Kevzara® (sarilumab)
Effective 03/01/2023

Plan	☐ MassHealth ☒ MassHealth (PUF) ☐Commercial/Exchange	**Program Type**	☒ Prior Authorization ☒ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ 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 the plan 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:

Rheumatoid Arthritis (RA)

Prescriber provides documentation of **ALL** the following:
1. Diagnosis of moderate to severe rheumatoid arthritis
2. **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
3. Appropriate dosing (see appendix for more frequent or higher doses)

<u>Off-Label Indications</u>

Polymyalgia Rheumatica (PMR)

Prescriber provides documentation of **ALL** of the following:

1. Diagnosis of polymyalgia rheumatica (PMR)
2. Paid claims or physician documented inadequate response or adverse reaction to **ONE** systemic corticosteroid or contraindication to **ALL** systemic corticosteroids
3. Paid claims or physician documented inadequate response, adverse reaction or contraindication to methotrexate

New members currently stable on Kevzara® can be approved without documentation of failed trials with the conventional therapies.

Continuation of Therapy

Reauthorization requires physician documentation of a positive response to therapy.

Limitations

1. Initial approvals will be for the following:
    a. Off-label indications: 3 months
    b. All other indications: 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

Appendix A. Dosing

Kevzara® (sarilumab)	**Rheumatoid arthritis:** 200 mg subcutaneously every two weeks, reduce dose to 150 mg for management of neutropenia, thrombocytopenia and elevated liver enzymes

Appendix B. Examples of Traditional DMARDs

Traditional DMARDs*
azathioprine
cyclosporine
hydroxychloroquine*
leflunomide
methotrexate*
sulfasalazine*
thalidomide

Appendix C. More Frequent or Higher Doses

Requests for more frequent or higher doses of injectable biologics may be approved if ALL of the following is provided:

1. Severe disease
2. Physician documentation of inadequate response or adverse reaction to **ONE** or contraindication to **ALL** other injectable biologic which is FDA-approved for the requested indication
3. Partial response to FDA-approved dosing of current biologic therapy
4. Specialist consult for the requested indication

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
01/11/2023 – Reviewed and updated for Jan P&T. Appropriate diagnosis was replaced with a specific indication throughout. Off-label indications added for: PMR. Added language regarding stability of requested medication for new members. Updated Appendix sections by removing conventional therapies for plaque psoriasis and added examples of traditional DMARDs and higher dose criteria. Effective 3/1/23.

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