

Clinical Policy: Rilonacept (Arcalyst)

Reference Number: CP.PHAR.266

Effective Date: 11.16.16

Last Review Date: 05.20

Line of Business: Commercial, HIM, Medicaid

[Coding Implications](#)[Revision Log](#)

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

Description

Rilonacept (Arcalyst[®]) is an interleukin-1 blocker.

FDA Approved Indication(s)

Arcalyst is indicated for the treatment of cryopyrin-associated periodic syndromes (CAPS), including familial cold autoinflammatory syndrome (FCAS) and Muckle-Wells syndrome (MWS) in adults and children 12 and older.

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[®] that Arcalyst is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria**A. Cryopyrin-Associated Periodic Syndromes (must meet all):**

1. Diagnosis of FCAS or MWS;
2. Prescribed by or in consultation with a rheumatologist;
3. Age \geq 12 years;
4. Dose does not exceed a loading dose of 320 mg (as two injections) and once weekly dosing of 160 mg (as a single injection).

Approval duration:**Medicaid/HIM** – 6 months**Commercial** – 6 months or to the member's renewal date, whichever is longer**B. Other diagnoses/indications**

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

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

1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
2. Member is responding positively to therapy;

3. If request is for a dose increase, new dose does not exceed once weekly dosing of 160 mg (as a single injection).

Approval duration:

Medicaid/HIM – 12 months

Commercial – 6 months or to the member's renewal date, whichever is longer

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

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

Approval duration: Duration of request or 6 months (whichever is less); or

2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and 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.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CAPS: Cryopyrin-Associated Periodic Syndromes

FCAS: Familial Cold Autoinflammatory Syndrome

FDA: Food and Drug Administration

MWS: Muckle-Wells Syndrome

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

None reported

Appendix D: General Information

- Three related conditions make up the broader disease known as CAPS: FCAS, MWS, and neonatal-onset multisystem inflammatory disease (NOMID), also known as chronic infantile neurologic cutaneous articular syndrome (CINCA). Arcalyst is not FDA-approved for use in patients with NOMID/CINCA.
- Concomitant administration of Arcalyst with tumor necrosis factor (TNF) inhibitors (e.g., Enbrel, Humira, or Remicade) and interleukin-1 blocking agents (e.g., Kineret) is not recommended because this may increase the risk of serious infections.
- Examples of positive response to therapy include reduction/normalization of: C-reactive protein levels, serum amyloid A levels, flare frequency, or severity and duration of symptoms (e.g., joint pain, rash, fever/chills, eye pain, fatigue).
- Do not initiate treatment with Arcalyst in patients with active or chronic infections.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
CAPS (FCAS, MWS)	Age \geq 18 years: 320 mg SC loading dose followed by 160 mg SC once weekly Age 12 to 17 years: 4.4 mg/kg SC loading dose followed by 2.2 mg/kg SC once weekly	Loading dose: 320 mg; Maintenance dose: 160 mg weekly

VI. Product Availability

Single-use vial for reconstitution: 220 mg (each reconstituted vial delivers 160 mg)

VII. References

1. Arcalyst Prescribing Information. Tarrytown, NY: Regeneron Pharmaceuticals, Inc.; September 2016. Available at https://www.regeneron.com/sites/default/files/Arcalyst_FPI.pdf. Accessed February 26, 2020.
2. Hoffman, HM, Throne ML, Amar NJ, et al. Efficacy and safety of rilonacept (interleukin-1 trap) in patients with cryopyrin-associated periodic syndromes. Arthritis and Rheumatism. 2008;58(8): 2443-2452.

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.

HCPSC Codes	Description
J2793	Injection, rilonacept, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy split from CP.PHAR.47 Cryopyrin-Associated Periodic Syndromes (CAPS) Treatments; Updated contraindications per PI.	5.16	07.16
Converted to new template. Section II: added examples of CAPS related symptoms to assess on continued authorization. Removed safety restrictions that are not a black box warning.	07.17	07.17
2Q 2018 annual review: policies combined for Medicaid and Commercial lines of business; commercial: split from CP.CPA.234; added HIM; moved examples of positive response to therapy to Appendix C: General Information; references reviewed and updated.	02.27.18	05.18
4Q 2018 annual review: no significant changes; references reviewed and updated.	09.04.18	11.18
2Q 2019 annual review: no significant changes; references reviewed and updated.	02.26.19	05.19

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2020 annual review: no significant changes; references reviewed and updated.	02.26.19	05.19

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.

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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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