CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Arkansas PASSE

DRUG NAME	Sylvant (siltuximab)
BENEFIT TYPE	Medical
STATUS	Prior Authorization Required

Sylvant, approved by the FDA in 2014, is an interleukin 6 (IL-6) antagonist indicated for the treatment of patients with multicentric Castleman's disease (MCD) who are human immunodeficiency virus (HIV) negative and human herpesvirus-8 (HHV-8) negative.
Castleman Disease (CD) is a rare lymphoproliferative disorder in which benign growths form in lymph node tissue. It is also associated with a number of malignancies. It can be unicentric or multicentric; MCD is further subtyped as human herpesvirus-8 (HHV-8) positive or as idiopathic. Symptoms range from mild to severe to life-threatening and involve systemic inflammatory symptoms, polyclonal lymphoproliferation, cytopenias, and multiple organ system dysfunction.
Sylvant is a first line treatment for CD per NCCN (category 2a) and is the preferred treatment per international guidelines (category 1).

Sylvant (siltuximab) will be considered for coverage when the following criteria are met:

Multicentric Castleman's Disease (MCD)

For **initial** authorization:
1. Medication must be prescribed by or in consultation with a hematologist or oncologist; AND
2. Member has a documented diagnosis of multicentric Castleman's Disease; AND
3. Member has active disease, with presence of signs/symptoms; AND
4. Member is human immunodeficiency virus (HIV) negative (lab report required); AND
5. Member is human herpesvirus-8 (HHV-8) negative (lab report required).
6. **Dosage allowed/Quantity limit:** 11 mg/kg by IV infusion every 3 weeks until treatment failure.

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

For **reauthorization**:
1. Chart notes indicate that disease has not progressed (based on labs, symptoms, and tumor response).

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

CareSource considers Sylvant (siltuximab) 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
06/06/2025	New policy for Sylvant created.

References:

1. Sylvant [prescribing information]. Recordati Rare Diseases Inc.; 2024.
2. National Comprehensive Cancer Network. Castleman Disease. (Version 2.2025). https://www.nccn.org/professionals/physician_gls/pdf/castleman.pdf. Accessed June 6, 2025.
3. van Rhee F, Rosenthal A, Kanhai K, et al. Siltuximab is associated with improved progression-free survival in idiopathic multicentric Castleman disease. *Blood Adv*. 2022;6(16):4773-4781. doi:10.1182/bloodadvances.2022007112
4. Fajgenbaum DC, Uldrick TS, Bagg A, et al. International, evidence-based consensus diagnostic criteria for HHV-8-negative/idiopathic multicentric Castleman disease. *Blood*. 2017;129(12):1646-1657. doi:10.1182/blood-2016-10-746933
5. van Rhee F, Voorhees P, Dispenzieri A, et al. International, evidence-based consensus treatment guidelines for idiopathic multicentric Castleman disease. *Blood*. 2018;132(20):2115-2124. doi:10.1182/blood-2018-07-862334

Effective date: 01/01/2026
Revised date: 06/06/2025