Clinical Policy: Tocilizumab (Actemra®)

Reference Number: QCP.PHAR.001
Date of Last Revision:

Coding Implications
Revision Log

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

Description
Tocilizumab (Actemra®) is an immunosuppressive drug.

Policy/Criteria
I. Initial Approval Criteria
A. Castleman's Disease (off-label) (must meet all):
1. Diagnosis of Castleman's disease;
2. Disease is relapsed/refractory or progressive;
3. Request is for intravenous Actemra;
4. Member is human immunodeficiency virus (HIV)-negative and human herpesvirus 8 (HHV-8)-negative;
5. Prescribed as second-line therapy as a single agent;
6. Member does not have combination use of biological disease-modifying antirheumatic drugs or JAK inhibitors (see Section III: Diagnoses/Indications for which coverage is NOT authorized);
7. 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 or to member's renewal date, whichever is longer

B. Cytokine Release Syndrome (must meet all):
1. Request is for an intravenous formulation of Actemra;
2. Age ≥ 2 years;
3. Member meets one of the following (a or b):
    a. Member has a scheduled CAR T cell therapy (e.g., Abecma®, Breyanzi®, Carvykti™, Kymriah™, Tecartus®, Yescarta™);
    b. Member has developed refractory 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 total doses

C. Giant Cell Arteritis (must meet all):
1. Diagnosis of GCA;
2. Request is for Actemra;
3. Prescribed by or in consultation with a rheumatologist;
4. Age ≥ 18 years;
5. Failure of a ≥ 3 consecutive months trial of a systemic corticosteroid at up to maximally tolerated doses in conjunction with MTX or azathioprine, unless clinically significant adverse effects are experienced or all are contraindicated;
6. Member does not have combination use of biological disease-modifying antirheumatic drugs or JAK inhibitors (see Section III: Diagnoses/Indications for which coverage is NOT authorized);
7. Dose does not exceed 162 mg SC every week.

Approval duration: 6 months

D. Polyarticular Juvenile Idiopathic Arthritis (must meet all):
1. Diagnosis of PJIA as evidenced by ≥ 5 joints with active arthritis;
2. Request is for Actemra
3. Prescribed by or in consultation with a rheumatologist;
4. Age ≥ 2 years;
5. Documented baseline 10-joint clinical juvenile arthritis disease activity score (cJADAS-10) (see Appendix I);
6. Member meets one of the following (a, b, c, or d):
    a. Failure of a ≥ 3 consecutive months trial of MTX at up to maximally indicated doses;
    b. Member has intolerance or contraindication to MTX (see Appendix D), failure of a ≥ 3 consecutive months trial of leflunomide or sulfasalazine at up to maximally indicated doses, unless clinically significant adverse effects are experienced or both are contraindicated;
    c. For sacroiliitis/axial spine involvement (i.e., spine, hip), failure of a ≥ 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);
7. Member meets BOTH of the following, unless clinically significant adverse effects are experienced or all are contraindicated (a and b):
    a. One of the following (i, ii, or iii, see Appendix D):
        i. Failure of BOTH of the following, each used for ≥ 3 consecutive months (1 and 2):
            1) Failure of Humira
            2) Enbrel;
        ii. If member has had a history of failure of one TNF blocker, then failure of one of the following TNF blockers used for ≥ 3 consecutive months: Enbrel or Humira

iii. History of failure of two TNF blockers and request is not for another TNF blocker;

b. If member has not responded or is intolerant to one or more TNF blockers, Xeljanz, used for ≥ 3 consecutive months, unless member has cardiovascular risk and benefits do not outweigh the risk of treatment;

8. Member does not have combination use of biological disease-modifying antirheumatic drugs or JAK inhibitors (see Section III: Diagnoses/Indications for which coverage is NOT authorized);
9. Dose does not exceed maximum dose indicated in Section V.

Approval duration: 6 months

E. Rheumatoid Arthritis (must meet all):

1. Diagnosis of RA per ACR criteria (see Appendix F);
2. Request is for Actemra
3. Prescribed by or in consultation with a rheumatologist;
4. Age ≥ 18 years;
5. Member meets one of the following (a or b):
   a. Failure of a ≥ 3 consecutive months trial of MTX at up to maximally indicated doses;
   b. Member has intolerance or contraindication to MTX (see Appendix D), and failure of a ≥ 3 consecutive months trial of at least ONE conventional DMARD (e.g., sulfasalazine, leflunomide, hydroxychloroquine) at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated;
6. Member meets BOTH of the following, unless clinically significant adverse effects are experienced or all are contraindicated (a and b):
   a. One of the following (i, ii, or iii, see Appendix D):
      i. Failure of both of the following, each used for ≥ 3 consecutive months (1 and 2):
         1) Humira~~;~~
         2) Enbrel;
      ii. If member has had a history of failure of one TNF blocker, then failure of one of the following TNF blockers used for ≥ 3 consecutive months: Enbrel or Humira
      iii. History of failure of two TNF blockers and request is not for another TNF blocker;
   b. If member has not responded or is intolerant to one or more TNF blockers, Xeljanz/Xeljanz XR and Rinvoq, each used for ≥ 3 consecutive months, unless member has cardiovascular risk and benefits do not outweigh the risk of treatment;
7. 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);

8. Member does not have combination use of biological disease-modifying antirheumatic drugs or JAK inhibitors (see Section III: Diagnoses/Indications for which coverage is NOT authorized);
9. Dose does not exceed maximum dose indicated in Section V.

Approval duration: 6 months

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

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

Approval duration: 6 months

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

1. Diagnosis of SSc-ILD;
2. Request is for subcutaneous formulation of Actemra;
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 ≥ 3 consecutive months 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) ≥ 40% of predicted;
7. Baseline carbon monoxide diffusing capacity (DLCO) ≥ 30% of predicted;
8. Member does not have combination use of biological disease-modifying antirheumatic drugs or JAK 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. Coronavirus-19 Infection:
1. Initiation of outpatient treatment will not be authorized as Actemra (FDA-approved is authorized for use only in the hospitalized setting (see Appendix K).

Approval duration: Not applicable

II. Continued Therapy

A. Coronavirus-19 Infection:
1. Continuation of therapy in the outpatient setting will not be authorized as Actemra (FDA-approved) is authorized for use only in the hospitalized setting (see Appendix K).

Approval duration: Not applicable

B. All Indications in Section I (must meet all):
1. Member meets one of the following (a, or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Documentation supports that member is currently receiving IV Actemra for CAR T cell-induced CRS and member has not yet received 4 total doses;
2. Member meets one of the following (a, b, c, d, e, or f):
   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 of biological disease-modifying antirheumatic drugs or JAK 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 maximum dose indicated in Section V.

Approval duration: CRS – Up to 4 doses total
For all other indications – 12 months

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 policy – HIM.PA.154 for health insurance marketplace or evidence of coverage documents;
B. Combination use of 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® (IL-12/23 inhibitor), Cosentyx® (IL-17A inhibitor), Taltz® (IL-17A inhibitor), Siliq™ (IL-17RA), Ilumya™ (IL-23 inhibitor), Skyrizi™ (IL-23 inhibitor), Tremfya® (IL23 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

ACR: American College of Rheumatology
AS: ankylosing spondylitis
CAR: chimeric antigen receptor
CDAI: clinical disease activity index
COVID-19: coronavirus disease 2019
CRS: cytokine release syndrome
DLCO: carbon monoxide diffusing capacity
DMARDs: disease-modifying antirheumatic drugs
FVC: forced vital capacity
GCA: giant cell arteritis
JAK: Janus kinase
MTX: methotrexate
nr-axSpA: non-radiographic axial spondyloarthritis
NSAIDs: non-steroidal antiinflammatory drugs
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
TNF: tumor necrosis factor

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 and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
azathioprine (Azasan®, Imuran®)	**RA**	3 mg/kg/day

	1 mg/kg/day PO QD or divided BID **GCA*** 1.5 – 2 mg/kg/day PO	
corticosteroids - Oral: e.g., prednisone, budesonide -Medium to very high potency topical: e.g., desoximetasone 0.05%, fluocinolone acetonide 0.025%, mometasone 0.1% cream, triamcinolone acetonide 0.1%, augmented betamethasone dipropionate 0.05%, clobetasol propionate 0.05% cream, ointment, gel, or solution, halobetasol propionate 0.05% cream, ointment	**GCA*** Various **SJIA*** < 0.5 mg/kg/day PO of prednisone or equivalent	Various
Cuprimine (d-penicillamine)	**RA*** Initial dose: 125 or 250 mg PO QD Maintenance dose: 500 – 750 mg/day PO QD	1,500 mg/day
cyclophosphamide (Cytoxan®)	**SSc-ILD*** • PO: 1 – 2 mg/kg/day • IV: 600 mg/m2 /month	PO: 2 mg/kg/day IV: 600 mg/m2 /month
cyclosporine (Sandimmune®, Neoral®)	**RA** 2.5 – 4 mg/kg/day PO divided BID	PsO, RA: 4 mg/kg/day
hydroxychloroquine (Plaquenil®)	**RA*** Initial dose: 400 – 600 mg/day PO QD Maintenance dose: 200 – 400 mg/day PO QD	600 mg/day
leflunomide (Arava®)	**PJIA*** • Weight < 20 kg: 10 mg every other day • Weight 20 - 40 kg: 10 mg/day • Weight > 40 kg: 20 mg/day **RA** Initial dose (for low risk hepatotoxicity or myelosuppression): 100 mg PO QD for 3 days	PJIA, RA: 20 mg/day SJIA: 10 mg every other day

	Maintenance dose: 20 mg PO QD **SJIA*** 100 mg PO every other day for 2 days, then 10 mg every other day	
methotrexate (Trexall®, Otrexup™, Rasuvo®, RediTrex®, Xatmep™, Rheumatrex®)	**GCA*** 20 – 25 mg/week PO **PJIA*** 10 – 20 mg/m2 /week PO, SC, or IM **RA** 7.5 mg/week PO, SC, or IM or 2.5 mg PO Q12 hr for 3 doses/week **SJIA*** 0.5 – 1 mg/kg/week PO or SC	30 mg/week
mycophenolate mofetil (Cellcept®)	**SSc-ILD*** PO: 1 – 3 g/day	Adult: 3 g/day Pediatric: 50mg/kg/day
NSAIDs (e.g., indomethacin, ibuprofen, naproxen, celecoxib)	**PJIA***: Varies	Varies
Ridaura® (auranofin)	**RA** 6 mg PO QD or 3 mg PO BID	9 mg/day (3 mg TID)
sulfasalazine (Azulfidine®)	**PJIA*** 30-50 mg/kg/day PO divided BID **RA** Initial dose: 500 mg to 1,000 mg PO QD for the first week. Increase the daily dose by 500 mg each week up to a maintenance dose of 2 g/day. Maintenance dose: 2 g/day PO in divided doses	PJIA, ERA: 2 g/day RA: 3 g/day
biologic DMARDs (e.g., Humira, Enbrel, Cosentyx, Remicade, Simponi Aria, Otezla, Xeljanz/Xeljanz XR, Kevzara)	See Section V. Dosing and Administration	See Section V. Dosing and Administration

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

Contraindications: Known hypersensitivity to Actemra

BBW: Risk of serious infections

Appendix D: General Information

- Definition of failure of MTX or DMARDs
  - Failure of a trial of conventional 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.
- TNF blockers:
  - Etanercept (Enbrel®), adalimumab (Humira®) and its biosimilars, infliximab (Remicade®) and its biosimilars (Avsola™, Renflexis™, Inflectra®), certolizumab pegol (Cimzia®), and golimumab (Simponi®, Simponi Aria®).

Appendix E: Dose Rounding Guidelines for Weight-Based Doses

Actemra for Intravenous Use 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.

A	Joint involvement	Score
	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	Serology (at least one test result is needed for classification)	Score
	Negative rheumatoid factor (RF) and negative anti-citrullinated protein antibody (ACPA)	0
	Low positive RF or low positive ACPA * Low: < 3 x upper limit of normal	2
	High positive RF or high positive ACPA * High: ≥ 3 x upper limit of normal	3

C	Acute phase reactants (at least one test result is needed for classification)	Score
	Normal C-reactive protein (CRP) and normal erythrocyte sedimentation rate (ESR)	0
	Abnormal CRP or abnormal ESR	1

D	Duration of symptoms	Score
	< 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.

CDAI Score	Disease state interpretation
≤ 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.

RAPID3 Score	Disease state interpretation
≤ 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 (cJADAS10)

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 SScILD. 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

Appendix K:

Coronavirus-19 Infection (FDA Emergency Use Authorization):

- An EUA is an FDA authorization for the emergency use of an unapproved product or unapproved use of an approved product (i.e., drug, biological product, or device) in the United States under certain circumstances including, but not limited to, when the Secretary of HHS declares that there is a public health

emergency that affects the national security or the health and security of United States citizens living abroad, and that involves biological agent(s) or a disease or condition that may be attributable to such agent(s).

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Tocilizumab (Actemra)* *Also see Appendix E: Dose Rounding Guidelines for Weight-Based Doses	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
	GCA	IV: 6 mg/kg every 4 weeks in combination with a tapering course of glucocorticoids SC: 162 mg SC every week (every other week may be given based on clinical considerations)	IV: 6 mg/kg every 4 weeks SC: 162 mg every week
	PIJA	Weight < 30 kg: 10 mg/kg IV every 4 weeks or 162 mg SC every 3 weeks Weight ≥ 30 kg: 8 mg/kg IV every 4 weeks or 162 mg SC every 2 weeks	IV: 10 mg/kg every 4 weeks SC: 162 mg every 2 weeks
	SIJA	IV: Weight < 30 kg: 12 mg/kg IV every 2 weeks Weight ≥ 30 kg: 8 mg/kg IV every 2 weeks 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
	CRS	Weight < 30 kg: 12 mg/kg IV per infusion Weight ≥ 30 kg: 8 mg/kg IV per infusion 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	IV: 800 mg/infusion, up to 4 doses

		interval between consecutive doses should be at least 8 hours	
	SSc-ILD	162 mg SC once weekly	SC: 162 mg every week

VI. Product Availability

Tocilizumab (Actemra):
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

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, 1mg

Revision Log

Reviews, Revisions, and Approvals	Revision Date	Approval Date

Important Reminder
This clinical policy has been developed by appropriately experienced and licensed healthcare 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.