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Last P&T Approval/Version: 10/30/2024
Next Review Due By: 10/2025
Policy Number: C10415-A

Kineret (anakinra)

PRODUCTS AFFECTED

Kineret (anakinra)

COVERAGE POLICY

Coverage for services, procedures, medical devices, and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Coverage Guideline must be read in its entirety to determine coverage eligibility, if any. This Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide Molina Healthcare complete medical rationale when requesting any exceptions to these guidelines.

Documentation Requirements:
Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational, or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

DIAGNOSIS:
Cryopyrin-associated periodic syndromes (CAPS), specifically Neonatal-Onset Multisystem Inflammatory Disease (NOMID), Rheumatoid arthritis (RA), Juvenile idiopathic arthritis (systemic and polyarticular), Deficiency of interleukin-1 receptor antagonist

REQUIRED MEDICAL INFORMATION:
This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. If a drug within this policy receives an updated FDA label within the last 180 days, medical necessity for the member will be reviewed using the updated FDA label information along with state and federal requirements, benefit being administered and formulary preferencing. Coverage will be determined on a case-by case basis until the criteria can be updated through Molina Healthcare, Inc. clinical governance. Additional information may be required on a case-by-case basis to allow for adequate review. When the requested drug product for coverage is dosed by weight, body surface area or other member specific measurement, this data element is required as part of the medical necessity review. The Pharmacy and Therapeutics Committee has determined that the drug benefit shall be a mandatory generic and that generic drugs will be dispensed whenever available.

FOR ALL INDICATIONS:

1. Prescriber attests member does not have an active or latent untreated infection (e.g., Hepatitis B, tuberculosis, etc.), including clinically important localized infections, according to the FDA label
   AND
2. Member is not on concurrent treatment or will not be used in combination with TNF- inhibitor, biologic response modifier or other biologic DMARDs, Janus kinase Inhibitors, or Phosphodiesterase 4 inhibitor (i.e., apremilast, tofacitinib, baricitinib) as verified by prescriber attestation, member medication fill history, or submitted documentation
   AND
3. IF THIS IS A NON-FORMULARY/NON-PREFERRED PRODUCT: Documentation of trial/failure of or serious side effects to a majority (not more than 3) of the preferred formulary PDL alternatives for the given diagnosis. Submit documentation including medication(s) tried, dates of trial(s) and reason for treatment failure(s).

A. MODERATE TO SEVERE RHEUMATOID ARTHRITIS:
1. Documentation of moderate to severe rheumatoid arthritis diagnosis
   AND
2. Documentation of prescriber baseline disease activity evaluation and goals for treatment to be used to evaluate efficacy of therapy at renewal [DOCUMENTATION REQUIRED]
   AND
3. (a) Member is currently receiving maximally tolerated dose of methotrexate and is not at goal disease activity
   OR
   (b) Member has an FDA labeled contraindication or serious side effects to methotrexate, as determined by the prescribing physician AND Member has tried one additional disease- modifying antirheumatic drug (DMARD) (brand or generic; oral or injectable) for at least 3 months
   NOTE: An exception to the requirement for a trial of one conventional synthetic DMARD can be made if the member has already had a 3-month trial of at least one biologic. These members who have already tried a biologic for RA are not required to "step back "and try a conventional synthetic DMARD.

B. CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES (CAPS):
1. Documented diagnosis of one Cryopyrin-Associated Periodic Syndromes (CAPS) disorder: Familial Cold Autoinflammatory Syndrome (FCAS), Muckle-Wells syndrome (MWS), OR Neonatal-Onset Multisystem Inflammatory Disorder (NOMID)
   AND
2. Documentation diagnosis confirmed by one of the following [DOCUMENTATION REQUIRED]:
   (a) Raised inflammatory markers (C-reactive protein [CRP] and serum amyloid A) AND at least two of six typical CAPS manifestations: urticaria-like rash, Cold-triggered episodes, Sensorineural hearing loss, Musculoskeletal symptoms, Chronic aseptic meningitis, Skeletal abnormalities
   OR
   (b) Confirmed by genetic testing for NLRP3 gene mutations (also called CIAS1)
   AND
3. Prescriber attests to significant functional impairment resulting in limitations of activities of daily living (ADLs)
   AND
4. Documentation of prescriber baseline disease activity evaluation and goals for treatment to be used to evaluate efficacy of therapy at renewal [DOCUMENTATION REQUIRED]

C. JUVENILE IDIOPATHIC ARTHRITIS (ACTIVE SYSTEMIC AND POLYARTICULAR):
1. Documented diagnosis of systemic juvenile idiopathic arthritis (SJIA) or polyarticular juvenile idiopathic arthritis (PJIA) in a pediatric member
   AND
2. Documentation of prescriber baseline disease activity evaluation and goals for treatment to be used to evaluate efficacy of therapy at renewal [DOCUMENTATION REQUIRED]
   AND
3. (a) FOR ACTIVE SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS: Documentation of treatment failure, serious side effects or clinical contraindication to an adequate trial (12 weeks) of one NSAID

or glucocorticoid
OR
(b) FOR POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS: Documentation of treatment failure, serious side effects or clinical contraindication to an adequate trial (generally ≥12 weeks) of one or more of the following: Methotrexate, hydroxychloroquine, sulfasalazine, leflunomide

D. DEFICIENCY OF INTERLEUKIN-1 RECEPTOR ANTAGONIST:
1. Documented diagnosis of Deficiency of Interleukin-1 Receptor Antagonist (DIRA)
AND
2. Documentation diagnosis confirmed by a genetic mutation of IL1RN OR the presence of ANY of the following: sterile multifocal osteomyelitis, periostitis, pustular rash, marked osteopenia, lytic bone lesions, respiratory insufficiency, or thrombosis [DOCUMENTATION REQUIRED]
AND
3. Documentation of prescriber baseline disease activity evaluation and goals for treatment to be used to evaluate efficacy of therapy at renewal [DOCUMENTATION REQUIRED]

CONTINUATION OF THERAPY:

A. ALL INDICATIONS:
1. Adherence to therapy at least 85% of the time as verified by the prescriber or member medication fill history OR adherence less than 85% of the time due to the need for surgery or treatment of an infection, causing temporary discontinuation
AND
2. Prescriber attests to or clinical reviewer has found no evidence of intolerable adverse effects or drug toxicity
AND
3. Documentation of positive clinical response as demonstrated by low disease activity and/or improvements in the condition's signs and symptoms [DOCUMENTATION REQUIRED]
AND
4. Prescriber attests to ongoing monitoring for development of infection (e.g., tuberculosis, Hepatitis B reactivation, etc.) according to the FDA label

DURATION OF APPROVAL:

Initial authorization: 6 months, Continuation of therapy: 12 months
MOLINA REVIEWER NOTE: For Texas Marketplace, please see Appendix.

PRESCRIBER REQUIREMENTS:

Prescribed by or in consultation with a board-certified rheumatologist, geneticist, or dermatologist [If prescribed in consultation, consultation notes must be submitted with initial request and reauthorization requests]

AGE RESTRICTIONS:

Juvenile idiopathic arthritis (JIA): 2 years of age and older
Rheumatoid Arthritis: 18 years of age and older
No requirement for all other indications

QUANTITY:

Rheumatoid Arthritis (RA): 100 mg daily (28 syringes per 28 days)
Cryopyrin-Associated Periodic Syndromes (CAPS): 1-2 mg/kg daily for NOMID patients; dose can be individually adjusted to a maximum of 8 mg/kg daily to control active inflammation
Deficiency of Interleukin-1 Receptor Antagonist (DIRA): 1-2 mg/kg daily; dose can be individually adjusted to a maximum of 8 mg/kg daily to control active inflammation
PJIA[17]: 1 mg/kg once daily; maximum dose: 100 mg
Systemic-onset JIA (SOJIA) [18]: Initial: 1 to 2 mg/kg/dose once daily; maximum initial dose: 100 mg; if no response, may titrate typically at 2-week intervals by doubling dose up to 4 mg/kg/dose once daily; maximum dose: 200 mg

PLACE OF ADMINISTRATION:
The recommendation is that injectable medications in this policy will be for pharmacy benefit coverage and patient self-administered.

DRUG INFORMATION

ROUTE OF ADMINISTRATION:
Subcutaneous

DRUG CLASS:
Interleukin-1 Receptor Antagonist (IL-1Ra)

FDA-APPROVED USES:
Indicated for:

- Rheumatoid Arthritis (RA) - Reduction in signs and symptoms and slowing the progression of structural damage in moderately to severely active rheumatoid arthritis, in patients 18 years of age or older who have failed 1 or more disease modifying antirheumatic drugs (DMARDs)
- Cryopyrin-Associated Periodic Syndromes (CAPS) - Treatment of Neonatal-Onset Multisystem Inflammatory Disease (NOMID)
- Deficiency of Interleukin-1 Receptor Antagonist (DIRA) - Treatment of Deficiency of Interleukin-1 Receptor Antagonist (DIRA)

COMPENDIAL APPROVED OFF-LABELED USES:
Juvenile idiopathic arthritis; Multisystem inflammatory syndrome in children, Refractory, associated with SARS-CoV-2 (COVID-19)

APPENDIX

APPENDIX:
Reserved for State specific information. *Information includes, but is not limited to, State contract language, Medicaid criteria and other mandated criteria.*

State Specific Information
State Marketplace
Texas (Source: Texas Statutes, Insurance Code)
"Sec. 1369.654. PROHIBITION ON MULTIPLE PRIOR AUTHORIZATIONS.
(a) A health benefit plan issuer that provides prescription drug benefits *may not require an enrollee to receive more than one prior authorization annually* of the prescription drug benefit for *a prescription drug prescribed to treat an autoimmune disease, hemophilia, or Von Willebrand disease*.
(b) This section does not apply to:
(1) opioids, benzodiazepines, barbiturates, or carisoprodol;
(2) prescription drugs that have a typical treatment period of less than 12 months;
(3) drugs that:
(A) have a boxed warning assigned by the United States Food and Drug Administration for use; and
(B) must have specific provider assessment; or
(4) the use of a drug approved for use by the United States Food and Drug Administration in a manner other than the approved use."

BACKGROUND AND OTHER CONSIDERATIONS

BACKGROUND:
Kineret is an interleukin-1 (IL-1) receptor antagonist. IL-1 production is induced in response to inflammation and mediates various physiologic responses including inflammatory and immunological responses. Kineret is indicated to reduce the signs and symptoms and slow the progression of structural

damage in adult patients with moderately to severely active rheumatoid arthritis (RA) who have failed one or more disease- modifying antirheumatic drugs (DMARDs). Kineret is also indicated in Cryopyrin-Associated Periodic Syndromes (CAPS) for treatment of Neonatal Onset Multisystem Inflammatory Disease (NOMID). In RA, Kineret can be used alone or in combination with DMARDs other than tumor necrosis factor (TNF) blocking agents (e.g., Cimzia® [certolizumab pegol SC injection], Enbrel [etanercept SC injection], Humira® [adalimumab SC injection], Remicade [infliximab intravenous {IV} infusion], Simponi® [golimumab SC injection], or Simponi Aria™ [golimumab for IV infusion]).

Multisystem inflammatory syndrome in children, Refractory; associated with SARS-CoV-2 (COVID-19)
Children with MIS-C typically respond briskly to immunomodulatory therapy and show clinical improvements within the first 24 hours of treatment. Treatment response is characterized by resolution of fever, improvement of organ function, and reduced levels of inflammatory markers, particularly C-reactive protein. By contrast, refractory disease is often accompanied by persistent fever, worsening organ dysfunction and increasing levels of inflammatory markers. Intensification therapy is recommended for children with refractory MIS-C who do not improve within 24 hours of initial immunomodulatory therapy (AIII). Children with uncontrolled MIS-C despite treatment with IVIG and low-to-moderate-dose glucocorticoids will often continue to deteriorate without further intervention, and this decline in clinical status can be quite rapid.
There are no comparative studies evaluating intensification therapies for MIS-C. Available data on this topic are limited to results from cohort studies in patients with MIS-C, expert opinion, and experience in treating other hyperinflammatory syndromes in children, such as Kawasaki disease and macrophage activation syndrome. For children with refractory MIS-C, the Panel recommends additional immunomodulatory therapy (in alphabetical order) with anakinra (BIIb), higher-dose glucocorticoids (BIIb), or infliximab (BIIb). Currently, there is insufficient evidence to determine which of these agents is most effective for intensification therapy in patients with refractory MIS-C. In certain patients with severe illness, intensification therapy may include dual therapy with higher-dose glucocorticoids and anakinra (BIII) or higher-dose glucocorticoids and infliximab (BIII). Anakinra and infliximab should not be used in combination.
Patients with MIS-C who receive multiple immunomodulatory agents are at risk for infection and need to be monitored carefully. Most children with MIS-C were previously healthy. In patients who have an immune disorder or are taking immunosuppression therapy, the risk of infection is greater. The risks and benefits of treating immunocompromised MIS-C patients with immunomodulatory agents need to be evaluated on a case-by-case basis.
High-dose anakinra (5–10 mg/kg/day) is recommended for MIS-C based on the improved efficacy of anakinra used at higher doses for macrophage activation syndrome. The duration of anakinra therapy varies in the literature and is used by some patients for long periods (e.g., up to 2 weeks) as a steroid sparing agent.

CONTRAINDICATIONS/EXCLUSIONS/DISCONTINUATION:
All other uses of Kineret (anakinra) are considered experimental/investigational and therefore, will follow Molina's Off-Label policy. Contraindications to Kineret (anakinra) include: patients with E. coli protein hypersensitivity or hypersensitivity to anakinra or any components of the product, do not initiate in patients with active infection. Not to be used in combination with other biologic therapies.

OTHER SPECIAL CONSIDERATIONS:
None

CODING/BILLING INFORMATION

CODING DISCLAIMER. *Codes listed in this policy are for reference purposes only and may not be all-inclusive or applicable for every state or line of business. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit*

document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry-standard coding practices for all submissions. Molina has the right to reject/deny the claim and recover claim payment(s) if it is determined it is not billed appropriately or not a covered benefit. Molina reserves the right to revise this policy as needed.

HCPCS CODE	DESCRIPTION
N/A	

AVAILABLE DOSAGE FORMS:
Kineret SOSY 100MG/0.67ML single-use prefilled syringe

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SUMMARY OF REVIEW/REVISIONS	DATE
REVISION- Notable revisions: Coding/Billing Information Template Update	Q4 2024
REVISION- Notable revisions: Required Medical Information Continuation of Therapy Contraindications/Exclusions/Discontinuation Available Dosage Forms References	Q4 2023
REVISION- Notable revisions: Required Medical Information Continuation of Therapy Quantity Compendial Approved Off-Labeled Uses References	Q4 2022
Q2 2022 Established tracking in new format	Historical changes on file