Reference number
1861-A

SPECIALTY GUIDELINE MANAGEMENT

SYLVANT (siltuximab)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indication
Sylvant is indicated for the treatment of patients with multicentric Castleman's disease who are human immunodeficiency virus (HIV) negative and human herpesvirus-8 (HHV-8) negative.

B. Compendial Use
Relapsed/refractory unicentric Castleman's disease

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Multicentric Castleman's disease or relapsed/refractory unicentric Castleman's disease.
Authorization of 12 months may be granted for the treatment of multicentric Castleman's disease or relapsed/refractory unicentric Castleman's disease.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet ALL initial authorization criteria.

IV. REFERENCES

1. Sylvant [package insert]. Horsham, PA: Janssen Biotech, Inc.; November 2015.
2. The NCCN Drugs & Biologics Compendium® © 2018 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed January 19, 2018.
3. The NCCN Clinical Practice Guidelines in Oncology® B-cell Lymphomas. (Version 7.2017). © 2018 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed January 19, 2018.