Mass General Brigham
Health Plan

Kevzara (sarilumab)
Effective 01/01/2027

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 Benefit** **Pharmacy Benefit**	Phone: 833-895-2611 Phone: 800-711-4555	Fax: 888-656-6671 Fax: 844-403-1029
Exceptions	N/A		

Overview
Kevzara (sarilumab) is an interleukin (IL-6) receptor antagonist indicated for the treatment of:

- Adult patients with moderately to severely active rheumatoid arthritis
- Adult patients with polymyalgia rheumatica (PMR)
- Patients who weigh 63 kilograms or more with active polyarticular juvenile idiopathic arthritis (pJIA)

Coverage Guidelines
If member is new to the plan (as evidenced by coverage effective date of less than or equal to 90 days), submission of medical records documenting that the member is currently receiving treatment with the requested drug, excluding when the product is obtained as samples or via manufacturer's patient assistance programs
OR
Authorization may be granted when all the following diagnosis-specific criteria have been met:

Moderately to severely active rheumatoid arthritis (RA)

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. Adalimumab-aaty, adalimumab-adaz, or Hadlima
    d. Rinvoq
    e. Simponi
3. Member has trial and failure, contraindication or intolerance to BOTH of the following:
    a. Tyenne or Avtozma
    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. Leflunomide
    c. Sulfasalazine

Active Polyarticular Juvenile Idiopathic Arthritis (pJIA)

1. Diagnosis of active polyarticular juvenile idiopathic arthritis (pJIA)
2. Minimum duration of a 6-week trial and failure, intolerance, or contraindication to ONE of the following conventional therapies at maximally tolerated doses
    a. Leflunomide
    b. Methotrexate
3. Member has trial and failure, contraindication or intolerance to TWO of the following:
    a. Cimzia
    b. Enbrel
    c. Adalimumab-aaty, adalimumab-adaz, or Hadlima
    d. Rinvoq/Rinvoq LQ
4. Member has a trial and failure, contraindication, or intolerance to BOTH of the following:
    a. Tyenne or Avtozma
    b. Orencia

Polymyalgia Rheumatica (PMR)

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

Requests for reauthorizations for all diagnoses will be granted when all of the following criteria are met:

1. Submission of medical records (e.g., chart notes) demonstrating an improvement in the member's condition, as evidenced by low disease activity or improvement in signs and symptoms of the condition

Limitations

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

Drug Name and Dosage Form	Quantity Limit
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. 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
2. 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.
3. Kevzara (sarilumab) [prescribing information]. sanofi-aventis U.S. LLC: Bridgewater, NJ; May 2025.
4. 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.

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
10/09/2024 – Reviewed and updated for October P&T. Updated RA criteria to include Amjevita (Nuvaila) as a preferred adalimumab product. Added criteria for pJIA. Updated reauthorization criteria to require documentation of clinical response to therapy. Effective 1/1/2025.
04/09/2025 – Reviewed and updated for April P&T. Updated RA and pJIA criteria to include Tyenne as a preferred tocilizumab product. Effective 06/01/2025.
10/08/2025 – Reviewed and updated for October P&T. Updated policy to remove Actemra as a preferred tocilizumab formulation and updated preferred adalimumab preferred product options to Humira, Hadlima, Simlandi and Yuflyma. Effective 01/01/2026.
03/11/2026 – Reviewed and updated for March P&T. Administrative update - changing verbiage in reauthorization criteria from “documentation is submitted” to “submission of medical records (e.g., chart notes…” and updating language for members who are new to the Plan. Effective 05/01/2026.
09/09/2026 – Reviewed and updated at September P&T. Updating preferred adalimumab and tocilizumab products throughout policy. Effective 01/01/2027.
10/14/2026 – Reviewed and updated at October P&T. Removing Xeljanz/tofacitinib as a previous trial option. Effective 01/01/2027.