Medical Policy

Healthcare Services Department

Policy Name	Policy Number	Scope
Sylvant (siltuximab)	MP-RX-FP-87-23	☒ MMM MA ☒ MMM Multihealth

Service Category

☐ Anesthesia
☐ Surgery
☐ Radiology Procedures
☐ Pathology and Laboratory Procedures
☐ Medicine Services and Procedures
☐ Evaluation and Management Services
☐ DME/Prosthetics or Supplies
☒ Part B DRUG

Service Description

This document addresses the use of Sylvant (siltuximab) , a drug approved by the Food and Drug Administration (FDA) for the treatment of t of multicentric Castleman's disease in individuals who are human immunodeficiency virus (HIV) negative and human herpesvirus-8 (HHV-8) negative.

Background Information

This document addresses the use of Sylvant (siltuximab). Sylvant is a monoclonal antibody which binds to interleukin-6 (IL-6) receptors and inhibits release of proinflammatory cytokines primarily used to treat multicentric Castleman's disease.

The FDA approved indications for Sylvant include treatment of multicentric Castleman's disease in individuals who are human immunodeficiency virus (HIV) negative and human herpesvirus-8 (HHV-8) negative. Sylvant has a labeled warning that it should not be administered to individuals with severe infections; and those with concurrent lymphoma were excluded from clinical trials.

Other Uses

The National Comprehensive Cancer Network® (NCCN) provides additional recommendations with a category 2A level of evidence for the use of Sylvant in relapsed or refractory, surgically unresectable unicentric Castleman's disease. NCCN guidelines for management of immunotherapy-related toxicities to include the use of siltuximab as an option for chimeric antigen receptor (CAR) T-cell related cytokine release syndrome refractory to high-dose corticosteroids and anti-IL-6 therapy.

Definitions and Measures Castleman's disease (CD):

A rare, non-cancerous disorder that affects the lymph nodes and other immune-cell structures throughout the body. CD has two variants: unicentric CD and multicentric Castleman's disease, and is also known as giant lymph node hyperplasia and angiofollicular lymph node hyperplasia

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Approved Indications

A. Multicentric Castleman's disease in individuals who are human immunodeficiency virus (HIV) negative and human herpesvirus-8 (HHV-8) negative.

Other Uses

A. relapsed or refractory, surgically unresectable unicentric Castleman's disease

B. cytokine release syndrome refractory to high-dose corticosteroids and anti-IL6 therapy or to replace tocilizumab when supplies limited

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS	Description
J2860	Injection, siltuximab, 10 mg [Sylvant]

ICD-10	Description
D47.Z2	Castleman disease

Medical Necessity Guidelines

When a drug is being reviewed for coverage under a member's medical benefit plan or is otherwise subject to clinical review (including prior authorization), the following criteria will be used to determine whether the drug meets any applicable medical necessity requirements for the intended/prescribed purpose.

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

Sylvant (siltuximab)

A. Criteria For Initial Approval (*Provider must submit documentation [such as office chart notes, lab results, pathology reports, imaging studies, and any other pertinent clinical information] supporting the patient's diagnosis for the drug and confirming that the patient has met **all** approval criteria.)*

i. Individual has a diagnosis of Multicentric Castleman's; **AND**
ii. Sylvant (siltuximab) is used as a single agent; **AND**
iii. Individual is human immunodeficiency virus negative; **AND**
iv. Individual is human herpesvirus-8 negative;

OR

v. Individual has a diagnosis of relapsed/refractory unicentric Castleman Disease (NCCN 2A); **AND**
vi. Sylvant (siltuximab) used as a single agent; **AND**
vii. Individual is Human immunodeficiency virus negative; **AND**
viii. Individual is Human herpes-8 negative;

OR

ix. Individual has a diagnosis of Grade 4 chimeric antigen receptor (CAR) T cell-induced CRS (NCCN 2A); **AND**
x. CRS is refractory to high-dose corticosteroids and other anti-IL-6 therapy.

B. Criteria For Continuation of Therapy

i. MMM considers continuation of Sylvant therapy medically necessary in members requesting reauthorization for an indication listed in Section A above (Criteria for Initial Approval) when all following criteria are met.
   a. For Multicentric Castleman's disease or relapsed/refractory unicentric Castleman's disease: there is no evidence of unacceptable toxicity or disease progression while on the current regimen, and the recommended duration of therapy has not been exceeded. The following information should be submitted for reauthorization:
      1. A current oncology note documenting the patient's response to treatment showing no progression of disease.
      2. Current imaging studies and other objective measures, as appropriate, showing no progression of disease when compared with previous results (every six months).
   b. For Cytokine release syndrome: Sylvant is typically administered as a single dose when used to manage cytokine release syndrome (CRS) associated with CAR-T cell

therapy. Given that CAR-T cell therapy is generally delivered as a single infusion, coverage for Sylvant will be provided for one dose only and may not eligible for reauthorization.

C. Authorization Duration

i. For Multicentric Castleman's disease or relapsed/refractory unicentric Castleman's disease
   a. Initial Approval Duration: Up to 6 months
   b. Reauthorization Approval Duration: Up to 6 months

ii. For Cytokine release syndrome
   a. Initial Approval Duration: 3 months (one dose)
   b. Reauthorization Approval Duration: Not applicable

D. Conditions Not Covered

Any other use is considered experimental, investigational, or unproven, including the following (this list may not be all inclusive):

Requests for Sylvant (siltuximab) may not be approved for the following:

I. Individual has a current severe infection; **OR**
II. When the above criteria are not met and for all other indications.

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Reference Information

1. DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. http://dailymed.nlm.nih.gov/dailymed/about.cfm. Accessed: January 3, 2023.
2. DrugPoints® System [electronic version]. Truven Health Analytics, Greenwood Village, CO. Updated periodically.
3. Lexi-Comp ONLINE™ with AHFS™, Hudson, Ohio: Lexi-Comp, Inc.; 2023; Updated periodically.
4. NCCN Clinical Practice Guidelines in Oncology™. © 2022 National Comprehensive Cancer Network, Inc. For additional information visit the NCCN website: http://www.nccn.org/index.asp. Accessed on January 3, 2023.
   a. B-Cell Lymphomas. V5.2022. Revised July 12, 2022.
   b. Management of Immunotherapy-related toxicities. V1.2022. Revised February 28, 2022.

Federal and state laws or requirements, contract language, and Plan utilization management programs or polices may take precedence over the application of this clinical criteria.

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Policy History

Revision Type	Summary of Changes	P&T Approval Date	UM/CMPC Approval Date
Annual Review 02/15/2024	Include use in immunotherapy-related toxicity and unicentric Castleman disease per NCCN; update multicentric Castleman disease per NCCN; Added continuation approval criteria and authorization duration; Added the following statement: (Provider must submit documentation [such as office chart notes, lab results, pathology reports, imaging studies, and any other pertinent clinical information] supporting the patient's diagnosis for the drug and confirming that the patient has met all approval criteria.); Coding Reviewed: No changes.	3/14/2025	4/2/2025
Policy Inception 02/24/2023	Elevance Health's Medical Policy adoption.	N/A	11/30/2023