Tocilizumab

NOTICE

This policy contains information which is clinical in nature. The policy is not medical advice. The information in this policy is used by Wellmark to make determinations whether medical treatment is covered under the terms of a Wellmark member's health benefit plan. Physicians and other health care providers are responsible for medical advice and treatment. If you have specific health care needs, you should consult an appropriate health care professional. If you would like to request an accessible version of this document, please contact customer service at 800-524-9242.

BENEFIT APPLICATION

Benefit determinations are based on the applicable contract language in effect at the time the services were rendered. Exclusions, limitations or exceptions may apply. Benefits may vary based on contract, and individual member benefits must be verified. Wellmark determines medical necessity only if the benefit exists and no contract exclusions are applicable. This medical policy may not apply to FEP. Benefits are determined by the Federal Employee Program.

DESCRIPTION

The intent of the Tocilizumab drug policy is to ensure appropriate selection of patients for therapy based on product labeling, clinical guidelines and clinical studies while steering utilization to the most cost-effective medication within the therapeutic class. The tocilizumab products in this policy include the following: Actemra, Avtozma (tocilizumab-anoh), Tofidence (tocilizumab-bavi), and Tyenne (tocilizumab-aazg). and For this program, adalimumab-aacf, Cosentyx, Enbrel, Entyvio, Otezla, Otulfi (ustekinumab-aauz), Rinvoq, Simponi, Skyrizi, Tremfya, Velsipity and Xeljanz/Xeljanz XR/Xeljanz Oral Solution are the preferred products and will apply to members requesting treatment with subcutaneous tocilizumab for an indication that is FDA-approved for the preferred product. The criteria will require the use of two of the health plan’s preferred products before the use of non-preferred products unless there are clinical circumstances that exclude the use of all the preferred products, the patient is currently receiving treatment with the non-preferred drug and experience a positive therapeutic outcome, or there is only one preferred product for an indication. Members that require tocilizumab will be required to use Tyenne (tocilizumab-aazg), unless there are clinical circumstances that exclude the use of that product. Additionally for this program, Avsola, Entyvio, Ilumya, Inflectra, Otulfi, Skyrizi, Simponi Aria, and Tyenne (tocilizumab-aazg) are the preferred products and will apply to members requesting treatment with intravenous Actemra (tocilizumab), Avtozma (tocilizumab-anoh) or Tofidence (tocilizumab-bavi) for an indication that is FDA-approved for the preferred product. Coverage for targeted products is provided based on clinical circumstances that would exclude the use of the preferred product and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made.

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.

FDA-Approved Indications

1. Adult patients with moderately to severely active rheumatoid arthritis (RA) who have had an inadequate response to one or more disease-modifying antirheumatic drugs (DMARDs).
2. Patients 2 years of age and older with active polyarticular juvenile idiopathic arthritis (pJIA).
3. Patients 2 years of age and older with active systemic juvenile idiopathic arthritis (sJIA).
4. Adult patients with giant cell arteritis (GCA).
5. Adult patients with systemic sclerosis-associated interstitial lung disease (SSc-ILD) for slowing the rate of decline in pulmonary function.
6. Adults and pediatric patients 2 years of age and older with chimeric antigen receptor (CAR) T cell-induced severe or life-threatening cytokine release syndrome (CRS).
7. Hospitalized adult patients with coronavirus disease 2019 (COVID-19) who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO).

Note: The criteria outlined in this policy are only applicable to coverage in the outpatient setting. Hospitalized members receiving Actemra, or a biosimilar, for the treatment of COVID-19 will be managed according to the member's inpatient benefit.

Compendial Uses

1. Unicentric Castleman disease
2. Multicentric Castleman disease
3. Oligoarticular juvenile idiopathic arthritis
4. Immune checkpoint inhibitor-related toxicities - inflammatory arthritis
5. Acute graft versus host disease
6. Cytokine release syndrome (other than severe or life-threatening CAR T cell-induced CRS)
7. Polymyalgia rheumatica

POLICY

Required Documentation

Submission of the following information is necessary to initiate the prior authorization review:

Rheumatoid arthritis (RA)

1. Initial requests:
    A. Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.
    B. Laboratory results, chart notes, or medical record documentation of biomarker testing (i.e., rheumatoid factor [RF], anti-cyclic citrullinated peptide [anti-CCP], and C-reactive protein [CRP] and/or erythrocyte sedimentation rate [ESR]) (if applicable).
2. Continuation requests: Chart notes or medical record documentation supporting positive clinical response.

Articular juvenile idiopathic arthritis (JIA), systemic juvenile idiopathic arthritis (sJIA), and Polymyalgia rheumatica (PMR)

1. Initial requests: Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.
2. Continuation requests: Chart notes or medical record documentation supporting positive clinical response.

Cytokine release syndrome, immunotherapy-related inflammatory arthritis, and acute graft versus host disease:

1. For initial requests: Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.

Giant cell arteritis (GCA):

1. For continuation requests: Chart notes or medical record documentation supporting positive clinical response.

Systemic sclerosis-associated interstitial lung disease (SSc-ILD):

1. For initial requests: Result of a chest high-resolution computed tomography (HRCT) study.

Must meet BOTH the Preferred Drug Plan Design and Criteria for Initial Approval/Continuation of Therapy when both are applicable.

Preferred Drug Plan Design for subcutaneous tocilizumab requests

Rheumatoid Arthritis (RA)

1. Criteria for initial approval for rheumatoid arthritis will only apply when **BOTH** of the following are met:
    A. Member meets **any** of the following:
        1) Member has had an inadequate response to treatment or intolerable adverse event with at least TWO of the preferred products (Enbrel, adalimumab-aacf, Simponi, Rinvoq, and Xeljanz/Xeljanz XR)
        2) Member has a clinical reason to avoid TNF inhibitors (Enbrel, adalimumab-aacf, and Simponi) (See Appendix A) AND has had an inadequate response to treatment or intolerable adverse event with the preferred products, Rinvoq AND Xeljanz or Xeljanz XR
        3) Member is currently receiving treatment with the requested product through insurance (excludes obtainment as samples or via manufacturer's patient assistance programs) and experiencing a positive therapeutic outcome
    B. If the request is for Actemra (tocilizumab) or Avtozma (tocilizumab-anoh), criteria for initial approval will only apply when the member has had a documented intolerable adverse event with Tyenne (tocilizumab-aazg) and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information.

Polyarticular juvenile idiopathic arthritis (pJIA)

1. Criteria for initial approval for polyarticular juvenile idiopathic arthritis will only apply when **BOTH** of the following are met:
    A. Member meets **any** of the following:
        1) Member has had an inadequate response to treatment or intolerable adverse event with at least TWO of the preferred products (adalimumab-aacf, Enbrel, and Xeljanz/Xeljanz Oral Solution)
        2) Member has a clinical reason to avoid Enbrel and adalimumab-aacf (See Appendix A) AND has had an inadequate response to treatment or intolerable adverse event with the preferred product Xeljanz or Xeljanz Oral Solution
        3) Member is currently receiving treatment with the requested product through insurance (excludes obtainment as samples or via manufacturer's patient assistance programs) and experiencing a positive therapeutic outcome
    B. If the request is for Actemra (tocilizumab) or Avtozma (tocilizumab-anoh), criteria for initial approval will only apply when the member has had a documented intolerable adverse event

with Tyenne (tocilizumab-aazg) and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information.

Giant cell arteritis (GCA)

1. Criteria for initial approval for giant cell arteritis will only apply when **BOTH** of the following are met:
    A. Member meets **any** of the following:
        1) Member has had an inadequate response to treatment or intolerable adverse effects with Rinvoq (Upadacitinib)
        2) Member has a clinical reason to avoid the use of Rinvoq (e.g., history or venous thromboembolism, recent cardiovascular event, malignancy risk, or other contraindication to JAK inhibitor therapy)
        3) The member is currently receiving treatment with the requested product through insurance (excludes obtainment as samples or via manufacturer's patient assistance programs) and experiencing a positive therapeutic outcome
    B. If the request is for Actemra (tocilizumab) or Avtozma (tocilizumab-anoh), criteria for initial approval will only apply when the member has had a documented intolerable adverse event with Tyenne (tocilizumab-aazg) and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information.

Other indications (excluding systemic sclerosis-associated interstitial lung disease)

1. Criteria for initial approval for all indications other than systemic sclerosis-associated interstitial lung disease will only apply when the member has had a documented intolerable adverse event with Tyenne (tocilizumab-aazg) and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information.

Preferred Drug Plan Design for intravenous tocilizumab requests

Must meet BOTH the Preferred Drug Plan Design for the indication and the Preferred Drug Plan Design for the tocilizumab intravenous products when both are applicable.

Rheumatoid Arthritis (RA)

1. Criteria for initial approval on rheumatoid arthritis will only apply when at least ONE of the following criteria are met:
    A. Member has a documented inadequate response or intolerable adverse event with each of the following:
        1) Avsola
        2) Inflectra
        3) Simponi Aria
    B. Member has a documented clinical reason to avoid TNF inhibitors (See Appendix A)
    C. Member is currently receiving treatment with the requested product through insurance (excludes obtainment as samples or via manufacturer's patient assistance programs) and experiencing a positive therapeutic outcome

Polyarticular juvenile idiopathic arthritis (pJIA)

1. Criteria for initial approval on polyarticular juvenile idiopathic arthritis will only apply when at least ONE of the following criteria are met:
    A. Member has a documented inadequate response or intolerable adverse event to Simponi Aria
    B. Member has a documented clinical reason to avoid TNF inhibitors (See Appendix A)
    C. Member is currently receiving treatment with the requested product through insurance (excludes obtainment as samples or via manufacturer's patient assistance programs) and experiencing a positive therapeutic outcome

Table. Intravenous Tocilizumab Products

Medication	Generic Name
Preferred Products:	
Tyenne	tocilizumab-aazg
Targeted/Non-Preferred Products:	
Actemra	tocilizumab
Avtozma	tocilizumab-anoh
Tofidence	tocilizumab-bavi

*Note: Requests for tocilizumab (intravenous) for the treatment of indications other than systemic sclerosis-associated interstitial lung disease, cytokine release syndrome, and coronavirus disease 2019 (COVID-19), Tyenne (tocilizumab-aazg) is the preferred product.

**Note: Submission of chart notes detailing the outcomes of treatment, intolerable adverse event(s) experienced, contraindication(s), or exclusion(s) to treatment with preferred product(s) is required (where applicable) that is not attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference product and biosimilar products).

Prescriber Specialties (initial approvals only)

This medication must be prescribed by or in consultation with one of the following:

1. Rheumatoid arthritis, articular juvenile idiopathic arthritis, systemic juvenile idiopathic arthritis, giant cell arteritis, and polymyalgia rheumatica: rheumatologist
2. Systemic sclerosis-associated interstitial lung disease: rheumatologist or pulmonologist
3. Immunotherapy-related inflammatory arthritis: oncologist, hematologist, or rheumatologist
4. Cytokine release syndrome, unicentric Castleman disease, multicentric Castleman disease, and acute graft versus host disease: oncologist or hematologist

Criteria for Initial Approval

Moderately to severely active rheumatoid arthritis (RA)

1. Authorization of 12 months may be granted for adult members who have previously received a biologic or targeted synthetic drug (e.g., Rinvoq, Xeljanz) indicated for moderately to severely active rheumatoid arthritis.
2. Authorization of 12 months may be granted for adult members for treatment of moderately to severely active RA when any of the following criteria is met:
    A. Member meets either of the following criteria:
        1) Member has been tested for either of the following biomarkers and the test was positive:
            a. Rheumatoid factor (RF)
            b. Anti-cyclic citrullinated peptide (anti-CCP)
        2) Member has been tested for ALL of the following biomarkers:
            a. RF
            b. Anti-CCP
            c. C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR)
    B. Member meets any of the following criteria:
        1) Member has experienced an inadequate response to at least a 3-month trial of methotrexate despite adequate dosing (i.e., titrated to at least 15 mg/week).

2) Member has an intolerance or contraindication to methotrexate (see Appendix B).
3) Member has experienced an inadequate response to an alternative DMARD (e.g., leflunomide, hydroxychloroquine, sulfasalazine)

Articular juvenile idiopathic arthritis (JIA)

1. Authorization of 12 months may be granted for members 2 years of age and older who have previously received a biologic or targeted synthetic drug (e.g., Xeljanz) indicated for active articular juvenile idiopathic arthritis.
2. Authorization of 12 months may be granted for members 2 years of age and older the treatment of active articular juvenile idiopathic arthritis when any of the following criteria are met:
    A. Member has had an inadequate response to methotrexate or another conventional synthetic drug (e.g., leflunomide, sulfasalazine, hydroxychloroquine) administered at an adequate dose and duration.
    B. Member has had an inadequate response to a trial of scheduled non-steroidal anti-inflammatory drugs (NSAIDs) and/or intra-articular glucocorticoids (e.g., triamcinolone hexacetonide) and one of the following risk factors for poor outcome:
        1) Involvement of ankle, wrist, hip, sacroiliac joint, and/or temporomandibular joint (TMJ)
        2) Presence of erosive disease or enthesitis
        3) Delay in diagnosis
        4) Elevated levels of inflammation markers
        5) Symmetric disease
    C. Member has risk factors for disease severity and potentially a more refractory disease course (See Appendix C) and the member also meets one of the following:
        1) High-risk joints are involved (e.g., cervical spine, wrist, or hip).
        2) High disease activity
        3) Are judged to be at high risk for disabling joint disease.

Systemic Juvenile Idiopathic Arthritis (sJIA)

1. Authorization of 12 months may be granted for members 2 years of age and older who have previously received a biologic indicated for active systemic juvenile idiopathic arthritis.
2. Authorization of 12 months may be granted for members 2 years of age and older for the treatment of active sJIA when both of the following criteria are met:
    A. Member has active systemic features (e.g., fever, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, or serositis).
    B. Member has an inadequate response to non-steroidal anti-inflammatory drugs (NSAIDs) or systemic glucocorticoids

Polymyalgia rheumatica (PMR)

1. Authorization of 12 months may be granted for treatment of polymyalgia rheumatica when any of the following criteria is met:
    A. Member has experienced an inadequate response to systemic corticosteroids
    B. Member has experienced a disease flare during a taper with systemic corticosteroids
    C. Member has experienced an inadequate response to methotrexate
    D. Member has experienced an intolerance or contraindication to both systemic corticosteroids and methotrexate (Appendix B)

Giant Cell Arteritis (GCA)

1. Authorization of 12 months may be granted for adult members for the treatment of giant cell arteritis when the member's diagnosis was confirmed by the following:

A. Temporal artery biopsy or cross-sectional imaging; or Acute-phase reactant elevation (i.e., high erythrocyte sedimentation rate [ESR] and/or high serum C-reactive protein [CRP])

Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD)

1. Authorization of 12 months may be granted for adult members for treatment of sclerosis-associated interstitial lung disease when the diagnosis was confirmed by a high-resolution computed tomography (HRCT) study of the chest.

Cytokine release syndrome

1. Authorization of 1 month may be granted for the treatment of chimeric antigen receptor (CAR) T cell-induced cytokine release syndrome (CRS).
2. Authorization of 1 month may be granted for treatment of cytokine release syndrome in members with refractory CRS related to blinatumomab therapy.

Unicentric Castleman Disease

1. Authorization of 12 months may be granted for treatment of unicentric Castleman's disease when all of the following are met:
    A. The member is HIV-negative.
    B. The member is human herpes virus-8-negative.
    C. The requested drug will be used as monotherapy.
    D. The requested drug is being used as second-line therapy for relapsed/refractory disease.

Multicentric Castleman Disease

1. Authorization of 12 months may be granted for treatment of multicentric Castleman's disease when both of the following are met:
    A. The requested drug will be used as monotherapy.
    B. The requested drug is being used as second-line therapy for relapsed/refractory or progressive disease.

Immune checkpoint inhibitor-related Inflammatory Arthritis

1. Authorization of 12 months may be granted for treatment of severe/refractory immunotherapy-related inflammatory arthritis and member has experienced an inadequate response, intolerance, or contraindication to corticosteroids.

Acute graft versus host disease

1. Authorization of 12 months may be granted for treatment of acute graft versus host disease when either of the following criteria is met:
    A. Member has experienced an inadequate response to systemic corticosteroids; or
    B. Member has an intolerance or contraindication to corticosteroids.

<u>Continuation of Therapy</u>

Moderately to severely active rheumatoid arthritis (RA)

1. Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for moderately to severely active RA and who achieve or maintain a positive clinical response as evidenced by disease activity improvement of at least 20% from baseline in tender joint count, swollen joint count, pain, or disability.

Articular juvenile idiopathic arthritis (JIA)

1. Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for active articular juvenile idiopathic arthritis and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:

A. Number of joints with active arthritis (e.g., swelling, pain, limitation of motion)
B. Number of joints with limitation of movement
C. Functional ability

Systemic Juvenile Idiopathic Arthritis (sJIA)

1. Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for sJIA and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:
    A. Number of joints with active arthritis (e.g., swelling, pain, limitation of motion)
    B. Number of joints with limitation of movement
    C. Functional ability
    D. Systemic features (e.g., fever, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, or serositis)

Polymyalgia rheumatica (PMR)

1. Authorization of 12 months may be granted for continue treatment in members who are using the requested medication for PMR and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:
    A. Morning stiffness
    B. Hip or shoulder pain
    C. Hip or shoulder range of motion
    D. C-reactive (CRP) and/or erythrocyte sedimentation rate (ESR)

Giant Cell Arteritis (GCA)

1. Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for GCA and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:
    A. Headaches
    B. Scalp tenderness
    C. Tenderness and/or thickening of superficial temporal arteries
    D. Constitutional symptoms (e.g., weight loss, fever, fatigue, night sweats)
    E. Jaw and/or tongue claudication
    F. Acute visual symptoms (e.g., amaurosis fugax, acute visual loss, diplopia)
    G. Symptoms of polymyalgia rheumatica (e.g., shoulder and/or hip girdle pain)
    H. Limb claudication

Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD)

1. Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for SSc-ILD when the member is currently receiving treatment with tocilizumab, excluding when tocilizumab is obtained as samples or via manufacturer's patient assistance programs.

Cytokine release syndrome, immune checkpoint inhibitor-related inflammatory arthritis, and graft versus host disease

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

All other diagnoses

1. Authorization of 12 months may be granted for continued treatment in members who are using Tocilizumab for an indication outlined in Criteria for Initial Approval when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

Other

For all indications: Member has had a documented negative tuberculosis (TB) test (which can include a tuberculosis skin test [TST] or an interferon-release assay [IGRA])* within 12 months of initiating therapy for persons who are naïve to biologic drugs or targeted synthetic drugs associated with an increased risk of TB.

* If the screening testing for TB is positive, there must be further testing to confirm there is no active disease (e.g., chest x-ray). Do not administer the requested medication to members with active TB infection. If there is latent disease, TB treatment must be started before initiation of the requested medication.

For all indications: Member cannot use the requested medication concomitantly with any other biologic drug or targeted synthetic drug for the same indication.

Tocilizumab is considered **not medically necessary** for members who do not meet the criteria set forth above.

Members currently receiving the requested medication as samples or via the manufacturer's patient assistance program will be required to meet the criteria for initial approval. This ensures that members are treated equally regardless of their provider's ability to access medication samples.

Non-Formulary Exception Criteria

Non-Formulary Exception criteria applies to formularies which do not include the requested product(s) on the formulary drug list. Meeting the criteria above may satisfy some, or all, portions of the Non-Formulary Exception Criteria. A medication that is non-formulary may be covered when the Criteria for Approval AND the following criteria are met:

1. The requested drug must be used for an FDA-approved indication, or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines). Diagnostic testing/lab results required when applicable.
2. The prescribed dose/quantity must fall within the FDA-approved labeling or dosing guidelines found in the compendia of current literature.
3. All covered formulary alternative drugs on any tier will be ineffective, have been ineffective, would not be as effective as the non-formulary drug, or would have adverse effects. Documentation is required and must include chart note(s) or other documentation indicating prior treatment failure, severity of the adverse event (if any), and dosage and duration of the prior treatment, or contraindication to formulary alternatives.

Dosage and Administration

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Quantity Limits

Trade Name	Generic Name	Quantity Limit
Actemra®	Tocilizumab IV	40 mL (800 mg) per 28 days
Actemra®	Tocilizumab SC	Up to 4 syringes/auto-injectors per 28 days

Trade Name	Generic Name	Quantity Limit
Avtozma®	Tocilizumab-anoh IV	40 mL (800 mg) per 28 days
Avtozma®	Tocilizumab-anoh SC	3.6 mL per 28 days
Tofidence®	Tocilizumab-bavi IV	40 mL (800 mg) per 28 days
Tyenne®	Tocilizumab-aazg IV	40 mL (800 mg) per 28 days
Tyenne®	Tocilizumab-aazg SC	Up to 4 syringes/auto-injectors per 28 days

Appendix

Appendix A: Clinical reasons to avoid TNF-inhibitors

1. History of demyelinating disorder
2. History of congestive heart failure
3. History of hepatitis B infection
4. Autoantibody formation/lupus-like syndrome
5. Risk of lymphoma

Note: Primary failure to respond to a TNF-inhibitor does not preclude successful response to a different TNF-inhibitor per 2019 AAD-NPF guidelines and therefore is not consider a clinical reason to avoid TNF-inhibitors.

Appendix B: Examples of Contraindications to Methotrexate

1. Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease
2. Breastfeeding
3. History of intolerance or adverse event
4. Hypersensitivity
5. Pregnancy or currently planning pregnancy
6. Renal impairment
7. Significant drug interaction
8. Risk of treatment-related toxicity
9. Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension)

Appendix C: Risk factors for articular juvenile idiopathic arthritis

1. Positive rheumatoid factor
2. Positive anti-cyclic citrullinated peptide antibodies
3. Pre-existing joint damage

PROCEDURES AND BILLING CODES

To report provider services, use appropriate CPT* codes, Alpha Numeric (HCPCS level 2) codes, Revenue codes, and/or ICD diagnostic codes.

- J3262 – Injection, tocilizumab, 1 mg (Actemra)
- Q5133 – Injection, tocilizumab-bavi (tofidence), biosimilar, 1 mg
- Q5135 – Injection, tocilizumab-aazg (tyenne), biosimilar, 1 mg (effective 10/01/2024)
- Q5156 – Injection, tocilizumab-anoh (avtozma), biosimilar, 1 mg (effective 10/01/2025)
- J3490 – Unclassified drugs
- J3590 – Unclassified biologics
- C9399 – Unclassified drugs or biologics

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POLICY HISTORY

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