Market Applicability							
Market	**DC**	**GA**	**KY**	**MD**	**NJ**	**NY**	**WA**
Applicable	X	X	X	X	X	X	X

Sylvant (siltuximab)

Override(s)	Approval Duration
Prior Authorization	1 year

Medications
Sylvant (siltuximab)

APPROVAL CRITERIA

Requests for Sylvant (siltuximab) may be approved if the following criteria are met:

I. Individual has a diagnosis of Multicentric Castleman's Disease; **AND**
II. Sylvant (siltuximab) is used as a single agent; **AND**
III. Individual is human immunodeficiency virus negative; **AND**
IV. Individual is human herpesvirus-8 negative; **AND**
V. No concurrent clinically significant infection (for example, Hepatitis B or C); **AND**
VI. No concurrent lymphoma.

Requests for Sylvant (siltuximab) may not be approved if the above criteria are not met and for all other indications.

Key References:

1. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.: 2020. URL: http://www.clinicalpharmacology.com. Updated periodically.
2. DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. http://dailymed.nlm.nih.gov/dailymed/about.cfm. Accessed: January 16, 2020.
3. DrugPoints® System [electronic version]. Truven Health Analytics, Greenwood Village, CO. Updated periodically.
4. Lexi-Comp ONLINE™ with AHFS™, Hudson, Ohio: Lexi-Comp, Inc.; 2020; Updated periodically.
5. NCCN Clinical Practice Guidelines in Oncology™. © 2019 National Comprehensive Cancer Network, Inc. For additional information visit the NCCN website: http://www.nccn.org/index.asp. Accessed on January 16, 2020.
   a. B-Cell Lymphomas. V7.2019. Revised December 18, 2019.

Market Applicability							
Market	**DC**	**GA**	**KY**	**MD**	**NJ**	**NY**	**WA**
Applicable	X	X	X	X	X	X	X

This policy does not apply to health plans or member categories that do not have pharmacy benefits, nor does it apply to Medicare. Note that market specific restrictions or transition-of-care benefit limitations may apply.