| PHARMACY POLICY STATEMENT<br>**Ohio 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)<br>Alternative preferred products include Humira, Enbrel, Actemra<br>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/$mm^3$, platelets less than 150,000/$mm^3$ 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: 09/01/2017
Revised date: 06/20/2017