Clinical Policy: Canakinumab (Ilaris)

Reference Number: CP.PHAR.246
Effective Date: 08/16
Last Review Date: 11/16

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
The intent of the criteria is to ensure that patients follow selection elements established by Centene® clinical policy for canakinumab (Ilaris®).

Policy/Criteria
It is the policy of health plans affiliated with Centene Corporation® that Ilaris is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

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

1. Prescribed by or in consultation with a rheumatologist or other physician experienced in the management of cryopyrin-associated periodic syndromes;
2. Diagnosis of familial cold autoinflammatory syndrome (FCAS) or Muckle-Wells syndrome (MWS);
3. Tuberculosis (TB) test within the past 12 months is negative, or if positive, active TB has been ruled out and the patient has received treatment for latent TB infection;
4. Prescribed dose of Ilaris does not exceed 150 mg every 8 weeks;
5. Member has none of the following contraindications:
   a. Known hypersensitivity to any component of Ilaris;
   b. Active infection, including localized infections.

Approval duration: 12 weeks

B. Systemic Juvenile Idiopathic Arthritis (must meet all):

1. Prescribed by or in consultation with a rheumatologist;
2. Diagnosis of systemic juvenile idiopathic arthritis (SJIA);
3. TB test within the past 12 months is negative, or if positive, active TB has been ruled out and the patient has received treatment for latent TB infection;
4. Member has failed one of the following therapies unless contraindicated:
   a. A biologic for SJIA other than Ilaris;
   b. One or more non-steroidal anti-inflammatory drug (NSAIDs) for ≥ 1 month and corticosteroids for ≥ 2 weeks;
   c. Methotrexate or leflunomide for ≥ 3 consecutive months;
5. Prescribed dose of Ilaris does not exceed 300 mg every 4 weeks;
6. Member has none of the following contraindications:
   a. Known hypersensitivity to any component of Ilaris;
   b. Active infection, including localized infections.

Approval duration: 8 weeks

C. Tumor Necrosis Factor Receptor Associated Periodic Syndrome (must meet all)**:**
1. Prescribed by or in consultation with a rheumatologist or other physician experienced in the management of tumor necrosis factor receptor associated periodic syndrome (TRAPS);
2. Diagnosis of TRAPS;
3. TB test within the past 12 months is negative, or if positive, active TB has been ruled out and the patient has received treatment for latent TB infection;
4. Prescribed dose of Ilaris does not exceed 300 mg every 4 weeks;
5. Member has none of the following contraindications:
   a. Known hypersensitivity to any component of Ilaris;
   b. Active infection, including localized infections.

Approval duration: 8 weeks

D. Hyperimmunoglobulin D Syndrome/Mevalonate Kinase Deficiency (must meet all)**:**
1. Prescribed by or in consultation with a rheumatologist or other physician experienced in the management of hyperimmunoglobulin D syndrome (HIDS)/mevalonate kinase deficiency (MKD);
2. Diagnosis of HIDS/MKD;
3. TB test within the past 12 months is negative, or if positive, active TB has been ruled out and the patient has received treatment for latent TB infection;
4. Prescribed dose of Ilaris does not exceed 300 mg every 4 weeks;
5. Member has none of the following contraindications:
   a. Known hypersensitivity to any component of Ilaris;
   b. Active infection, including localized infections.

Approval duration: 8 weeks

E. Familial Mediterranean Fever (must meet all)**:**
1. Prescribed by or in consultation with a rheumatologist or other physician experienced in the management of familial Mediterranean fever (FMF);
2. Diagnosis of FMF;
3. TB test within the past 12 months is negative, or if positive, active TB has been ruled out and the patient has received treatment for latent TB infection;
4. Member meets one of the following (a or b):
   a. Age < 4 years;
   b. Member has failed ≥ 6 months of colchicine at maximum indicated doses, unless intolerant or contraindicated;
5. Prescribed dose of Ilaris does not exceed 300 mg every 4 weeks;
6. Member has none of the following contraindications:
   a. Known hypersensitivity to any component of Ilaris;
   b. Active infection, including localized infections.

Approval duration: 8 weeks

F. Other diagnoses/indications: Refer to CP.PHAR.57 - Global Biopharm Policy.

II. Continued Approval

A. All Indications (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
2. Member meets one of the following (a or b):
   a. Member is responding positively to therapy as evidenced by documentation of clinical response which may include:
      i. For FCAS, MWS, TRAPS, HIDS/MKD, and FMF: reduction/normalization of C-reactive protein (CRP) or serum amyloid A (SAA) levels; reduction of flare frequency, symptom severity, or duration;
      ii. For SJIA: quantitative measures such as physician global assessment of disease activity, parent or patient global assessment of wellbeing, number of joints with active arthritis, number of joints with limited range of motion, CRP, and functional ability (Childhood Health Assessment Questionnaire – [CHAQ]);
   b. Member has had an inadequate response to therapy, and request is for a dose increase;
3. Prescribed regimen does not exceed the following:
   a. For FCAS and MWS: 150 mg every eight weeks;
   b. For SJIA, TRAPS, HIDS/MKD, and FMF: 300 mg every four weeks;
4. Member has none of the following reasons to discontinue:
   a. Known hypersensitivity to any component of Ilaris;
   b. Development of serious infection.

Approval duration: 12 months

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

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy; or
2. Refer to CP.PHAR.57 - Global Biopharm Policy.

Background

Description/Mechanism of Action:

Canakinumab is a human monoclonal anti-human IL-1β antibody of the IgG1/κ isotype. Ilaris binds to human IL- 1β and neutralizes its activity by blocking its interaction with IL-1 receptors, but it does not bind IL-1α or IL-1 receptor antagonist (IL-1ra).

Cryopyrin-associated periodic syndromes (CAPS) refer to rare genetic syndromes generally caused by mutations in the NLRP-3 [nucleotide-binding domain, leucine rich family (NLR), pyrin domain containing 3] gene (also known as Cold-Induced Auto-inflammatory Syndrome-1 [CIAS1]). CAPS disorders are inherited in an autosomal dominant pattern with male and female offspring equally affected. Features common to all disorders include fever, urticaria-like rash, arthralgia, myalgia, fatigue, and conjunctivitis. The NLRP-3 gene encodes the protein cryopyrin, an important component of the inflammasome. Cryopyrin regulates the protease caspase-1 and controls the activation of interleukin-1 beta (IL-1β). Mutations in NLRP-3 result in an overactive inflammasome resulting in excessive release of activated IL-1β that drives inflammation. SJIA is

a severe autoinflammatory disease, driven by innate immunity by means of pro-inflammatory cytokines such as interleukin 1β (IL-1β).

Formulations:
Ilaris is supplied in a sterile, single-use, colorless, 6 mL glass vial containing 150 of canakinumab as a white, preservative-free, lyophilized powder. Reconstitution with 1 mL of preservative-free sterile water for injection is required prior to administration.

FDA Approved Indications:
Ilaris is an interleukin-1β blocker/subcutaneous injectable formulation indicated for the treatment of:

- Periodic fever syndromes:
  - CAPS in adults and children 4 years of age and older including:
    - Familial cold autoinflammatory syndrome (FCAS)
    - Muckle-Wells syndrome (MWS)
  - Tumor necrosis factor receptor associated periodic syndrome (TRAPS) in adult and pediatric patients
  - Hyperimmunoglobulin D syndrome (HIDS)/mevalonate kinase deficiency (MKD) in adult and pediatric patients
  - Familial Mediterranean fever (FMF) in adult and pediatric patients
- Active SJIA in patients aged 2 years and older

Appendices
Appendix A: Abbreviation Key
CAPS: cryopyrin-associated periodic syndromes
CHAQ: Childhood Health Assessment Questionnaire
CRP: C-reactive protein
FCAS: familial cold autoinflammatory syndrome
FMF: familial Mediterranean fever
HIDS: hyperimmunoglobulin D syndrome
MKD: mevalonate kinase deficiency
MWS: Muckle-Wells syndrome
NSAID: non-steroidal anti-inflammatory drug
SAA: serum amyloid A
SJIA: active systemic juvenile idiopathic arthritis
TB: tuberculosis
TRAPS: tumor necrosis factor receptor associated periodic syndrome

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
J0638	Injection, canakinumab, 1 mg

Reviews, Revisions, and Approvals	Date	Approval Date
Policy split from CP.PHAR.86.Arthritis Treatments and CP.PHAR.47.CAPS. FCAS, MWS: Removed criteria related to HBV, malignant disease, concomitant use with other biologics, and concurrent administration of live vaccines; added requirement related to dosing based on FDA approved dosing guidelines. SJIA: removed question related to active systemic features; modified duration of treatment of NSAIDs and corticosteroids to for ≥ 1 month and ≥ 2 weeks, respectively; added MTX or leflunomide as an option for failure. Re-auth: combined into All Indications; added criteria related to dosing reasons to discontinue. Modified approval duration to 6 months for initial and 12 months for renewal.	06/16	08/16
Added criteria for the new FDA-approved indications: TRAPS, HIDS/MKD, and FMF. Made the following changes to the existing criteria: -CAPS: Modified specialist requirement to include physicians experienced in the management of CAPS. Removed age restriction. Added maximum dose criteria. Modified initial approval duration to 12 weeks. -SJIA: Removed age restriction. Added maximum dose criteria per package insert. Modified initial approval duration to 8 weeks. -Re-auth: Added examples of positive response for all indications. Added that continued therapy may be approved despite inadequate response if request is for a dose increase. Updated formulation section in background to 150 mg powder (vs 180 mg powder), and modified to be more concise. Updated references.	11/16	12/16

References

1. Ilaris Prescribing Information. East Hanover, NJ; Novartis Pharmaceuticals Corporation; September 2016. Available at www.ilaris.com. Accessed November 28, 2016.
2. Ringold S, Weiss PF, et al. 2013 update of the 2011 American College of Rheumatology recommendations for the treatment of juvenile idiopathic arthritis. Arthritis Care Res. 2013; 65(10): 2499-2512.
3. Beukelman T, et al. 2011 American College of Rheumatology recommendations for the treatment of juvenile idiopathic arthritis: initiation and safety monitoring of therapeutic agents for the treatment of arthritis and systemic features. Arthritis Care & Research, 2011; 63(4): 465-482.
4. Kimura Y. Systemic juvenile idiopathic arthritis: Treatment. In: UpToDate, Waltham, MA: Walters Kluwer Health; 2016. Available at: www.UpToDate.com. Accessed June 14, 2016.
5. Ozen S, Demirkaya E, Erer B, et al. EULAR recommendations for the management of familial Mediterranean fever. Ann Rheum Dis. 2016; 75(4): 644-651.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content

of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.