

## Clinical Policy: Tocilizumab (Actemra)

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Line of Business: Medicaid

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### Description

Tocilizumab (Actemra<sup>®</sup>) is an interleukin 6 (IL-6) receptor antagonist.

### FDA Approved Indication(s)

Actemra is indicated for the treatment of:

- Adult patients with moderately to severely active rheumatoid arthritis (RA) who have had an inadequate response to one or more Disease-Modifying Anti-Rheumatic Drugs (DMARDs)
- Adult patients with giant cell arteritis (GCA)
- Slowing the rate of decline in pulmonary function in adult patients with systemic sclerosis-associated interstitial lung disease (SSc-ILD)
- Patients 2 years of age and older with active polyarticular juvenile idiopathic arthritis (PJIA)
- Patients 2 years of age and older with active systemic juvenile idiopathic arthritis (SJIA)
- Adults and pediatric patients 2 years of age and older with chimeric antigen receptor (CAR) T cell-induced severe or life-threatening cytokine release syndrome (CRS)
- Hospitalized adult patients with coronavirus disease 2019 (COVID-19) who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO).

### 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 health plans affiliated with Centene Corporation<sup>®</sup> that Actemra is **medically necessary** when the following criteria are met:

#### I. Initial Approval Criteria

##### A. Coronavirus-19 Infection

1. Initiation of outpatient treatment will not be authorized as Actemra is FDA-approved for use only in the hospitalized setting).

**Approval duration: Not Applicable**

##### B. Rheumatoid Arthritis (must meet all):

1. Diagnosis of RA per American College of Rheumatology (ACR) criteria (*see Appendix F*);

2. Prescribed by or in consultation with a rheumatologist;
3. Age  $\geq$  18 years;
4. Member meets one of the following (a or b):
  - a. Failure of a  $\geq$  3 consecutive month trial of methotrexate (MTX) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
  - b. If intolerance or contraindication to MTX (*see Appendix D*), failure of a  $\geq$  3 consecutive month trial of at least ONE conventional DMARD (e.g., sulfasalazine, leflunomide, hydroxychloroquine) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
5. Failure of at least TWO of the following, each used for  $\geq$  3 consecutive months, unless contraindicated or clinically significant adverse effects are experienced: Enbrel<sup>®</sup>, Humira<sup>®</sup>, Cimzia, Xeljanz<sup>®</sup>/Xeljanz XR<sup>®</sup>;  
*\*Prior authorization is required for Enbrel, Humira, Cimzia, and Xeljanz/Xeljanz XR*
6. Documentation of one of the following baseline assessment scores (a or b):
  - a. Clinical disease activity index (CDAI) score (*see Appendix G*);
  - b. Routine assessment of patient index data 3 (RAPID3) score (*see Appendix H*);
7. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
8. Dose does not exceed one of the following (a or b):
  - a. IV: 800 mg every 4 weeks;
  - b. SC: 162 mg every week.

**Approval duration: 6 months**

**C. Giant Cell Arteritis (must meet all):**

1. Diagnosis of GCA;
2. Request is for SC formulation;
3. Prescribed by or in consultation with a rheumatologist;
4. Age  $\geq$  18 years;
5. Failure of a  $\geq$  3 consecutive month trial of a systemic corticosteroid at up to maximally tolerated doses in conjunction with MTX or azathioprine, unless contraindicated or clinically significant adverse effects are experienced;
6. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
7. Dose does not exceed one of the following (a or b):
  - a. a. SC: 162 mg every week;
  - b. b. IV: 6 mg/kg every 4 weeks.

**Approval duration: 6 months**

**D. Polyarticular Juvenile Idiopathic Arthritis (must meet all):**

2. 1. Diagnosis of PJIA as evidenced by  $\geq$  5 joints with active arthritis; Prescribed by or in consultation with a rheumatologist;

3. Age  $\geq$  2 years;
4. Documented baseline 10-joint clinical juvenile arthritis disease activity score (cJADAS-10) (*see Appendix I*);
5. Member meets one of the following (a,b,c,or, d):
  - a. Failure of a  $\geq$  3 consecutive month trial of MTX at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
  - b. If intolerance or contraindication to MTX (*see Appendix D*), failure of a  $\geq$  3 consecutive month trial of sulfasalazine or leflunomide at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
  - c. For sacroiliitis/axial spine involvement (i.e., spine, hip), failure of a  $\geq$  4 week trial of an NSAID at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
  - d. Documented presence of high disease activity as evidenced by a cJADAS-10  $>$  8.5 (*see Appendix I*);
6. Failure of two of the following: Xeljanz, etanercept (*Enbrel is preferred*), or adalimumab (*Humira is preferred*), each used for  $\geq$  3 consecutive months, unless contraindicated or clinically significant adverse effects are experienced;  
*\*Prior authorization is required for Xeljanz, etanercept and adalimumab.*
7. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
8. Dose does not exceed one of the following (a or b):
  - e. Weight  $<$  30 kg: 10 mg/kg IV every 4 weeks or 162 mg SC every 3 weeks;
  - f. Weight  $\geq$  30 kg: 8 mg/kg IV every 4 weeks or 162 mg SC every 2 weeks.

**Approval duration: 6 months**

**E. Systemic Juvenile Idiopathic Arthritis (must meet all):**

1. Diagnosis of SJIA;
2. Prescribed by or in consultation with a dermatologist, rheumatologist, or gastroenterologist;
3. Age  $\geq$  2 years;
4. Member meets one of the following (a or b):
  - a. Failure of a  $\geq$  3 consecutive month trial of MTX or leflunomide at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
  - b. Failure of a  $\geq$  2-week trial of a systemic corticosteroid at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
5. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
6. Dose does not exceed one of the following (a or b):
  - a. IV:

- i. Weight < 30 kg: 12 mg/kg every 2 weeks;
- ii. Weight  $\geq$  30 kg: 8 mg/kg every 2 weeks;
- b. SC:
  - i. Weight < 30 kg: 162 mg every 2 weeks;
  - ii. Weight  $\geq$  30 kg: 162 mg every week.

**Approval duration: 6 months**

**F. Cytokine Release Syndrome (must meet all):**

1. Request is for IV formulation;
2. Age  $\geq$  2 years;
3. Member meets one of the following (a or b):
  - a. Member has a scheduled CAR T cell therapy (e.g., Kymriah™, Yescarta™);
  - b. Member has developed refractory (i.e., inadequate response to steroids, vasopressors) CRS related to blinatumomab therapy;
4. Request meets one of the following (a or b):\*
  - a. Dose does not exceed 800 mg per infusion for up to 4 total doses;
  - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

*\*Prescribed regimen must be FDA-approved or recommended by NCCN*

**Approval duration: Up to 4 doses total**

**G. Systemic Sclerosis –Associated Interstitial Lung Disease (must meet all):**

1. Diagnosis of SSc-ILD;
2. Request is for SC formulation;
3. Prescribed by or in consultation with a pulmonologist or rheumatologist;
4. Member meets both of the following (a and b):
  - a. Pulmonary fibrosis on high-resolution computed tomography (HRCT);
  - b. Additional signs of SSc are identified (*see Appendix J*);
5. Failure of a  $\geq$  3 consecutive month trial of cyclophosphamide or mycophenolate mofetil, at up to maximally indicated doses, unless both are contraindicated or clinically significant adverse effects are experienced;
6. Baseline forced vital capacity (FVC)  $\geq$  40% of predicted;
7. Baseline carbon monoxide diffusing capacity (DLCO)  $\geq$  30% of predicted;
8. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
9. Dose does not exceed 162 mg every week.

**Approval duration: 6 months**

**H. Castleman’s Disease (off-label) (must meet all):**

1. Diagnosis of Castleman’s disease;
2. Disease is relapsed/refractory or progressive;
3. Member is human immunodeficiency virus (HIV)-negative and human herpesvirus 8 (HHV-8)-negative;
4. Prescribed as second-line therapy as a single agent;

5. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
6. Request meets one of the following (a or b):\*
  - a. Dose does not exceed 8 mg/kg per infusion every 2 weeks;
  - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

*\*Prescribed regimen must be FDA-approved or recommended by NCCN*

**Approval duration: 6 months**

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
  - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
  - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

**II. Continued Therapy**

**A. Coronavirus-19 Infection:**

1. Continuation of therapy in the outpatient setting will not be authorized as Actemra is FDA-approved for use only in the hospitalized setting as a single dose, with an optional second dose.

**B. All Indications in Section I** (must meet all):

1. Member meets one of the following (a, b, or, c):
  - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
  - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
  - c. Documentation supports that member is currently receiving Actemra IV for CAR T cell-induced CRS and member has not yet received 4 doses total;
2. Member meets one of the following (a, b, or c):
  - a. For RA: member is responding positively to therapy as evidenced by one of the following (i or ii):

- i. A decrease in CDAI (*see Appendix G*) or RAPID3 (*see Appendix H*) score from baseline;
    - ii. Medical justification stating inability to conduct CDAI re-assessment, and submission of RAPID3 score associated with disease severity that is similar to initial CDAI assessment or improved;
  - b. For pJIA, member is responding positively to therapy as evidenced by a decrease in cJADAS-10 from baseline (*see Appendix I*);
  - c. For all other indications: member is responding positively to therapy;
3. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
4. If request is for a dose increase, new dose does not exceed one of the following (a, b, c, d, or e):
  - a. RA (i or ii):
    - i. IV: 800 mg every 4 weeks;
    - ii. SC: 162 mg every week;
  - b. GCA: 162 mg SC every week;
  - g. PJIA (i or ii):
    - i. Weight < 30 kg: 10 mg/kg IV every 4 weeks or 162 mg SC every 3 weeks;
    - ii. Weight ≥ 30 kg: 8 mg/kg IV every 4 weeks or 162 mg SC every 2 weeks;
  - h. SJIA (i or ii):
    - i. Weight < 30 kg: 12 mg/kg IV every 2 weeks 162 mg SC 2 every week;
    - ii. Weight ≥ 30 kg: 8 mg/kg IV every 2 weeks or 162 mg SC every week;
  - i. CRS: 800 mg per infusion for up to 4 doses total, or dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).
  - j. Castleman's Disease (i or ii):\*
    - i. Dose does not exceed 8 mg/kg per infusion every 2 weeks;
    - ii. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

*\*Prescribed regimen must be FDA-approved or recommended by NCCN*

**Approval duration:**

**CRS: Up to 4 doses total**

**All other indications: 12 months**

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
  - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or

- b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

**III. Diagnoses/Indications for which coverage is NOT authorized:**

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.PMN.53 for Medicaid or evidence of coverage documents.
- B. Combination use with biological disease-modifying antirheumatic drugs (bDMARDs) or potent immunosuppressants, including but not limited to any tumor necrosis factor (TNF) antagonists [e.g., Cimzia®, Enbrel®, Humira® and its biosimilars, Simponi®, Avsola™, Inflectra™, Remicade®, Renflexis™], interleukin agents [e.g., Arcalyst® (IL-1 blocker), Ilaris® (IL-1 blocker), Kineret® (IL-1RA), Actemra® (IL-6RA), Kevzara® (IL-6RA), Stelara® (IL12/23 inhibitor), Cosentyx® (IL-17A inhibitor), Taltz® (IL-17A inhibitor), Siliq™ (IL17RA), Ilumya™ (IL-23 inhibitor), Skyrizi™ (IL-23 inhibitor), Tremfya® (IL-23 inhibitor)], Janus kinase inhibitors (JAKi) [e.g., Xeljanz®/Xeljanz® XR, Cibinqo™, Olumiant™, Rinvoq™], anti-CD20 monoclonal antibodies [Rituxan®, Riabni™, Ruxience™, Truxima®, Rituxan Hycela®], selective co-stimulation modulators [Orencia®], and integrin receptor antagonists [Entyvio®] because of the additive immunosuppression, increased risk of neutropenia, as well as increased risk of serious infections.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

CAR: chimeric antigen receptor

CDAI: clinical disease activity index

cJADAS: clinical juvenile arthritis  
disease activity score

COVID-19: Coronavirus Disease 2019

CRS: cytokine release syndrome

DLCO: carbon monoxide diffusing  
capacity

DMARDs: disease-modifying anti-  
rheumatic drugs

FDA: Food and Drug Administration

FVC: forced vital capacity

GCA: giant cell arteritis

GI: gastrointestinal

HHV-8: human herpesvirus 8

HIV: human immunodeficiency virus

IL-6: interleukin 6

MTX: methotrexate

PJIA: polyarticular juvenile idiopathic  
arthritis

RA: rheumatoid arthritis

RAPID3: routine assessment of patient  
index data 3

SJIA: systemic juvenile idiopathic  
arthritis

SSc-ILD: systemic sclerosis-associated  
interstitial lung disease

*Appendix B: Therapeutic Alternatives*

*This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.*

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
azathioprine (Azasan <sup>®</sup> , Imuran <sup>®</sup> )	<b>RA</b> 1 mg/kg/day PO QD or divided BID  <b>GCA*</b> 1.5 – 2 mg/kg/day PO	2.5 mg/kg/day
corticosteroids	<b>GCA*, SJIA*</b> Various	Various
Cuprimine <sup>®</sup> (d-penicillamine)	<b>RA*</b> <u>Initial dose:</u> 125 or 250 mg PO QD <u>Maintenance dose:</u> 500 – 750 mg/day PO QD	1,500 mg/day
cyclosporine (Sandimmune <sup>®</sup> , Neoral <sup>®</sup> )	<b>RA</b> 2.5 – 4 mg/kg/day PO divided BID	4 mg/kg/day
hydroxychloroquine (Plaquenil <sup>®</sup> )	<b>RA*</b> <u>Initial dose:</u> 400 – 600 mg/day PO QD <u>Maintenance dose:</u> 200 – 400 mg/day PO QD	600 mg/day
leflunomide (Arava <sup>®</sup> )	<b>PJIA*</b> Weight < 20 kg: 10 mg every other day Weight 20 - 40 kg: 10 mg/day Weight > 40 kg: 20 mg/day  <b>RA</b> <u>Initial dose (for low risk hepatotoxicity or myelosuppression):</u> 100 mg PO QD for 3 days  <u>Maintenance dose:</u> 20 mg PO QD  <b>SJIA*</b> 100 mg PO every other day for 2 days, then 10 mg every other day	PJIA, RA: 20 mg/day  SJIA: 10 mg every other day
methotrexate (Trexall <sup>®</sup> , Otrexup <sup>™</sup> ,	<b>GCA*</b> 20 – 25 mg/week PO	30 mg/week



Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Rasuvo <sup>®</sup> , RediTrex <sup>®</sup> , Xatmep <sup>™</sup> , Rheumatrex <sup>®</sup> )	<p><b>PJIA*</b> 10 – 20 mg/m<sup>2</sup>/week PO, SC, or IM</p> <p><b>RA</b> 7.5 mg/week PO, SC, or IM or 2.5 mg PO Q12 hr for 3 doses/week</p> <p><b>SJIA*</b> 0.5-1 mg/kg/week PO or SC</p>	
Ridaura <sup>®</sup> (auranofin)	<p><b>RA</b> 6 mg PO QD or 3 mg PO BID</p>	9 mg/day (3 mg TID)
sulfasalazine (Azulfidine <sup>®</sup> )	<p><b>PJIA*</b> 30-50 mg/kg/day PO divided BID</p> <p><b>RA</b> 2 g/day PO in divided doses</p>	<p>PJIA: 2 g/day</p> <p>RA: 3 g/day</p>
Enbrel <sup>®</sup> (etanercept)	<p><b>RA</b> 25 mg SC twice weekly or 50 mg SC once weekly</p> <p><b>PJIA</b> Weight &lt; 63 kg: 0.8 mg/kg SC once weekly Weight ≥ 63 kg: 50 mg SC once weekly</p>	50 mg/week
Humira <sup>®</sup> (adalimumab)	<p><b>RA</b> 40 mg SC every other week (may increase to once weekly)</p> <p><b>PJIA</b> Weight 10 kg (22 lbs) to &lt;15 kg (33 lbs): 10 mg every other week Weight 15 kg (33 lbs) to &lt; 30 kg (66 lbs): 20 mg every other week Weight ≥ 30 kg (66 lbs): 40 mg every other week</p>	<p>RA: 40 mg/week</p> <p>PJIA: 40 mg every other week</p>
Xeljanz <sup>®</sup> (tofacitinib)	<p><b>RA</b> 5 mg PO BID</p>	10 mg/day
Xeljanz XR <sup>®</sup> (tofacitinib extended-release)	<p><b>RA</b> 11 mg PO QD</p>	11 mg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Cimzia® (certolizumab)	<b>RA</b> <u>Initial dose:</u> 400 mg SC at 0, 2, and 4 weeks <u>Maintenance dose:</u> 200 mg SC every other week (or 400 mg SC every 4 weeks)	400 mg every 4 weeks

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

\*Off-label

*Appendix C: Contraindications/Boxed Warnings*

- Contraindication(s): known hypersensitivity to Actemra
- Boxed warning(s): risk of serious infections

*Appendix D: General Information*

- Definition of failure of MTX or DMARDs
  - Child-bearing age is not considered a contraindication for use of MTX. Each drug has risks in pregnancy. An educated patient and family planning would allow use of MTX in patients who have no intention of immediate pregnancy.
  - Social use of alcohol is not considered a contraindication for use of MTX. MTX may only be contraindicated if patients choose to drink over 14 units of alcohol per week. However, excessive alcohol drinking can lead to worsening of the condition, so patients who are serious about clinical response to therapy should refrain from excessive alcohol consumption.
- Examples of positive response to therapy may include, but are not limited to:
  - Reduction in joint pain/swelling/tenderness
  - Improvement in ESR/CRP levels
  - Improvements in activities of daily living

*Appendix E: Dose Rounding Guidelines for PJIA and SJIA*

Weight-based Dose Range	Vial Quantity Recommendation
≤ 83.99 mg	1 vial of 80 mg/4 mL
84 to 209.99 mg	1 vial of 200 mg/10 mL
210 to 419.99 mg	1 vial of 400 mg/20 mL
420 to 503.99 mg	1 vial of 80 mg/4 mL and 1 vial 400 mg/20 mL
504 to 629.99 mg	1 vial of 200 mg/10 mL and 1 vial 400 mg/20 mL
630 to 839.99 mg	2 vials 400 mg/20 mL
840 to 923.99 mg	1 vial of 80 mg/4 mL and 2 vials 400 mg/20 mL
924 to 1,049.99 mg	1 vial of 200 mg/10 mL and 2 vials 400 mg/20 mL
1050 to 1,259.99 mg	3 vials 400 mg/20 mL

*Appendix F: The 2010 ACR Classification Criteria for RA*

Add score of categories A through D; a score of ≥ 6 out of 10 is needed for classification of a patient as having definite RA.

<b>A</b>	<b>Joint involvement</b>	<b>Score</b>
	1 large joint	0
	2-10 large joints	1
	1-3 small joints (with or without involvement of large joints)	2
	4-10 small joints (with or without involvement of large joints)	3
	> 10 joints (at least one small joint)	5
<b>B</b>	<b>Serology (at least one test result is needed for classification)</b>	
	Negative rheumatoid factor (RF) <i>and</i> negative anti-citrullinated protein antibody (ACPA)	0
	Low positive RF <i>or</i> low positive ACPA <i>* Low: &lt; 3 x upper limit of normal</i>	2
	High positive RF <i>or</i> high positive ACPA <i>* High: ≥ 3 x upper limit of normal</i>	3
<b>C</b>	<b>Acute phase reactants (at least one test result is needed for classification)</b>	
	Normal C-reactive protein (CRP) and normal erythrocyte sedimentation rate (ESR)	0
	Abnormal CRP or abnormal ESR	1
<b>D</b>	<b>Duration of symptoms</b>	
	< 6 weeks	0
	≥ 6 weeks	1

*Appendix G: Clinical Disease Activity Index (CDAI) Score*

The Clinical Disease Activity Index (CDAI) is a composite index for assessing disease activity in RA. CDAI is based on the simple summation of the count of swollen/tender joint count of 28 joints along with patient and physician global assessment on VAS (0–10 cm) Scale for estimating disease activity. The CDAI score ranges from 0 to 76.

<b>CDAI Score</b>	<b>Disease state interpretation</b>
≤ 2.8	Remission
2.8 to ≤ 10	Low disease activity
10 to ≤ 22	Moderate disease activity
> 22	High disease activity

*Appendix H: Routine Assessment of Patient Index Data 3 (RAPID3) Score*

The Routine Assessment of Patient Index Data 3 (RAPID3) is a pooled index of the three patient-reported ACR core data set measures: function, pain, and patient global estimate of status. Each of the individual measures is scored 0 – 10, and the maximum achievable score is 30.

<b>RAPID3 Score</b>	<b>Disease state interpretation</b>
≤ 3	Remission
3.1 to 6	Low disease activity
6.1 to 12	Moderate disease activity
> 12	High disease activity

*Appendix I: Clinical Juvenile Arthritis Disease Activity Score based on 10 joints (cJADAS-10)*

The cJADAS10 is a continuous disease activity score specific to JIA and consisting of the following three parameters totaling a maximum of 30 points:

- Physician’s global assessment of disease activity measured on a 0-10 visual analog scale (VAS), where 0 = no activity and 10 = maximum activity;
- Parent global assessment of well-being measured on a 0-10 VAS, where 0 = very well and 10 = very poor;
- Count of joints with active disease to a maximum count of 10 active joints\*

\*ACR definition of active joint: presence of swelling (not due to currently inactive synovitis or to bony enlargement) or, if swelling is not present, limitation of motion accompanied by pain, tenderness, or both

cJADAS-10	Disease state interpretation
≤ 1	Inactive disease
1.1 to 2.5	Low disease activity
2.51 to 8.5	Moderate disease activity
> 8.5	High disease activity

*Appendix J: American College of Rheumatology (ACR) 2013 SSc Classification Criteria*

While the majority of patients with SSc experience skin thickening and variable involvement of internal organs, there is no one confirmatory test for SSc. Similar to the IPF guidelines above, ACR lists HRCT as a diagnostic method for determining pulmonary fibrosis in SSc-ILD. The other diagnostic parameters below are drawn from ACR’s scoring system purposed for clinical trials. While informative, ACR cautions that the scoring system parameters are not all inclusive of the myriad of SSc manifestations that may occur across musculoskeletal, cardiovascular, renal, neuromuscular and genitourinary systems.

Examples of SSc skin/internal organ manifestations and associated laboratory tests:

- Skin thickening of the fingers
- Fingertip lesions
- Telangiectasia
- Abnormal nailfold capillaries
- Raynaud’s phenomenon
- SSc-ILD
- Pulmonary arterial hypertension
- SSc-related autoantibodies
- Anticentromere
- Anti-topoisomerase I (anti-Scl-70)
- Anti-RNA polymerase III

**V. Dosage and Administration**

CRS	Weight < 30 kg: 12 mg/kg IV per infusion Weight ≥ 30 kg: 8 mg/kg IV per infusion	IV: 800 mg/infusion, up to 4 doses
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	If no clinical improvement in the signs and symptoms of CRS occurs after the first dose, up to 3 additional doses of Actemra may be administered. The interval between consecutive doses should be at least 8 hours.	
GCA	162 mg SC every week (every other week may be given based on clinical considerations)	SC: 162 mg every week
PJIA	<ul style="list-style-type: none"> <li>• Weight &lt; 30 kg: 10 mg/kg IV every 4 weeks or 162 mg SC every 3 weeks</li> <li>• Weight ≥ 30 kg: 8 mg/kg IV every 4 weeks or 162 mg SC every 2 weeks</li> </ul> <i>See Appendix E for dose rounding guidelines</i>	IV: 10 mg/kg every 4 weeks  SC: 162 mg every 2 weeks
RA	IV: 4 mg/kg every 4 weeks followed by an increase to 8 mg/kg every 4 weeks based on clinical response  SC: Weight < 100 kg: 162 mg SC every other week, followed by an increase to every week based on clinical response Weight ≥ 100 kg: 162 mg SC every week	IV: 800 mg every 4 weeks  SC: 162 mg every week
SJIA	IV: Weight < 30 kg: 12 mg/kg IV every 2 weeks Weight ≥ 30 kg: 8 mg/kg IV every 2 weeks <i>See Appendix E for dose rounding guidelines</i>  SC: Weight < 30 kg: 162 mg SC every 2 weeks Weight ≥ 30 kg: 162 mg SC every week	IV: 12 mg/kg every 2 weeks  SC: 162 mg every week
SSc-ILD	162 mg SC once weekly	SC: 162 mg every week

**VI. Product Availability**

- Single-use vial: 80 mg/4 mL, 200 mg/10 mL, 400 mg/20 mL
- Single-dose prefilled syringe: 162 mg/0.9 mL
- Single-dose prefilled autoinjector: 162 mg/0.9 mL

**VII. References**

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**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
J3262	Injection, tocilizumab, 1 mg
J3590, C9399	Subcutaneous tocilizumab (unclassified drugs or biologicals)
Q0249	Injection, tocilizumab, for hospitalized adults and pediatric patients (2 years of age and older) with covid-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO) only, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created, adapted from CP.PHAR.263 Tocilizumab (Actemra) for migration to HFS PDL.	1.14.2020	
2Q 2021 annual review. Updated pJIA criteria to require diagnosis as evidenced by $\geq 5$ joints, cJADAS assessment, and redirection to Enbrel <i>Humira</i> , and Xeljanz per SDC. Additionally, updated criteria to allow tiered redirection or bypass of MTX in the event of sacroiliitis or high disease activity. Added criteria for CDAI score and RAPID3 assessment for RA given limited in-person visits during COVID-19 pandemic, updated appendices. added off-label use criteria for Castle man’s disease per NCCN; References reviewed and updated	4.13.2021	
<b>Added</b> information regarding Actemra EUA for COVID-19 hospitalized patients; Added criteria Systemic Sclerosis –Associated Interstitial Lung Disease; reviewed and updated references	9.8.21	
4Q 2022 annual review: updated Appendix A; RT4: added newly FDA-approved dosing for intravenous Actemra for GCA; reiterated requirement against combination use with a bDMARD or JAKi from Section III to Sections I and II; references reviewed and updated.	11.14.22	
RT4: revised criteria for COVID-19 emergency authorized use to FDA-approved indication; removed Appendix K since Actemra does not have EUA and is approved for COVID-19; updated off-label dosing in Appendix B; reiterated requirement against combination use with a bDMARD or JAKi from Section III to Sections I and II; template changes applied to other diagnoses/indications and continued therapy section; coding implications section updated; References reviewed and updated.	4.19.23	

**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

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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.

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**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.

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