Mass General Brigham
Health Plan

Kevzara (sarilumab)
Effective 01/01/2024

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
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 Indication
Kevzara is indicated for treatment of adult patients with moderately to severely active rheumatoid arthritis who have had an inadequate response or intolerance to one or more disease-modifying antirheumatic drugs (DMARDs). Kevzara is also indicated for the treatment of adult patients with polymyalgia rheumatica who have an inadequate response to corticosteroids or who cannot tolerate corticosteroid taper.

All other indications are considered experimental/investigational and are not a covered benefit.

Coverage Guidelines

Moderately to severely active rheumatoid arthritis (RA)
Authorization may be granted for members who are currently receiving treatment with Kevzara, excluding when the product is obtained as samples or via manufacturer's patient assistance programs.

OR

Authorization may be granted when the following criteria is met:

1. Diagnosis of moderately to severely active RA
2. Member has trial and failure, contraindication or intolerance to TWO of the following:
    a. Cimzia
    b. Enbrel
    c. Humira, Adalimumab-adaz, Adalimumab-fkjp, or Hadlima
    d. Rinvoq
    e. Simponi
    f. Xeljanz or Xeljanz XR

3. Member has trial and failure, contraindication or intolerance to BOTH of the following:
    a. Actemra
    b. Orencia
4. Member has had minimum duration of a 3-month trial and failure, contraindication, or intolerance to ONE of the following conventional therapies at maximally tolerated doses.
    a. Methotrexate
    b. Leflunamide
    c. sulfasalazine

Polymyalgia Rheumatica (PMR)
Authorization may be granted for members who are currently receiving treatment with Kevzara, excluding when the product is obtained as samples or via manufacturer's patient assistance programs.

OR

Authorization may be granted when the following criteria is met:
1. Diagnosis of polymyalgia rheumatica (PMR)
2. Member meets ONE of the following:
    a. Member has had inadequate response to corticosteroids (e.g., prednisone)
    b. Member cannot tolerate tapering of corticosteroids (e.g., prednisone)

Continuation of Therapy
Reauthorization may be granted for members who achieve or maintain positive clinical response after at least 3 months of therapy with Kevzara as evidenced by low disease activity or improvement in signs and symptoms.

Limitations
1. Approvals will be granted for 24 months
2. The following quantity limits apply:

Kevzara pen 150 mg/1.14 mL	1 pack (2 x 150 mg pen) per 4 weeks
Kevzara pen 200 mg/1.14 mL	1 pack (2 x 200 mg pen) per 4 weeks

References

1. Kevzara prescribing information. sanofi-aventis U.S. LLC. Bridgewater, NJ. February 2023.
2. Singh JA, Saag KG, Bridges SL Jr, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. Arthritis Care Res. 2015;68(1):1-25.
3. Fraenkel L, Bathon JM, England BR, et al. 2021 American College of Rheumatology guideline for the treatment of rheumatoid arthritis. 2021;73(7):924-939.
4. Dejaco C, Singh YP, Perel P, et al. 2015 recommendations for the management of polymyalgia rheumatica: a European League Against Rheumatism/American College of Rheumatology collaborative initiative. 2015;74(10):1799-807

Review History
02/26/18 – Reviewed
06/01/18 – Implemented
02/20/19 – Updated
11/20/19 – Added Rinvoq as a preferred trial for RA.
11/15/2023 – Reviewed and Updated for Nov P&T; Removed TB requirement. Updated preferred drugs to prior use of TWO of the following: Cimzia, Enbrel, Humira or biosimilars, Rinvoq, Simponi, Xeljanz or Xeljanz XR AND

Actemra AND Orencia. Added additional conventional therapies. Added indication of polymyalgia rheumatica. Removed appendix. Effective 1/1/2024