Clinical Policy: Siltuximab (Sylvant)

Reference Number: PA.CP.PHAR.329
Effective Date: 01/2018
Last Review Date: 01/2024

Coding Implications
Revision Log

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 ≥ 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*).

Approval duration: 6 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®);
2. Sylvant is prescribed in one of the following ways (a or b):
   a. For the management of grade 4 CRS that is refractory to high-dose corticosteroids and anti-IL-6 therapy;
   b. As a replacement for the second dose of Actemra® or Tofidence™ when supplies are limited or unavailable for CRS or immunotherapy related neurotoxicity;
3. Dose 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. 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.LTSS.PHAR.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. Dose 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. 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.LTSS.PHAR.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
CD: Castleman's disease
CRS: cytokine release syndrome
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

IV. Dosage and Administration

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

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.; December 2019. Available at https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/125496s018lbl.pdf. , Accessed October 27, 2023.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.nccn.org. Accessed October 27, 2023.
3. B-Cell Lymphomas Version 6.2023. National Comprehensive Cancer Network Guidelines. Available at https://www.nccn.org/professionals/physician_gls/pdf/b-cell.pdf. Accessed October 27, 2023.
4. Management of Immunotherapy-Related Toxicities Version 3.2023. National Comprehensive Cancer Network Guidelines. Available at https://www.nccn.org/professionals/physician_gls/pdf/immunotherapy.pdf. Accessed October 27, 2023.

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

Reviews, Revisions, and Approvals	Date
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
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