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Actemra (tocilizumab)

PRODUCTS AFFECTED

Actemra (tocilizumab)

COVERAGE POLICY

Coverage for services, procedures, medical devices, and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide Molina Healthcare complete medical rationale when requesting any exceptions to these guidelines.

Documentation Requirements:

Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational, or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

DIAGNOSIS:

Moderately to severely active rheumatoid arthritis (RA), Polyarticular juvenile idiopathic arthritis, Systemic juvenile idiopathic arthritis, Temporal arteritis, also known as giant cell arteritis (GCA), Chimeric antigen receptor (CAR) T-cell-induced severe or life-threatening cytokine release syndrome (CRS), Systemic sclerosis-associated interstitial lung disease (SSc-ILD)

REQUIRED MEDICAL INFORMATION:

This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. If a drug within this policy receives an updated FDA label within the last 180 days, medical necessity for the member will be reviewed using the updated FDA label information along with state and federal requirements, benefit being administered and formulary preferencing. Coverage will be determined on a case-by-case basis until the criteria can be updated through Molina Healthcare, Inc. clinical governance. Additional information may be required on a case-by-case basis to allow for adequate review.

Drug and Biologic Coverage Criteria

FOR ALL INDICATIONS (EXCEPT CRS):

1. (a) Prescriber attests member has had a negative TB screening or TB test result within the last 12 months for initial and continuation of therapy requests
OR
(b) For members who have a positive test for latent TB, provider documents member has completed a treatment course (a negative chest x-ray is also required every 12 months) OR that member has been cleared by an infectious disease specialist to begin treatment
AND
2. Prescriber attests member has been evaluated and screened for the presence of hepatitis B virus (HBV) prior to initiating treatment
AND
3. Member is not on concurrent treatment or will not be used in combination with other TNF-inhibitor, biologic response modifier or other biologic DMARDs, Janus kinase Inhibitors, or Phosphodiesterase 4 inhibitor (i.e., apremilast, tofacitinib, baricitinib) as verified by prescriber attestation, member medication fill history, or submitted documentation
AND
4. Prescriber attests member does not have an active infection, including clinically important localized infections
AND
5. Prescriber attests that member does NOT have an ANC less than 2000/mm³, platelets less than 100,000/mm³ or liver transaminases above 1.5 times ULN
AND
6. IF THIS IS A NON-FORMULARY/NON-PREFERRED PRODUCT: Documentation of trial/failure of or intolerance to a majority (not more than 3) of the preferred formulary/PDL alternatives for the given diagnosis. Submit documentation including medication(s) tried, dates of trial(s) and reason for treatment failure(s).

A. MODERATE TO SEVERE RHEUMATOID ARTHRITIS:

1. Documentation of moderate to severe rheumatoid arthritis diagnosis
AND
2. Documentation of prescriber baseline disease activity evaluation and goals for treatment to be used to evaluate efficacy of therapy at renewal [DOCUMENTATION REQUIRED]
AND
3. (a) Member is currently receiving maximally tolerated dose of methotrexate and is not at goal disease activity
OR
(b) Member has an FDA labeled contraindication or serious side effects to methotrexate, as determined by the prescribing physician AND member has tried one additional disease-modifying antirheumatic drug (DMARD) (brand or generic; oral or injectable) for at least 3 months (*NOTE: An exception to the requirement for a trial of one conventional synthetic DMARD can be made if the Member has already had a 3-month trial of at least one biologic. These patients who have already tried a biologic for RA are not required to "step back" and try a conventional synthetic DMARD.*)

B. JUVENILE IDIOPATHIC ARTHRITIS (ACTIVE SYSTEMIC AND POLYARTICULAR):

1. Member must have a diagnosis of systemic juvenile idiopathic arthritis (SJIA) or polyarticular juvenile idiopathic arthritis (PJIA) in children 2 years of age or older
AND
2. Documentation of prescriber baseline disease activity evaluation and goals for treatment to be used to evaluate efficacy of therapy at renewal [DOCUMENTATION REQUIRED]
AND
3. (a) FOR ACTIVE SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS: Documentation of treatment failure, serious side effects or clinical contraindication to an adequate trial (12 weeks) of one NSAID or glucocorticoid

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OR

(b) FOR POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS: Documentation of treatment failure, serious side effects or clinical contraindication to an adequate trial (generally ≥ 12 weeks) of one or more of the following: Methotrexate, hydroxychloroquine, sulfasalazine, leflunomide

C. GIANT CELL ARTERITIS (GCA):

1. Documentation of Giant Cell Arteritis (GCA) diagnosis by one of the following:
 - (a) Member must have confirmed diagnosis of giant cell arteritis by results of a temporal-artery biopsy showing features of giant-cell arteritis OR
 - (b) Evidence of large- vessel vasculitis on angiography, computed tomographic or magnetic resonance angiography, or positron-emission tomography OR
 - (c) High clinical suspicion despite negative biopsy and imagingAND
2. Documentation of prescriber baseline disease activity evaluation and goals for treatment to be used to evaluate efficacy of therapy at renewal [DOCUMENTATION REQUIRED]
AND
3. Documented disease activity defined as (i) unequivocal evidence of cranial symptoms of giant-cell arteritis or polymyalgia rheumatica and (ii) increased concentrations of serum acute-phase reactants (ESR > 30 mm/hour or CRP > 1 mg/dL)
AND
4. Member must have documented need for a glucocorticoid sparing agent use such as: presence of significant premorbid diseases, emergence of significant glucocorticoid-related side effects during the course of treatment, a relapsing course necessitating protracted glucocorticoid use, preexisting diabetes mellitus on treatment, osteoporosis, or significant obesity
AND
5. (a) Documentation of an inadequate clinical response to an adherent regimen of methotrexate for ≥ 3 months OR
(b) Contraindication to methotrexate, as evidenced by one or more of the following: Known hypersensitivity to methotrexate, History of intolerance or adverse event to methotrexate, currently pregnant or planning for pregnancy, Breastfeeding, Alcoholism, Alcoholic liver disease or other chronic liver disease, Elevated liver transaminases, Interstitial pneumonitis or clinically significant pulmonary fibrosis, Renal impairment (CrCl < 40 mL/min), Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia), Myelodysplasia, Significant drug interaction, Overt or laboratory evidence of immunodeficiency, Active pulmonary disease, Peptic ulcer disease

D. CYTOKINE RELEASE SYNDROME (CAR-T THERAPY INDUCED): APPROVED ONLY IF CART- T IS APPROVED BY TRANSPLANT TEAM. VERIFICATION OF CAR-T IS REQUIRED DOCUMENTATION.

1. Prescriber attests that member does NOT have an ANC less than 2000/mm³, platelets less than 100,000/mm³ or liver transaminases above 1.5 times ULN OR prescriber attests the benefit of treating CRS outweighs the risks of short-term treatment with Actemra
NOTE: Patients with severe or life-threatening CRS frequently have cytopenias or elevated ALT or AST due to the lymphodepleting chemotherapy or the CRS. The decision to administer ACTEMRA should take into account the potential benefit of treating the CRS versus the risks of short-term treatment with ACTEMRA.

E. SYSTEMIC SCLEROSIS-ASSOCIATED INTERSTITIAL LUNG DISEASE (SSc-ILD) (Subcutaneous syringes only):

1. Documented diagnosis of systemic sclerosis-associated interstitial lung disease
AND
2. Documentation of chest high resolution computed tomography (HRCT) scan confirming diagnosis of interstitial lung disease [DOCUMENTATION REQUIRED]

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AND

3. Documentation member has elevated acute-phase reactants as documented by at least one of the following [DOCUMENTATION REQUIRED]: CRP level ≥ 6 mg/L, erythrocyte sedimentation rate ≥ 28 mm/hour, platelet count $\geq 330 \times 10^9/L$

AND

4. Prescriber attests or clinical reviewer has found that Tocilizumab is not being prescribed for use with nintedanib (Ofev)

AND

5. Documentation of treatment failure, serious side effects or clinical contraindication to mycophenolate mofetil

AND

6. Documentation of prescriber baseline disease activity evaluation and goals for treatment to be used to evaluate efficacy of therapy at renewal (e.g., respiratory symptoms, subjective exercise tolerance, physical exam, pulmonary function tests [spirometry, diffusing capacity for carbon monoxide (DLCO), six-minute walk test] [DOCUMENTATION REQUIRED]

CONTINUATION OF THERAPY:

A. ALL INDICATIONS (EXCEPT CRS):

1. Adherence to therapy at least 85% of the time as verified by the prescriber or member medication fill history OR adherence less than 85% of the time due to the need for surgery or treatment of an infection, causing temporary discontinuation
AND
2. Prescriber attests to or clinical reviewer has found no evidence of intolerable adverse effects or drug toxicity
AND
3. Documentation of positive clinical response as demonstrated by low disease activity and/or improvements in the condition's signs and symptoms [DOCUMENTATION REQUIRED]
AND
4. (a) Prescriber attests member has had a negative TB screening or TB test result within the last 12 months for initial and continuation of therapy requests
OR
(b) For members who have a positive test for latent TB, provider documents member has completed a treatment course (a negative chest x-ray is also required every 12 months) OR that member has been cleared by an infectious disease specialist to begin treatment
AND
5. Prescriber attests that ANC, platelets, and liver transaminases will be monitored as clinically indicated while the member is on treatment.

DURATION OF APPROVAL:

Initial authorization: 6 months, Continuation of therapy: 12 months.

PRESCRIBER REQUIREMENTS:

CYTOKINE RELEASE SYNDROME (CAR-T THERAPY INDUCED): Prescribed by or in consultation with a board-certified oncologist.

SYSTEMIC SCLEROSIS-ASSOCIATED INTERSTITIAL LUNG DISEASE (SSc-ILD): Prescribed by or in consultation with a board-certified rheumatologist or pulmonologist.

ALL OTHER INDICATIONS: Prescribed by or in consultation with a board-certified rheumatologist.

[If prescribed in consultation, consultation notes must be submitted with initial request and reauthorization requests]

AGE RESTRICTIONS:

PJIA, SJIA and CAR T-cell-induced cytokine release syndrome: 2 years of age and older All

other indications: 18 years of age and older

Drug and Biologic Coverage Criteria

QUANTITY:

CYTOKINE RELEASE SYNDROME (CAR-T THERAPY INDUCED): max 8 single dose vials per lifetime, not to exceed 800 mg. NOTE: PLEASE SEND TO MEDICAL DIRECTOR FOR REVIEW FOR AUTHORIZATION CONCURRENTLY WITH CART THERAPY

ALL OTHER INDICATIONS:

Subcutaneous:

Rheumatoid arthritis: Up to 162 mg every week

Giant cell arteritis: Up to 162 mg every week

SSc-ILD: 162 mg every week

PJIA: < 30 kg – 162 mg every 3 weeks; 30 kg or greater – 162 mg every 2 weeks

SJIA: <30 kg – 162 mg every 2 weeks; 30 kg or greater – 162 mg every week

Intravenous:

Rheumatoid arthritis: 4 mg/kg every 4 weeks, may increase to 8 mg/kg every 4 weeks, not to exceed 800 mg per infusion

Giant cell arteritis: 6 mg/kg every 4 weeks, not to exceed 600 mg per infusion

PJIA: < 30 kg – 10 mg/kg every 4 weeks; 30 kg or greater – 8 mg/kg every 4 weeks

SJIA: < 30 kg – 12 mg/kg every 2 weeks; 30 kg or greater – 8 mg/kg every 2 weeks

CRS: < 30 kg – 12 mg/kg; 30 kg or greater – 8 mg/kg every 4 weeks, not to exceed 800 mg per infusion

Maximum Quantity Limits –

SC: 4 packages (4 syringes) per 28 days

IV: 80 mg/4 mL vial: 1 vial per 14 days, 200 mg/10 mL vial: 1 vial per 14 days, 400 mg/20 mL vial: 2 vials per 14 days

PLACE OF ADMINISTRATION:

The recommendation is that injectable medications in this policy will be for pharmacy or medical benefit coverage and the subcutaneous injectable products administered in a place of service that is a non-hospital facility-based location.

The recommendation is that infused medications in this policy will be for pharmacy or medical benefit coverage administered in a place of service that is a non-hospital facility-based location as per the Molina Health Care Site of Care program.

Note: Site of Care Utilization Management Policy applies for Actemra (tocilizumab) IV. For information on site of care, see

[Specialty Medication Administration Site of Care Coverage Criteria \(molinamarketplace.com\)](https://www.molinamarketplace.com/specialty-medication-administration-site-of-care-coverage-criteria)

DRUG INFORMATION

ROUTE OF ADMINISTRATION:

Intravenous, Subcutaneous

DRUG CLASS:

Interleukin-6 Receptor Inhibitors

FDA-APPROVED USES:

Actemra IV and SQ: Indicated for the treatment of adult patients with moderately to severely active rheumatoid arthritis who have had an inadequate response to one or more Disease-Modifying Anti-Rheumatic Drugs (DMARDs). Indicated for the treatment of active polyarticular juvenile idiopathic arthritis and active systemic juvenile idiopathic arthritis in patients 2 years of age and older. Indicated for the treatment of giant cell arteritis (GCA) in adult patients.

Actemra SQ (only): Indicated for slowing the rate of decline in pulmonary function in adult patients with systemic sclerosis-associated interstitial lung disease.

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Drug and Biologic Coverage Criteria

Actemra IV (only): chimeric antigen receptor (CAR) T-cell-induced severe or life-threatening cytokine release syndrome (CRS) in adults and pediatric patients 2 years of age and older.

COMPENDIAL APPROVED OFF-LABELED USES:
None

APPENDIX

APPENDIX:
OBJECTIVE MEASURES FOR RA:
[Clinical Disease Activity Index (CDAI), Disease Activity Score with 28-joint counts (erythrocyte sedimentation rate or C-reactive protein), Member Activity Scale (PAS or PAS- II), Routine Assessment of Member Index Data with 3 measures, Simplified Disease Activity Index (SDAI)] OBJECTIVE MEASURES FOR PJA:
Global Arthritis Score (GAS), Clinical Disease Activity Index (CDAI), Disease Activity Score (DAS), Disease Activity Score based on 28-joint evaluation (DAS28), Simple Disease Activity Index (SDAI), Health Assessment Questionnaire disability index (HAQ-DI), Visual Analogue Scale (VAS), Likert scales of global response or pain by the member or global response by the physician, Joint tenderness and/or swelling counts, Laboratory data

Table 1. The American College of Rheumatology/European League Against Rheumatism criteria for the classification of systemic sclerosis (SSc)*

Item	Sub-item(s)	Weight/score†
Skin thickening of the fingers of both hands extending proximal to the metacarpophalangeal joints (<i>sufficient criterion</i>)	–	9
Skin thickening of the fingers (<i>only count the higher score</i>)	Puffy fingers	2
	Sclerodactyly of the fingers (distal to the metacarpophalangeal joints but proximal to the proximal interphalangeal joints)	4
Fingertip lesions (<i>only count the higher score</i>)	Digital tip ulcers	2
	Fingertip pitting scars	3
Telangiectasia	–	2
Abnormal nailfold capillaries	–	2
Pulmonary arterial hypertension and/or interstitial lung disease (<i>maximum score is 2</i>)	Pulmonary arterial hypertension	2
	Interstitial lung disease	2
Raynaud’s phenomenon	–	3
SSc-related autoantibodies (anticentromere, anti-topoisomerase I [anti-Scl-70], anti-RNA polymerase III) (<i>maximum score is 3</i>)	Anticentromere Anti-topoisomerase I Anti-RNA polymerase III	3

* These criteria are applicable to any patient considered for inclusion in an SSc study. The criteria are not applicable to patients with skin thickening sparing the fingers or to patients who have a scleroderma-like disorder that better explains their manifestations (e.g., nephrogenic sclerosing fibrosis, generalized morphea, eosinophilic fasciitis, scleredema diabeticorum, scleromyxedema, erythromyalgia, porphyria, lichen sclerosis, graft-versus-host disease, diabetic cheiroarthropathy).
† The total score is determined by adding the maximum weight (score) in each category. Patients with a total score of ≥9 are classified as having definite SSc.

BACKGROUND AND OTHER CONSIDERATIONS

BACKGROUND:

Tocilizumab (Actemra) is a recombinant humanized anti-human interleukin-6 (IL-6) receptor monoclonal antibody (IgG1κ). The drug binds to membrane-bound (mIL-6R) and soluble (sIL-6R) forms of the interleukin-6 receptor, thereby reducing the inflammatory process by inhibiting signaling through these receptors. Interleukin-6 is a pleiotropic pro-inflammatory cytokine involved in multiple phases of the inflammatory response, including T-cell activation and induction of immunoglobulin secretion. Actemra SC has demonstrated efficacy and is indicated for the treatment of rheumatoid arthritis (RA) in adults with moderate to severe active RA who have had an inadequate response to one or more disease modifying anti-rheumatic drugs (DMARDs). Actemra SC has been shown to inhibit and slow structural joint damage, improve physical function, and achieve a major clinical response in patients taking methotrexate (MTX). In addition to RA, Actemra SC is also indicated in adults with giant cell arteritis (GCA). It is recommended to be given once weekly and may be given in combination with a tapering course of glucocorticoids. Actemra SC can be used alone following the discontinuation of glucocorticoids. The subcutaneous formulation is also indicated for SSc-ILD and has been shown slow the rate of decline in pulmonary function in adult patients. Actemra is also available as an intravenous (IV) formulation which, in addition to RA, is indicated in patients 2 years of age and older for the treatment of active systemic juvenile idiopathic arthritis (SJIA) or polyarticular juvenile idiopathic arthritis (PJIA). The IV formulation is not indicated in GCA or SSc-ILD.

CONTRAINDICATIONS/EXCLUSIONS/DISCONTINUATION:

All other uses of Actemra (tocilizumab) are considered experimental/investigational and therefore, will follow Molina's Off- Label policy. Contraindications to Actemra (tocilizumab) include: patients with known hypersensitivity to ACTEMRA, administration during an active infection including localized infections, use with live vaccines.

OTHER SPECIAL CONSIDERATIONS:

None

CODING/BILLING INFORMATION

Note: 1) This list of codes may not be all-inclusive. 2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement

HCPSC CODE	DESCRIPTION
J3262	Injection, tocilizumab, 1 mg

AVAILABLE DOSAGE FORMS:

Actemra 80MG/4ML
Actemra 200MG/10ML
Actemra 400MG/20ML
Actemra ACT Pen 162MG/0.9ML
Actemra Prefilled Syringe 162MG/0.9ML

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SUMMARY OF REVIEW/REVISIONS	DATE
REVISION- Notable revisions: Required Medical Information Continuation of Therapy Age Restrictions Quantity FDA-Approved Uses Contraindications/Exclusions/Discontinuation Other Special Considerations Available Dosage Forms References	Q4 2022
Q2 2022 Established tracking in new format	Historical changes on file