

## PHARMACY POLICY STATEMENT

### Common Ground Healthcare Cooperative (CGHC)

<b>DRUG NAME</b>	<b>Ilaris (canakinumab)</b>
BENEFIT TYPE	Pharmacy
STATUS	Prior Authorization Required

Ilaris is an interleukin-1 $\beta$  blocker that was initially approved by the FDA in 2009. It is indicated for the treatment of certain autoinflammatory Periodic Fever Syndromes (CAPS, TRAPS, FMF, HIDS/MKD), Active Still's Disease (Adult-Onset Still's Disease [AOSD] and Systemic Juvenile Idiopathic Arthritis [SJIA]), and gout flares. Ilaris binds to IL-1 $\beta$  and neutralizes its activity by blocking its interaction with IL-1 receptors, but it does not bind IL-1 $\alpha$  or IL-1 receptor antagonist (IL-1ra).

Cryopyrin-Associated Periodic Syndrome (CAPS) refer to rare genetic syndromes generally caused by mutations in the NLRP-3 gene (also known as CIAS1). The NLRP-3 gene encodes the protein cryopyrin, an important component of the inflammasome. Cryopyrin controls the activation of IL-1 $\beta$ . Mutations in NLRP-3 result in an overactive inflammasome resulting in excessive release of activated IL-1 $\beta$  that drives inflammation.

Still's disease is a severe autoinflammatory disease, driven by innate immunity by means of proinflammatory cytokines such as IL-1 $\beta$ . AOSD and SJIA are thought to represent a continuum of the same disease entity.

Ilaris (canakinumab) will be considered for coverage when the following criteria are met:

#### Adult-Onset Still's Disease (AOSD)

For **initial** authorization:

1. Member has a confirmed diagnosis of active AOSD supported by chart notes; AND
2. Medication must be prescribed by or in consultation with a rheumatologist; AND
3. Member has tried and failed a corticosteroid; AND
4. Member has moderate to severe disease, OR has tried and failed a conventional DMARD (e.g., methotrexate, cyclosporine); AND
5. Must have a negative tuberculosis test within the past 12 months.
6. **Dosage allowed/Quantity limit:** 4 mg/kg (up to max dose 300 mg) subcutaneously every 4 weeks.  
QL: 2 vials (2 mL) per 28 days

***If all the above requirements are met, the medication will be approved for 6 months.***

For **reauthorization**:

1. Chart notes have been provided that show improvement of signs and symptoms of disease (i.e., systemic and articular manifestations, normalized CRP, reduced corticosteroid use).

***If all the above requirements are met, the medication will be approved for an additional 12 months.***

### **Cryopyrin-Associated Periodic Syndrome (CAPS)**

For **initial** authorization:

1. Member must be at least 4 years of age; AND
2. Medication must be prescribed by or in consultation with a rheumatologist or other physician experienced with periodic fever syndromes; AND
3. Member must be diagnosed with Familial Cold Autoinflammatory Syndrome (FCAS) or Muckle-Wells Syndrome (MWS); AND
4. Genetic testing results show gain-of-function mutation in the *NLRP3* gene; AND
5. Member has elevated inflammatory markers (e.g., serum amyloid A, C-reactive protein, erythrocyte sedimentation rate [SAA, CRP, ESR]); AND
6. Member displays symptoms of CAPS (e.g., rash, cold/stress-triggered episodes, hearing loss); AND
7. Must have a negative tuberculosis test within the past 12 months.
8. **Dosage allowed/Quantity limit:** 150 mg for body weight > 40 kg; 2 mg/kg for body weight between 15 kg and 40 kg. For children 15 kg to 40 kg with an inadequate response, the dose can be increased to 3 mg/kg. Administer subQ every 8 weeks.  
QL: 1 vial (1 mL) per 56 days

***If all the above requirements are met, the medication will be approved for 6 months.***

For **reauthorization**:

1. Chart notes demonstrate positive clinical response including decreased inflammatory marker values and symptom improvement.

***If all the above requirements are met, the medication will be approved for an additional 12 months.***

### **Familial Mediterranean Fever (FMF)**

For **initial** authorization:

1. Medication is prescribed by or in consultation with a rheumatologist or other physician experienced with periodic fever syndromes; AND
2. Member has a diagnosis of familial Mediterranean fever; AND
3. Member is resistant to a **compliant** trial of colchicine at maximal appropriate dose (i.e., 1-3 mg/day) with ongoing disease activity reflected by:
  - a) Recurrent clinical attacks (average 1 or more per month over a 3-month period) and/or
  - b) Persistently elevated CRP or SAA between attacks; AND
4. Colchicine will be continued unless contraindicated or intolerable; AND
5. Must have a negative tuberculosis test within the past 12 months.
6. **Dosage allowed/Quantity limit:**

Body weight  $\leq$  40 kg: starting dose is 2 mg/kg subQ every 4 weeks. The dose can be increased to 4 mg/kg every 4 weeks if the clinical response is not adequate.  
 Body weight  $>$  40 kg: starting dose is 150 mg subQ every 4 weeks. The dose can be increased to 300 mg every 4 weeks if the clinical response is not adequate.  
 QL: 2 vials (2 mL) per 28 days

***If all the above requirements are met, the medication will be approved for 6 months.***

For **reauthorization**:

1. Chart notes have been provided showing response to therapy such as reduced severity and/or frequency of flares, reduced SAA and/or CRP levels.

***If all the above requirements are met, the medication will be approved for an additional 12 months.***

### **Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD)**

For **initial** authorization:

1. Medication is prescribed by or in consultation with a rheumatologist or other physician experienced with periodic fever syndromes; AND
2. Member has a diagnosis of HIDS/MKD, confirmed by genetic testing results that show loss-of-function mutation in *MVK* gene; AND
3. Member has elevated inflammatory markers (e.g., serum levels of amyloid A, C-reactive protein, erythrocyte sedimentation rate [SAA, CRP, ESR]); AND
4. Member displays signs or symptoms of HIDS/MKD (e.g., GI symptoms, rash, fever attack triggered by vaccination, elevated urine mevalonate levels during disease flare); AND
5. Must have a negative tuberculosis test within the past 12 months.
6. **Dosage allowed/Quantity limit:**  
 Body weight  $\leq$  40 kg: starting dose is 2 mg/kg subQ every 4 weeks. The dose can be increased to 4 mg/kg every 4 weeks if the clinical response is not adequate.  
 Body weight  $>$  40 kg: starting dose is 150 mg subQ every 4 weeks. The dose can be increased to 300 mg every 4 weeks if the clinical response is not adequate.  
 QL: 2 vials (2 mL) per 28 days

***If all the above requirements are met, the medication will be approved for 6 months.***

For **reauthorization**:

1. Chart notes have been provided showing response to therapy such as reduced severity and/or frequency of flares.

***If all the above requirements are met, the medication will be approved for an additional 12 months.***

### Systemic Juvenile Idiopathic Arthritis (SJIA)

For **initial** authorization:

1. Member must be 2 years of age or older and weigh  $\geq 7.5$  kg; AND
2. Medication must be prescribed by or in consultation with a rheumatologist; AND
3. Member must have active SJIA; AND
4. Member must have inadequate response to **ONE** of the following:
  - a) Glucocorticoid;
  - b) NSAID; AND
5. Member has had a negative tuberculosis test within the past 12 months.
6. **Dosage allowed/Quantity limit:** 4 mg/kg subcutaneously every 4 weeks with a maximum dose of 300 mg. Quantity limit: 2 vials per 28 days.

***If all the above requirements are met, the medication will be approved for 12 months.***

For **reauthorization**:

1. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease such as decreased joint swelling, decreased pain and improved quality of life.

***If all the above requirements are met, the medication will be approved for an additional 12 months.***

### Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS)

For **initial** authorization:

1. Medication is prescribed by or in consultation with a rheumatologist or other physician experienced with periodic fever syndromes; AND
2. Member has a diagnosis of TRAPS, confirmed by genetic testing results that show gain-of-function mutation in *TNFRSF1A* gene; AND
3. Member has elevated inflammatory markers (e.g., serum levels of amyloid A, C-reactive protein, erythrocyte sedimentation rate [SAA, CRP, ESR]); AND
4. Member displays signs or symptoms of TRAPS (e.g., long-lasting fever episodes, abdominal pain, migratory rash, periorbital edema, myalgia, positive family history); AND
5. Must have a negative tuberculosis test within the past 12 months.
6. **Dosage allowed/Quantity limit:**

Body weight  $\leq 40$  kg: starting dose is 2 mg/kg subQ every 4 weeks. The dose can be increased to 4 mg/kg every 4 weeks if the clinical response is not adequate.

Body weight  $> 40$  kg: starting dose is 150 mg subQ every 4 weeks. The dose can be increased to 300 mg every 4 weeks if the clinical response is not adequate.

QL: 2 vials (2 mL) per 28 days

***If all the above requirements are met, the medication will be approved for 6 months.***

For **reauthorization**:

1. Chart notes have been provided showing response to therapy such as reduced severity and/or frequency of flares.

***If all the above requirements are met, the medication will be approved for an additional 12 months.***

### Gout Flare

For **initial** authorization:

1. Member is at least 18 years of age; AND
2. Medication is prescribed by or in consultation with a rheumatologist; AND
3. Member has a diagnosis of gout with documentation of at least 3 flares in the past year; AND
4. Member has documentation of trial and failure of ALL 3 of the following:
  - a) Non-steroidal anti-inflammatory drugs (NSAIDs)
  - b) Colchicine
  - c) Corticosteroids; AND
5. Member has a negative tuberculosis test within the past 12 months.
6. **Dosage allowed/Quantity limit:** 150 mg subQ. If retreatment is required, there must be an interval of at least 12 weeks before a new dose can be given.

***If all the above requirements are met, the medication will be approved for 3 months.***

For **reauthorization**:

1. Chart notes must show documentation of response to therapy such as reduced pain severity and/or fewer flares; AND
2. Member is experiencing a new flare; AND
3. Re-treatment is not occurring more frequently than every 12 weeks.

***If all the above requirements are met, the medication will be approved for an additional 6 months.***

**CareSource considers Ilaris (canakinumab) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.**

DATE	ACTION/DESCRIPTION
05/09/2017	New policy for Ilaris created. Policy SRx-0042 archived. For CAPS diagnosis: laboratory evidence requirement of a genetic mutation added. Diagnoses of TRAPS, HIDS/MKD and FMF were added. List of diagnoses considered not medically necessary added.
07/14/2017	Documentation of negative TB test was added to all diagnosis.
03/20/2019	TB test allowed to be done within 12 months prior to initiation of therapy; chest x-ray option removed.
09/29/2020	New diagnosis of Adult Onset Still's Disease added. Status corrected.
06/15/2021	At end of policy, replaced specific list of excluded diseases with general statement.

	<p>CAPS: Updated references. Removed genetic test requirement (mutation not present in many patients), added biomarker and symptoms instead. Reduced initial approval duration from 12 months to 6 months, should see response much sooner. Specified renewal criteria.</p> <p>FMF: Updated references. Added specialist. Added diagnosis. Removed baseline PGA score. Removed CRP level. Removed minimum number of flares. Added trial of colchicine per guidelines. Specified renewal criteria.</p> <p>HIDS/MKD: Updated references. Added specialist. Added diagnosis. Removed baseline PGA score. Removed CRP level. Removed minimum number of flares. Reduced initial approval duration. Specified renewal criteria.</p> <p>TRAPS: Updated references. Added specialist. Added diagnosis. Removed baseline PGA score. Removed CRP level. Removed minimum number of flares. Reduced initial approval duration. Specified renewal criteria.</p>
<b>02/18/2022</b>	Transferred to new template. AOSD: Added new reference. Changed wording of TB test requirement. Removed meet initial criteria from reauth section.
<b>11/16/2023</b>	Added new indication for gout flares.
<b>06/21/2024</b>	<p>SJIA: added in consultation with for prescriber specialty; removed TB test and compliance with initial criteria from reauthorization criteria; added examples to improvement of signs and symptoms in reauthorization criteria; simplified TB test wording; replaced 12 week trial of NSAID with just a trial of an NSAID per 2021 ACR guideline; removed methotrexate trial per 2021 ACR guideline; removed list of signs and symptoms for confirmation of diagnosis; added quantity limit; moved weight required from dosing to initial criteria.</p> <p>CAPS/TRAPS/MKD: Updated references, added new guideline ref (Romano 2022); added genetic testing requirements, edited symptom examples for CAPS, added symptomatology and inflammatory markers to TRAPS and MKD.</p> <p>FMF: Added reference. Changed “trial and failure” of colchicine to colchicine resistance, with definition (Lancieri 2023); added CRP and SAA to renewal. Added concomitant colchicine (Ozen 2016).</p> <p>AOSD: Updated references. Added specific renewal criteria (Colafrancesco 2019). Changed DMARD trial to only apply to mild disease instead of all, also removed duration and leflunomide (Vordenbaumen 2023).</p> <p>AOSD/CAPS/TRAPS/MKD/FMF: Added QL.</p>

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Effective date: 01/01/2025

Revised date: 06/21/2024