

PHARMACY POLICY STATEMENT

Indiana Medicaid

DRUG NAME	Kevzara (sarilumab)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include Humira, Enbrel, Actemra QUANTITY LIMIT – 200 mg for 28 days
LIST OF DIAGNOSES CONSIDERED NOT MEDICALLY NECESSARY	Click Here

Kevzara (sarilumab) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

MODERATELY TO SEVERELY ACTIVE RHEUMATOID ARTHRITIS

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Must have a documented negative TB test (i.e. tuberculosis skin test (PPD), an interferon-release assay (IGRA), or a chest x-ray) within 6 months prior to starting therapy; AND
3. Medication must be prescribed by a rheumatologist; AND
4. Member has at least 8 tender and 6 swollen joints at baseline; AND
5. Member does **not** have ANC less than 2000/mm³, platelets less than 150,000/mm³ or liver transaminases above 1.5 times ULN; AND
6. Member must have tried and failed treatment with at least **two** non-biologic DMARDS (i.e. methotrexate, hydroxychloroquine, sulfasalazine (pregnancy category B), and leflunomide) or must have documented contraindication to all non-biologic DMARDS. Treatment trial duration with each non-biologic DMARD agent must have been at least 12 weeks; AND
7. Member has tried and failed treatment with Enbrel, Humira and Actemra.
8. **Dosage allowed:** 200 mg once every two weeks given as a subcutaneous injection.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Must have been retested for TB with a negative result within the past 12 months; AND
2. Member must be in compliance with all other initial criteria; AND
3. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved.

CareSource considers Kevzara (sarilumab) not medically necessary for the treatment of the following disease states based on a lack of robust clinical



controlled trials showing superior efficacy compared to currently available treatments:

- Adult-onset Still disease
- Ankylosing spondylitis
- Crohn's disease
- Giant cell arteritis
- Neuromyelitis optica
- Polymyalgia rheumatica
- Psoriatic arthritis
- Relapsing polychondritis
- Systemic lupus erythematosus
- Systemic sclerosis-associated myopathy/polyarthritis
- Systemic vasculitis
- Takayasu arteritis
- Tumor necrosis factor receptor associated periodic syndrome (TRAPS)
- Uveitis

DATE	ACTION/DESCRIPTION
06/20/2017	New policy for Kevzara created.

References:

1. Kevzara [package insert]. Bridgewater, NJ; SANOFI-AVENTIS U.S. LLC: May 2017.

Effective date: 01/01/2018

Revised date: 06/20/2017