

Ilaris® (Canakinumab)

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[➔ Instructions for Use](#)

Table of Contents	Page
Coverage Rationale	1
Applicable Codes	3
Background	4
Benefit Considerations	5
Clinical Evidence	5
U.S. Food and Drug Administration	7
References	7
Policy History/Revision Information	8
Instructions for Use	8

Related Commercial Policy
<ul style="list-style-type: none"> Provider Administered Drugs – Site of Care
Community Plan Policy
<ul style="list-style-type: none"> Ilaris® (Canakinumab)

Coverage Rationale

[➔ See Benefit Considerations](#)

Cryopyrin-Associated Periodic Syndromes (CAPS) including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS)

Ilaris® (canakinumab) is proven for the treatment of Cryopyrin-associated periodic syndromes (CAPS) including familial cold autoinflammatory syndrome (FCAS) and Muckle-Wells syndrome (MWS).

Ilaris is medically necessary for the treatment of Cryopyrin-associated periodic syndromes (CAPS) including familial cold autoinflammatory syndrome (FCAS) and Muckle-Wells syndrome (MWS) when all of the following criteria are met:

- For **initial therapy**, all of the following:
 - One of the following, as diagnosed by, or in consultation with, a rheumatologist or immunologist with expertise in the diagnosis of the following:
 - FCAS
 - MWS
 - and**
 - Ilaris dosing for FCAS/MWS is in accordance with the United States Food and Drug Administration approved labeling;
 - and**
 - Initial authorization will be for no more than 12 months
- For **continuation of therapy**, all of the following:
 - Patient is currently on Ilaris therapy for one of the following:
 - FCAS
 - MWS
 - and**
 - Ilaris dosing for FCAS/MWS is in accordance with the United States Food and Drug Administration approved labeling;
 - and**
 - Documentation of positive clinical response to Ilaris therapy; **and**
 - Reauthorization will be for no more than 12 months

Tumor Necrosis Factor (TNF) Receptor-Associated Periodic Syndrome (TRAPS)

Ilaris is proven for the treatment of tumor necrosis factor (TNF) receptor-associated periodic syndrome (TRAPS).

Ilaris is medically necessary for the treatment of tumor necrosis factor (TNF) receptor-associated periodic syndrome (TRAPS) when all of the following criteria are met:

- For **initial therapy**, all of the following:
 - Diagnosis of TRAPS by, or in consultation with, a rheumatologist or immunologist with expertise in the diagnosis of TRAPS; **and**
 - Ilaris dosing for TRAPS is in accordance with the United States Food and Drug Administration approved labeling; **and**
 - Initial authorization will be for no more than 12 months
- For **continuation of therapy**, all of the following:
 - Patient is currently receiving Ilaris therapy for TRAPS; **and**
 - Documentation of a positive clinical response to therapy; **and**
 - Ilaris dosing for TRAPS is in accordance with the United States Food and Drug Administration approved labeling; **and**
 - Reauthorization will be for no more than 12 months

Hyperimmunoglobulin D (Hyper-IgD) Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD)

Ilaris is proven for the treatment of hyperimmunoglobulin D (Hyper-IgD) syndrome (HIDS)/mevalonate kinase deficiency (MKD).

Ilaris is medically necessary for the treatment of hyperimmunoglobulin D (Hyper-IgD) syndrome (HIDS)/mevalonate kinase deficiency (MKD) when all of the following criteria are met:

- For **initial therapy**, all of the following:
 - One of the following, as diagnosed by, or in consultation with, a rheumatologist or immunologist with expertise in the diagnosis of the following:
 - HIDS
 - MKD
 - and**
 - Ilaris dosing for HIDS/MKD is in accordance with the United States Food and Drug Administration approved labeling; **and**
 - Initial authorization will be for no more than 12 months
- For **continuation of therapy**, all of the following:
 - Patient is currently receiving Ilaris for one of the following:
 - HIDS
 - MKD
 - and**
 - Documentation of a positive clinical response to therapy; **and**
 - Ilaris dosing for HIDS/MKD is in accordance with the United States Food and Drug Administration approved labeling; **and**
 - Reauthorization will be for no more than 12 months

Familial Mediterranean Fever (FMF)

Ilaris is proven for the treatment of Familial Mediterranean fever (FMF).

Ilaris is medically necessary for the treatment of Familial Mediterranean fever (FMF) when all of the following criteria are met:

- For **initial therapy**, all of the following:
 - Diagnosis of FMF by, or in consultation with, a rheumatologist or immunologist with expertise in the diagnosis of FMF; **and**
 - History of failure, contraindication, or intolerance to colchicine; **and**
 - Ilaris dosing for FMF is in accordance with the United States Food and Drug Administration approved labeling; **and**
 - Initial authorization will be for no more than 12 months
- For **continuation of therapy**, all of the following:

- Patient is currently receiving Ilaris for FMF; **and**
- Documentation of a positive clinical response to therapy; **and**
- Ilaris dosing for FMF is in accordance with the United States Food and Drug Administration approved labeling; **and**
- Reauthorization will be for no more than 12 months

Active Still's Disease including Adult-Onset Still's Disease (AOSD) and Systemic Juvenile Idiopathic Arthritis (SJIA)

Ilaris is proven for the treatment of active Still's disease including adult-onset Still's disease (AOSD) and systemic juvenile idiopathic arthritis (SJIA).

Ilaris is medically necessary for the treatment of active Still's disease including adult-onset Still's disease (AOSD) and systemic juvenile idiopathic arthritis (SJIA) when all of the following criteria are met:

- For **initial therapy**, all of the following:
 - One of the following, as diagnosed by, or in consultation with, a rheumatologist or immunologist with expertise in the diagnosis of the following:
 - AOSD
 - SJIA**and**
 - Ilaris dosing for AOSD/SJIA is in accordance with the United States Food and Drug Administration approved labeling; **and**
 - Patient is not receiving Ilaris in combination with another biologic [e.g., Actemra]; **and**
 - Initial authorization will be for no more than 12 months
- For **continuation of therapy**, all of the following:
 - Patient is currently receiving Ilaris for AOSD/SJIA; **and**
 - Documentation of a positive clinical response to therapy; **and**
 - Ilaris dosing for AOSD/SJIA is in accordance with the United States Food and Drug Administration approved labeling; **and**
 - Patient is not receiving Ilaris in combination with another biologic [e.g., Actemra]; **and**
 - Reauthorization will be for no more than 12 months

Ilaris is not proven or medically necessary for the management or treatment of cardiovascular disease.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS Code	Description
J0638	Injection, canakinumab, 1 mg

Diagnosis Code	Description
M04.1	Periodic fever syndromes
M04.2	Cryopyrin-associated periodic syndromes
M06.1	Adult-onset Still's disease
M08.20	Juvenile rheumatoid arthritis with systemic onset, unspecified site
M08.211	Juvenile rheumatoid arthritis with systemic onset, right shoulder
M08.212	Juvenile rheumatoid arthritis with systemic onset, left shoulder
M08.219	Juvenile rheumatoid arthritis with systemic onset, unspecified shoulder

Diagnosis Code	Description
M08.221	Juvenile rheumatoid arthritis with systemic onset, right elbow
M08.222	Juvenile rheumatoid arthritis with systemic onset, left elbow
M08.229	Juvenile rheumatoid arthritis with systemic onset, unspecified elbow
M08.231	Juvenile rheumatoid arthritis with systemic onset, right wrist
M08.232	Juvenile rheumatoid arthritis with systemic onset, left wrist
M08.239	Juvenile rheumatoid arthritis with systemic onset, unspecified wrist
M08.241	Juvenile rheumatoid arthritis with systemic onset, right hand
M08.242	Juvenile rheumatoid arthritis with systemic onset, left hand
M08.249	Juvenile rheumatoid arthritis with systemic onset, unspecified hand
M08.251	Juvenile rheumatoid arthritis with systemic onset, right hip
M08.252	Juvenile rheumatoid arthritis with systemic onset, left hip
M08.259	Juvenile rheumatoid arthritis with systemic onset, unspecified hip
M08.261	Juvenile rheumatoid arthritis with systemic onset, right knee
M08.262	Juvenile rheumatoid arthritis with systemic onset, left knee
M08.269	Juvenile rheumatoid arthritis with systemic onset, unspecified knee
M08.271	Juvenile rheumatoid arthritis with systemic onset, right ankle and foot
M08.272	Juvenile rheumatoid arthritis with systemic onset, left ankle and foot
M08.279	Juvenile rheumatoid arthritis with systemic onset, unspecified ankle and foot
M08.28	Juvenile rheumatoid arthritis with systemic onset, vertebrae
M08.29	Juvenile rheumatoid arthritis with systemic onset, multiple sites
M08.2A	Juvenile rheumatoid arthritis with systemic onset, other specified site

Background

CAPS refer to rare genetic syndromes generally caused by mutations in the NLRP-3 [nucleotide-binding domain, leucine rich family (NLR), pyrin domain containing 3] gene. CAPS disorders are inherited in an autosomal dominant pattern with male and female offspring equally affected. Features common to all disorders include fever, urticaria-like rash, arthralgia, myalgia, fatigue, and conjunctivitis.¹

The NLRP-3 gene encodes the protein cryopyrin, an important component of the inflammasome. Cryopyrin regulates the protease caspase-1 and controls the activation of IL-1 β . Mutations in NLRP-3 result in an overactive inflammasome resulting in excessive release of activated IL-1 β that drives inflammation. SJIA is a severe autoinflammatory disease, driven by innate immunity by means of proinflammatory cytokines such as IL-1 β .¹

Canakinumab is a recombinant, human anti-human-IL-1 β monoclonal antibody that belongs to the IgG1/ κ isotype subclass. It is expressed in a murine Sp2/0-Ag14 cell line and comprised of two 447- (or 448-) residue heavy chains and two 214-residue light chains, with a molecular mass of 145157 Daltons when deglycosylated. Both heavy chains of canakinumab contain oligosaccharide chains linked to the protein backbone at asparagine 298. The biological activity of canakinumab is measured by comparing its inhibition of IL-1 β -dependent expression of the reporter gene luciferase to that of a canakinumab internal reference standard, using a stably transfected cell line.¹

Canakinumab binds to human IL-1 β and neutralizes its activity by blocking its interaction with IL-1 receptors, but it does not bind IL-1 α or IL-1 receptor antagonist (IL-1ra).¹

Benefit Considerations

Some Certificates of Coverage allow for coverage of experimental/investigational/unproven treatments for life-threatening illnesses when certain conditions are met. The member specific benefit plan document must be consulted to make coverage decisions for this service. Some states mandate benefit coverage for off-label use of medications for some diagnoses or under some circumstances when certain conditions are met. Where such mandates apply, they supersede language in the benefit document or in the medical or drug policy. Benefit coverage for an otherwise unproven service for the treatment of serious rare diseases may occur when certain conditions are met. Refer to the Policy and Procedure addressing the treatment of serious rare diseases.

Clinical Evidence

Cryopyrin-Associated Periodic Syndromes

Kuemmerle-Deschner et al (2011) assessed the long-term safety and tolerability of canakinumab in a multinational, open-label, single treatment arm study in patients with cryopyrin-associated periodic syndrome.² In this study, adult and pediatric patients received canakinumab every 8 weeks for up to two years. The 166 patients included canakinumab-naïve, as well as treatment experienced patients from previous studies. C-reactive protein (CRP), serum amyloid A (SAA) levels, disease activity, and/or skin rash were used to assess response to therapy. In the study, 85 of 109 canakinumab-naïve patients (78%; 79/85 patients within 8 days, and five patients between days 10 and 21) achieved complete response. In the 141 patients who were assessed for relapse, 90% did not relapse, and experienced normalization of CRP/SAA levels (< 10 mg/l) by day 8, which were sustained. Treatment duration ranged from 29-687 days, with a median of 414 days. Of the population, 24.1% of patients received dose increase or frequency adjustments. The most common adverse events were infections (65.7%). In addition, 18 (10.8%) patients experienced serious adverse events, which were mostly infections that responded to standard care. Regarding injection site reactions, 92% reported no injection-site reaction, while 8% reported mild-to-moderate reactions. Normal immune response was seen in patients receiving a vaccine (15%). The investigators concluded that canakinumab 150 mg every 8 weeks was well tolerated and provided substantial disease control in children and adults across all CAPS phenotypes. Higher canakinumab doses in younger patients and more severe CAPS disease were efficacious in achieving complete responses without evidence of increased adverse events.²

Lachmann et al (2009) evaluated the use of use of canakinumab in the cryopyrin-associated periodic syndrome in a three-part, 48-week, double-blind, placebo-controlled, randomized withdrawal study of canakinumab in patients with CAPS.³ In the first part 1 of the study, 35 patients received 150 mg of canakinumab subcutaneously. Patients experiencing a complete response to therapy were enrolled in part 2, where they received either 150 mg of canakinumab or placebo every 8 weeks for up to 24 weeks, based on random group assignment. Patients were moved to part 3 upon completion of part 2 or at the time of relapse, whichever occurred first. In part 3, patients received at least two more doses of canakinumab. Therapeutic responses using disease-activity scores and analysis of levels of C-reactive protein (CRP) and serum amyloid A protein (SAA) were used for evaluation. In part 1 of the study, complete response was achieved by 34 out of 35 patients (97%). From part 1, 31 patients moved to part 2, and all 15 patients receiving canakinumab remained in remission. For patients in the placebo group, 13 of the 16 patients (81%) ($P < 0.001$) experienced disease flares. At the end of part 2, Median CRP and SAA values were normal (< 10 mg per liter for both measures) in patients receiving canakinumab at the end of part 2. For the placebo group median CRP and SAA values were elevated ($P < 0.001$ and $P = 0.002$, respectively). Of the 31 patients, 28 (90%) remained in remission at the close of part 3. Specific to adverse events, there was a higher incidence of suspected infections in the treatment group compared to the placebo group ($P = 0.03$), as well as two serious adverse events in the treatment group, one case of urosepsis and an episode of vertigo.³

Familial Mediterranean Fever, Hyperimmunoglobulin D (Hyper-IgD) Syndrome/Mevalonate Kinase Deficiency and Tumor Necrosis Factor Receptor Associated Periodic Syndrome

The efficacy and safety of Ilaris for the treatment of TRAPS, HIDS/MKD, and FMF were demonstrated in a randomized, double-blind, placebo-controlled study of canakinumab in patients with FMF, HIDS/MKD or TRAPS.⁷ The study followed 3 randomized groups (FMF, HIDS/MKD, TRAPS) over 4 Epochs as follow: a 12 week lead in period, randomization at flare onset, to a blinded or open-label treatment group, a randomized withdrawal of 24 weeks, followed by an open-label treatment of 72 weeks. The proportion of patients who were responders for the primary outcome at week 16 was significantly higher with canakinumab than that with placebo for all 3 disease cohorts. The median duration of exposure to canakinumab (150 mg every 4 weeks) and

placebo was 113 days (range: 110-129 days) and 113 days (range: 12-119 days), respectively, for all disease cohorts. Regarding adverse events, infections and infestations were the most frequently affected system organ class across the 3 cohorts, with the most common infection being upper respiratory tract infection. The investigators concluded that the results demonstrate canakinumab had a higher rate, compared with placebo in the proportion of patients who resolved their index disease flare at Day 15 and had no new flare over the 16 weeks of treatment.

Ahmet et al conducted an open-label pilot study to investigate the efficacy of canakinumab in FMF patients.⁶ Patients taking colchicine experiencing one or more attacks per month in the most recent 3 months were eligible to enter a 30-day run-in period. Patients experiencing an attack during the first run-in period moved to a second 30-day period, where they received canakinumab upon their first attack, 150mg subcutaneously every 4 weeks. The dose was increased to 300 mg, if a patient experienced an attack between the first and second doses. Patients were permitted to remain on their current dose of colchicine throughout the study. After 12 weeks of treatment, patients were followed for an additional 2 months or until the next attack happened. All the included patients, in the treatment period achieved the primary endpoint of $\geq 50\%$ reduction in frequency of attacks compared with the time-adjusted pre-treatment frequency of attacks. The time-adjusted frequency of attacks over 84 days observed both in the screening and run-in periods, including the baseline attack (median 3.29, range 2.47 to 4.2), saw a steep decrease during the treatment period (median 0, mean 0.11). 5 of the patients receiving 2 mg/day colchicine, experienced an attack within the 2-month follow up, which occurred at a range of 31 to 78 days (median 71 days) after the last canakinumab injection.

Systemic Juvenile Idiopathic Arthritis and Adult Onset Still's Disease

Ruperto et al conducted an open-label active treatment extension study, which enrolled SJIA patients, previously treated with canakinumab in phase III trials as well as those who did not.⁸ Patients received canakinumab (4 mg/kg) subcutaneously every 4 weeks. In the trial, the proportion of patients with inactive disease increased over time, from 32.7% at baseline to 49.0% at the last assessment. The most frequently affected system organ class was infections, with nasopharyngitis being the most common event at 32%. The investigators concluded that in patients previously treated with canakinumab in pivotal trials, response to treatment was sustained or improved during long-term treatment in the extension study.

Ruperto et al conducted 2 phase 3, randomized, double-blind, placebo controlled trials to evaluate the efficacy and safety of canakinumab for the treatment of SJIA.⁴ In trial 1, patients aged 2-19 years, with systemic JIA with active systemic features (fever; ≥ 2 active joints; C-reactive protein, > 30 mg per liter; and glucocorticoid dose, ≤ 1.0 mg per kilogram of body weight per day), were randomly assigned in a double-blind fashion, to a single subcutaneous dose of canakinumab (4 mg per kilogram) or placebo. The study used the adapted JIA ACR 30 response and the primary outcome, which was defined as improvement of 30% or more in at least three of the six core criteria for JIA, worsening of more than 30% in no more than one of the criteria, and resolution of fever. In trial 2, after 32 weeks of open-label treatment with canakinumab, patients who had a response and underwent glucocorticoid tapering were randomly assigned to continued treatment with canakinumab or to placebo. The primary outcome was time to flare of SJIA. For trial 1, 36 of 43 (84%) patients had an adapted JIA ACR 30 response at day 15 compared to the placebo group, for which 4 of 41 (10%) $P < 0.001$ patients had an adapted JIA ACR 30 response at day 15. In trial 2, among the 100 patients (of 177 in the open-label phase) who underwent randomization in the withdrawal phase, the risk of flare was lower among patients who continued to receive canakinumab than among those who were switched to placebo (74% of patients in the canakinumab group had no flare, vs. 25% in the placebo group, according to Kaplan–Meier estimates; hazard ratio, 0.36; $P = 0.003$). Regarding glucocorticoids, use was discontinued in 33% of patients (42 of 128) and the average dose decreased to 0.05 mg per kilogram per day from 0.34 mg per kilogram per day. Seven patients experienced macrophage activation syndrome. The patients receiving canakinumab had a higher frequency of infection than with placebo. The investigators concluded that these two phase 3 studies show efficacy of canakinumab in systemic JIA with active systemic features.

Kedor et al conducted a double-blind, randomized placebo-controlled trial to evaluate the efficacy and safety of canakinumab in patients with AOSD and active joint involvement. Patients aged 22-70 years, with high active AOSD were enrolled, with 12 patients in the canakinumab group and 7 patients in the placebo group. The primary outcome was defined as the proportion of patients with a clinically relevant reduction of the articular manifestation measured by change in disease activity score. The study was terminated prematurely, due to the rarity and severity of disease and conditional approval of AOSD by the European Medicines Agency, therefore, only 36 out of the planned 68 patients could be included in the efficacy analysis. The primary endpoint did not achieve statistical significance, however, treatment of patient with AOSD and active joint involvement led to an improvement of ACR30, ACR 50% response and ACR 70% response, as well as disease activity score. The safety profile was

similar to that reporting in SJIA. The authors concluded that efficacy data were generally consistent with the results of the pooled efficacy analysis of SJIA patients.⁹

In the 2021 American College of Rheumatology Guideline for the Treatment of Juvenile Idiopathic Arthritis: Therapeutic Approaches for Oligoarthritis, Temporomandibular Joint Arthritis, and Systemic Juvenile Idiopathic Arthritis, biologic DMARDs (IL-1 and IL-6 inhibitors) are conditionally recommended as initial monotherapy for systemic JIA without macrophage activation syndrome (MAS) and there is no preferred agent.¹⁰ NSAIDs are also conditionally recommended as initial monotherapy for systemic JIA without MAS, though only for a small proportion of patients with mild to moderate symptoms. IL-1 and IL-6 inhibitors are strongly recommended over a single or combination of conventional synthetic DMARDs for inadequate response to or intolerance of NSAIDs and/or glucocorticoids. For systemic JIA with MAS, IL-1 and IL-6 inhibitors are conditionally recommended over calcineurin inhibitors alone to achieve inactive disease and resolution of MAS and there is no preferred agent.

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Ilaris is indicated for the treatment of cryopyrin-associated periodic syndromes (CAPS), in adults and children 4 years of age and older including, familial cold autoinflammatory syndrome (FCAS) and Muckle-Wells syndrome (MWS). Ilaris is also indicated for the treatment of tumor necrosis factor (TNF) receptor-associated periodic syndrome (TRAPS) in adult and pediatric patients, hyperimmunoglobulin D (Hyper-IgD) syndrome (HIDS)/mevalonate kinase deficiency (MKD) in adult and pediatric patients, familial Mediterranean fever (FMF) in adult and pediatric patients, and active Still's disease, including adult-onset Still's disease (AOSD) and systemic juvenile idiopathic arthritis (SJIA) in patients aged 2 years and older.¹

References

1. Ilaris [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation, September 2020.
2. Kuemmerle-Deschner JB, Hachulla E, Cartwright R. Two-year results from an open-label, multicenter, phase III study evaluating the safety and efficacy of canakinumab in patients with cryopyrin-associated periodic syndrome across different severity phenotypes. *Ann Rheum Dis* 2011; 70:2095–2102.
3. Lachmann JH, Kone-Paut I, Kuemmerle-Deschner JB. Use of canakinumab in the Cryopyrin-Associated Periodic Syndrome. *N Engl J Med*. 2009; 360(23):2416-25.
4. Ruperto N, Brunner H I, Quartier P, Two Randomized Trials of Canakinumab in Systemic Juvenile Idiopathic Arthritis. *N Engl J Med* 2012; 367:2396-406.
5. Novartis Pharmaceuticals. A Study of Canakinumab in Patients With Systemic Juvenile Idiopathic Arthritis or Hereditary Periodic Fevers Who Participated in the CACZ885G2301E1, CACZ885G2306 or CACZ885N2301 Studies. In *ClinicalTrials.gov* [Internet]. Bethesda (MD): National Library of medicine (US). 2014- [cited 2017 July 6]. Available from: <https://www.clinicaltrials.gov/ct2/show/NCT02334748>. NLM Identifier: NCT 02334748.
6. Ahmet Gül, Huri Ozdogan, Burak Erer, Efficacy and safety of canakinumab in adolescents and adults with colchicine resistant familial Mediterranean fever. *Arthritis Research & Therapy* (2015) 17:243.
7. De Benedetti F, Gattorno M, Anton J, et al. Canakinumab for the Treatment of Autoinflammatory Recurrent Fever Syndromes. *N Engl J Med*. 2018 May 17;378(20):1908-1919.
8. Ruperto N, Brunner HI, Quartier P, et al. Canakinumab in patients with systemic juvenile idiopathic arthritis and active systemic features: results from the 5-year long-term extension of the phase III pivotal trials. *Ann Rheum Dis*. 2018;77(12):1710-1719. doi:10.1136/annrheumdis-2018-213150 Kedor, C, Listing, J, Zernicke, J, et al. Canakinumab for treatment of Adult-Onset Still's Disease to achieve reduction of arthritic manifestation (CONSIDER): phase II, randomized, double-blind, placebo-controlled, multicenter, investigator-initiated trial. *Ann Rheum Dis*. 2020;79:1090–1097.
9. Onel KB, Horton DB, Lovell DJ, et al. 2021 American College of Rheumatology Guideline for the Treatment of Juvenile Idiopathic Arthritis: Therapeutic Approaches for Oligoarthritis, Temporomandibular Joint Arthritis, and Systemic Juvenile Idiopathic Arthritis. *Arthritis Care Res (Hoboken)*. 2022;74(4):521-537. doi:10.1002/acr.24853.

Policy History/Revision Information

Date	Summary of Changes
11/01/2023	<p data-bbox="337 220 594 247">Coverage Rationale</p> <p data-bbox="337 256 1446 359"><i>Tumor Necrosis Factor (TNF) Receptor-Associated Periodic Syndrome (TRAPS); Hyperimmunoglobulin D (Hyper-IgD) Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD); and Familial Mediterranean Fever (FMF)</i></p> <ul data-bbox="337 367 1463 464" style="list-style-type: none"><li data-bbox="337 367 1463 464">• Revised coverage criteria for continuation of coverage; replaced criterion requiring “documentation of a positive clinical response to therapy, <i>defined as a decrease in frequency or severity of attacks</i>” with “documentation of a positive clinical response to therapy” <p data-bbox="337 472 643 499">Supporting Information</p> <ul data-bbox="337 508 1138 569" style="list-style-type: none"><li data-bbox="337 508 1138 535">• Updated <i>References</i> section to reflect the most current information<li data-bbox="337 543 906 569">• Archived previous policy version 2022D0066H

Instructions for Use

This Medical Benefit Drug Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Benefit Drug Policy is provided for informational purposes. It does not constitute medical advice.

This Medical Benefit Drug Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence ([Medicare IOM Pub. No. 100-16, Ch. 4, §90.5](#)).

UnitedHealthcare may also use tools developed by third parties, such as the InterQual[®] criteria, to assist us in administering health benefits. UnitedHealthcare Medical Benefit Drug Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.