

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

Plan	<input checked="" type="checkbox"/> MassHealth <input type="checkbox"/> Commercial/Exchange	Program Type	<input checked="" type="checkbox"/> Prior Authorization <input checked="" type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
Benefit	<input checked="" type="checkbox"/> Pharmacy Benefit <input type="checkbox"/> Medical Benefit (NLX)		
Specialty Limitations	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	Specialty Medications		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	Non-Specialty Medications		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	Medical Specialty Medications (NLX)		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
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 AllWays Health Partners 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 (AQP4) 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
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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

Disclaimer

AllWays Health Partners complies with applicable federal civil rights laws and does not discriminate or exclude people on the basis of race, color, national origin, age, disability, or sex.