Mass General Brigham
Health Plan

Enspryng (satralizumab-mwge)
Effective 05/01/2021

Plan	☐ MassHealth UPPL ☒Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit		
Specialty Limitations	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	**Medical and Specialty Medications**		
	All Plans	Phone: 877-519-1908	Fax: 855-540-3693
	Non-Specialty Medications		
	All Plans	Phone: 800-711-4555	Fax: 844-403-1029
Exceptions	N/A		

Overview
Neuromyelitis optica spectrum disorder (NMOSD) is a chronic disorder of the brain and spinal cord dominated by inflammation of the optic nerve (optic neuritis) and inflammation of the spinal cord (myelitis)

Enspryng is an interleukin-6 (IL-6) receptor antagonist indicated for the treatment of neuromyelitis optica spectrum disorder (NMOSD) in adult patients who are anti-aquaporin-4 (AQP4) antibody positive.

Coverage Guidelines
Authorization may be reviewed for members new to the plan who are currently receiving treatment with Enspryng, excluding when the product is obtained as samples or via manufacturer's patient assistance programs
OR
Authorization may be granted for members when ALL the following criteria are met, and documentation is provided:

1. The member has a diagnosis of neuromyelitis optica spectrum disorder
2. The member has a diagnosis is anti-aquaporin-4 (AQPR) antibody positive
3. The member exhibits at least one of the following core characteristics of NMOSD
    a. Optic Neuritis
    b. Acute myelitis
    c. Area postrema syndrome (episode of otherwise unexplained hiccups or nausea and vomiting)
    d. Acute brainstem syndrome
    e. Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions
4. The member will not receive the requested drug concomitantly with other biologics for the treatment of NMOSD
5. The member is ≥18 years of age

Continuation of Therapy

Reauthorizations may be granted when patient demonstrates a positive response to therapy and the member will not receive Enspryng in combination with other biologics for the treatment of NMOSD.

Limitations

1. Initial approvals and reauthorizations will be for 12 months.
2. The following quantity limits apply:

Enspryng 120mg/mL (1mL)	1mL per 28 days

References

1. Enspryng (satralizumab-mwge) [prescribing information]. South San Francisco, CA: Genentech, Inc.; August 2020.
2. Weinshenker B. In NORD Guide to Rare Disorders. Philadelphia, PA: Lippincott, Williams & Wilkins; 2003:567.

Review History

3/17/2021 – Created and Reviewed at March P&T. Effective 05/01/2021.