MEDICAL MUTUAL®

Drug Policy

Policy:	**CDP 210501**	**Initial Effective Date: 04/15/2021**
Code(s):	**HCPCS J2793**	**Annual Review Date: 08/24/2023**
SUBJECT:	**Arcalyst ® (rilonacept)**	**Last Revised Date: 08/24/2023**

☐Subject to Site of Care

Prior approval is required for some or all procedure codes listed in this Corporate Drug Policy.

I. Length of Authorization

Coverage will be provided for 6 months and may be renewed.

II. Dosing Limits

A. Quantity Limit (max daily dose) [NDC Unit]:

- Arcalyst 220 mg injection: 8 vials every 28 days

B. Max Units (per dose and over time) [HCPCS Unit]:

Cryopyrin-Associated Periodic Syndromes (CAPS)/Recurrent Pericarditis (RP)

- Loading Dose: 320 billable units on Day 1
- Maintenance Dose: 160 billable units every 7 days

Deficiency of Interleukin-1 Receptor Antagonist (DIRA)

- 320 billable units every 7 days

III. Initial Approval Criteria [1]

Coverage is provided in the following conditions:

- Patient is up to date with all vaccinations, in accordance with current vaccination guidelines, prior to initiating therapy; **AND**

Universal Criteria [1]

- Patient has been evaluated and screened for the presence of latent tuberculosis (TB) infection prior to initiating treatment and will receive ongoing monitoring for the presence of TB during treatment; **AND**

- Patient does not have an active infection, including clinically important localized infections; **AND**
- Will not be administered concurrently with live vaccines; **AND**
- Patient is not on concurrent therapy with other IL-1 blocking agents (e.g., canakinumab, anakinra*****, etc.) [***Note:** *For DIRA, anakinra must be discontinued 24 hours prior to starting Arcalyst*]; **AND**
- Patient is not on concurrent treatment with another TNF inhibitor, biologic response modifier or other non-biologic immunomodulating agent (e.g., apremilast, tofacitinib, baricitinib, upadacitinib, abrocitinib, deucravacitinib, etc.); **AND**

Cryopyrin-Associated Periodic Syndromes (CAPS) † Φ [1-4]

- Patient is at least 12 years of age; **AND**
- Used as a single agent; **AND**
- Patient has documented baseline serum levels of inflammatory proteins (C-Reactive Protein [CRP] and/or Serum Amyloid A [SAA], etc.); **AND**
- Patient has documented laboratory evidence of a genetic mutation in the Cold-Induced Auto-inflammatory Syndrome 1 (CIAS1), also known as NLRP3; **AND**
    - Documented diagnosis of Familial Cold Autoinflammatory Syndrome (FCAS); **OR**
    - Documented diagnosis of Muckle-Wells Syndrome (MWS); **AND**
- Patient has two or more of any of the CAPS-typical symptoms:
    - urticaria-like rash
    - cold-triggered episodes
    - sensorineural hearing loss
    - musculoskeletal symptoms
    - chronic aseptic meningitis
    - skeletal abnormalities

Deficiency of Interleukin-1 Receptor Antagonist (DIRA) † [1,5]

- Patient weighs at least 10 kg; **AND**
- Patient has a confirmed diagnosis of DIRA as evidenced by a mutation in the *IL1RN* gene; **AND**
- Used as maintenance of remission in patients who have previously experienced clinical benefit from anakinra therapy for the treatment of DIRA

Recurrent Pericarditis (RP) † Φ [6,7]

- Patient is at least 12 years of age; **AND**
- Used for the treatment of recurrent pericarditis and/or reducing the recurrence of disease; **AND**
- Patient has documented baseline serum levels of inflammatory proteins (C-Reactive Protein [CRP], etc.); **AND**
- Patient has failed standard therapy (e.g., NSAID, colchicine, corticosteroids, etc.)

† FDA Approved Indication(s); ‡ Compendia recommended indication(s); **Φ** Orphan Drug

IV. Renewal Criteria [1-7]

Coverage can be renewed based upon the following criteria:

- Patient continues to meet universal and other indication-specific relevant criteria identified in section III; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: severe hypersensitivity reactions, serious infections (including but not limited to tuberculosis), lipid profile changes, etc.; **AND**

Cryopyrin-Associated Periodic Syndromes

- Disease response as indicated by improvement in patient's symptoms from baseline AND improvement in serum levels of inflammatory proteins (e.g. CRP and/or SAA, etc.) from baseline

Deficiency of Interleukin-1 Receptor Antagonist (DIRA)

- Disease response as indicated by improvement in patient's symptoms (e.g., fever, skin rash, bone pain), inflammatory markers (e.g., CRP, ESR), and/or radiological evidence of active bone lesions compared to baseline

Recurrent Pericarditis (RP)

- Disease response as indicated by improvement in patient's symptoms (e.g., pericarditis pain, etc.), inflammatory markers (e.g., CRP, etc.), and/or decreased rate of recurrence of disease compared to baseline

V. Dosage/Administration [1]

Indication	Dose
Cryopyrin-Associated Periodic Syndromes & Recurrent Pericarditis (Adult patients 18 and older)	Initiate treatment with a loading dose of 320 mg delivered as two, 2-mL, subcutaneous injections of 160 mg on the same day at two different sites. Continue dosing with a once-weekly injection of 160 mg administered as a single, 2-mL, subcutaneous injection.
Cryopyrin-Associated Periodic Syndromes & Recurrent Pericarditis	Initiate treatment with a loading dose of 4.4 mg/kg, up to a maximum of 320 mg, delivered as one or two subcutaneous injections with a maximum single-injection volume of 2-mL. Continue dosing with a once-weekly injection of 2.2 mg/kg, up to a maximum of 160 mg,

(Pediatric patients aged 12 to 17)	administered as a single subcutaneous injection, up to 2-mL. If the initial dose is given as two injections, they should be given on the same day at two different sites.
Deficiency of Interleukin-1 Receptor Antagonist (Adult patients 18 and older)	The recommended dose is 320 mg once weekly delivered as two, 2-mL, subcutaneous injections of 160 mg on the same day at two different sites. ***NOTE:** Treatment with anakinra will be stopped 24 hours before initiation of Arcalyst*
Deficiency of Interleukin-1 Receptor Antagonist (Pediatric patients < 18 years of age and weighing at least 10 kg)	The recommended dose is 4.4 mg/kg (up to a maximum of 320 mg) once weekly delivered as one or two, subcutaneous injections with a maximum single-injection volume of 2 mL (160 mg). If the dose is given as two injections, they should be given on the same day at two different sites. ***NOTE:** Treatment with anakinra will be stopped 24 hours before initiation of Arcalyst*

VI. Billing Code/Availability Information

HCPCS Code:

- J2793 – Injection, rilonacept, 1 mg : 1 billable unit = 1 mg

NDC:

- Arcalyst 220 mg injection single-dose vial: 73604-0914-xx

VII. References

1. Arcalyst [package insert]. London, UK; Kiniksa Pharmaceuticals, Ltd.; May 2021. Accessed July 2023.
2. Hoffman HM, Throne ML, Amar NJ, et al. Efficacy and safety of rilonacept (interleukin-1 Trap) in patients with cryopyrin-associated periodic syndromes: results from two sequential placebo-controlled studies. Arthritis Rheum. 2008 Aug;58(8):2443-52.
3. Kuemmerle-Deschner JB, Ozen S, Tyrrell PN, et al. Diagnostic criteria for cryopyrin-associated periodic syndrome (CAPS). Ann Rheum Dis. 2017 Jun;76(6):942-947. doi: 10.1136/annrheumdis-2016-209686.
4. Terreri MT, Bernardo WM, Len CA, et al. Guidelines for the management and treatment of periodic fever syndromes: Cryopyrin-associated periodic syndromes (cryopyrinopathies - CAPS). Rev Bras Reumatol Engl Ed. 2016 Jan-Feb;56(1):44-51. doi: 10.1016/j.rbre.2015.08.020.
5. Garg M, de Jesus AA, Chapelle D, et al. Rilonacept maintains long-term inflammatory remission in patients with deficiency of the IL-1 receptor antagonist. JCI Insight. 2017 Aug 17;2(16):e94838. doi: 10.1172/jci.insight.94838.

6. Klein AL, Imazio M, Cremer P, et al; RHAPSODY Investigators. Phase 3 Trial of Interleukin-1 Trap Rilonacept in Recurrent Pericarditis. N Engl J Med. 2021 Jan 7;384(1):31-41. doi: 10.1056/NEJMoa2027892. Epub 2020 Nov 16.
7. Klein AL, Imazio M, Brucato A, et al. RHAPSODY: Rationale for and design of a pivotal Phase 3 trial to assess efficacy and safety of rilonacept, an interleukin-1α and interleukin-1β trap, in patients with recurrent pericarditis. Am Heart J. 2020 Oct;228:81-90. doi: 10.1016/j.ahj.2020.07.004. Epub 2020 Jul 14.

Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
E85.0	Non-neuropathic heredofamilial amyloidosis
I24.1	Dressler's Syndrome
L50.2	Urticaria due to cold and heat
M04.2	Cryopyrin-associated periodic syndromes
M04.8	Other autoinflammatory syndromes

Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) may exist and compliance with these policies is required where applicable. They can be found at: http://www.cms.gov/medicare-coverage-database/search.aspx. Additional indications may be covered at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCD/LCA: N/A

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	**Applicable State/US Territory**	**Contractor**
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT,	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA, LLC

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	**Applicable State/US Territory**	**Contractor**
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA, LLC
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC

Documentation Requirements:

The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the drug provided or services performed were not medically necessary, investigational or experimental, not within the scope of benefits afforded to the member and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

Prior approval is required for HCPCS Codes J2793