Tofidence per NCCN; references reviewed and updated.	01/2024
1Q 2025 annual review: in CRS initial criteria, added Sylvant may be used to replace the second dose of Tyenne per NCCN and added Carvykti as an additional example of a CAR-T therapy; references reviewed and updated.	01/2025
1Q 2026 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.	01/2026