Mass General Brigham
Health Plan

Enspryng (satralizumab-mwge)
Effective 10/01/2025

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
Enspryng (satralizumab-mwge) 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 within the past 90 days who are currently receiving treatment with the requested medication, excluding when the product is obtained as samples or via manufacturer's patient assistance programs
OR
Authorization may be granted for members when all of the following criteria are met:

1. Member has a diagnosis of neuromyelitis optica spectrum disorder
2. Member is anti-aquaporin-4 (AQPR) antibody positive confirmed by use of immunoassay
3. 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
    f. Symptomatic cerebral syndrome with NMOSD-typical brain lesions
4. The member will not receive the requested drug concomitantly with other biologics for the treatment of NMOSD
5. Member is 18 years of age or older

<u>Continuation of Therapy</u>
Requests for reauthorization will be approved when the following criteria are met:

1. Documentation of a positive clinical response to therapy (e.g., reduction in number of relapses)

2. Member will not administer the requested medication 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:

Drug Name and Dosage Form	Quantity Limitation
Enspryng 120mg/mL (1mL) prefilled syringe	1 mL per 28 days

References

1. Enspryng (satralizumab-mwge) [prescribing information]. South San Francisco, CA: Genentech, Inc.; March 2022.
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.
07/09/2025 – Reviewed and Updated at July P&T. Updated language for members who are new to the Plan. Updated initial criteria to require that AQPR antibody is confirmed by immunoassay. Added symptomatic cerebral syndrome with NMOSD-typical brain lesions as a core NMOSD characteristic. Updated reauthorization criteria to require documentation of clinical response to therapy. Effective 10/01/2025.