



**Kevzara® (sarilumab)
Effective January 1, 2021**

Plan	<input type="checkbox"/> MassHealth <input checked="" type="checkbox"/> MassHealth (PUF) <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

Kevzara® (sarilumab) is an interleukin-6 (IL-6) receptor blocker indicated for:

- Treatment of adult patients with moderately to severely active rheumatoid arthritis

Coverage Guidelines

Authorization may be reviewed on a case by case basis for members new to AllWays Health Partners 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 if the member meets ALL following criteria and documentation has been submitted:

Moderate to Severe Rheumatoid Arthritis (RA)

Prescriber provides documentation of ALL the following:

- Appropriate diagnosis
- **ONE** of the following:
 - a. Paid claims or physician documented inadequate response or adverse reaction to at least **ONE** traditional DMARD (See Appendix B) or contraindication to traditional DMARDs
 - b. Paid claims or physician documented inadequate response or adverse reaction to **ONE** biologic DMARD that is FDA-approved for the requested indication
- Dosing is appropriate

Continuation of Therapy



Reauthorization requires physician documentation of continuation of therapy, positive response to therapy, FDA approved indication and appropriate dosing.

Limitations

1. Initial approvals will be for 6 months.
2. Reauthorizations will be for 12 months.
3. The following quantity limits apply:

Kevzara 150mg/1.14mL Kevzara 200mg/1.14mL	2 syringes/pens per 28 days
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Appendix A

Kevzara® (sarilumab)	Rheumatoid arthritis: 200 mg subcutaneously every two weeks, reduce dose to 150 mg for management of neutropenia, thrombocytopenia and elevated liver enzymes
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Appendix B. Conventional Therapies for Plaque Psoriasis

Conventional Treatment Lines	Agents Used
Topical Agents	emollients, keratolytics, corticosteroids, coal tar, anthralin, calcipotriene, tazarotene, calcitriol, calcineurin inhibitors
Systemic Agents	Traditional DMARDs: methotrexate, apremilast, acitretin,
Phototherapy	ultraviolet A and topical psoralens (topical PUVA), ultraviolet A and oral psoralens (systemic PUVA), narrow band UV-B (NUVB)

References

1. Kevzara (sarilumab) [prescribing information]. Bridgewater, NJ: Sanofi-Aventis; April 2018.
2. Genovese MC, Fleischmann R, Kivitz AJ, et al. Sarilumab plus methotrexate in patients with active rheumatoid arthritis and inadequate response to methotrexate: results of a phase III study. *Arthritis Rheumatol.* June 2015;67(6):1424-37.
3. Strand V, Reaney M, Chen C, et al. Sarilumab improves patient-reported outcomes in rheumatoid arthritis patients with inadequate response/intolerance to tumour necrosis factor inhibitors. *RMD Open.* 2017; 3:e000416. doi: 10.1136/rmdopen-2016-000416.

Review History

03/01/18 – Effective

02/20/19 – Reviewed in P&T Meeting

10/21/2020 – Reviewed and Updated; separated out Comm/Exch vs. MassHealth. Matched MassHealth Preferred Unified Formulary for implementation 1/1/2021

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