Health Alliance™ Health Alliance NORTHWEST™

# Pharmacy Drug Policy & Procedure

| **Policy Name:** | **Actemra (tocilizumab)** | **Policy#:** | **1836P** |
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## Purpose of the Policy

The purpose of this policy is to define coverage criteria for Actemra (tocilizumab).

## Statement of the Policy

Health Alliance Medical Plans and Health Alliance Northwest will approve the use of Actemra (tocilizumab) if the following criteria are met.

## Criteria

**1. Coverage Criteria for Rheumatoid Arthritis (RA)**

1.1 See Rheumatoid Arthritis Immunomodulator Therapies policy

**2. Coverage Criteria for Polyarticular Juvenile Idiopathic Arthritis (PJIA)**

2.1 See Polyarticular Juvenile Idiopathic Arthritis Immunomodulator Therapies policy

**3. Coverage Criteria for Systemic Juvenile Idiopathic Arthritis (SJIA)**

3.1 Diagnosis of Systemic Juvenile Idiopathic Arthritis (SJIA)

3.2 Ordered by a Rheumatologist (musculoskeletal doctor)

3.3 Documentation to support one of the following:

- Documented trial and failure of one non-steroidal anti-inflammatory drug (NSAID, such as ibuprofen or naproxen) for at least 2 weeks
- Documentation the patient has moderate-to-severe disease including any one of the following systemic manifestations:
  - Fever
  - Serositis
  - Early Macrophage Activation Syndrome (MAS)

**4. Coverage Criteria for Giant Cell Arteritis**

4.1 Diagnosis of Giant Cell Arteritis

4.2 Ordered by a Rheumatologist (musculoskeletal doctor), Ophthalmologist (eye doctor), or Neuro-Ophthalmologist (brain and eye doctor)

4.3 Documented failure to respond to a minimum 3 month trial of glucocorticoids

**5. Coverage Criteria for Cytokine Release Syndrome (due to CAR T-cell therapy)**

5.1 Ordered by an Oncologist

5.2 Diagnosis of Grade 2 CRS following CAR T-cell therapy, OR approval on file for one of the CAR T-cell therapies

**6. Coverage Criteria for Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD)**

6.1 Diagnosis of Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD)

6.2 Age 18 years or older

6.3 Ordered by or in consultation with a pulmonologist (lung doctor) or rheumatologist (musculoskeletal doctor)

6.4 Documented trial and subsequent failure or contraindication to mycophenolate mofetil or

cyclophosphamde

6.5 Only subcutaneous, not IV, Actemra will be used for this indication

6.6 Medication will not be used in combination with Ofev or other immunomodulators

**7. Exclusion Criteria**

7.1 Inadequate response to initial or previous tocilizumab therapy

7.2 Health Alliance does not cover concurrent therapy with other immunomodulators based upon the possible increased risk for infections and other potential pharmacological interactions

**8. Approval Period**

8.1 Initial Authorization will be placed for 12 months

8.2 All subsequent authorizations will be placed for 12 months, based upon clinical response to therapy

| **CPT Codes** | |
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| **HCPCS Codes** | |
| J3262 | Injection, tocilizumab, 1 mg |

**References**


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4. Ringold S, Weiss PF, Colbert RA, et al. Childhood Arthritis and Rheumatology Research Alliance consensus treatment plans for new-onset polyarticular juvenile idiopathic arthritis. Arthritis Care Res (Hoboken). 2014 Jul;66(7):1063-72.
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7. Santomasso BD, Nastoupil LJ, Adkins S, et al. Management of immune-related adverse events in patients treated with chimeric antigen receptor T-cell therapy: ASCO guideline. J Clin Oncol. 2021;39(35):3978-3992.
8. Hoogen FV, Khanna D, Fransen J, et al. 2013 classification criteria for systemic sclerosis: an American college of rheumatology/European league against rheumatism collaborative initiative. Ann Rheum Dis. 2013 Nov;72(11):1747-55.
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DISCLAIMER

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