

Pharmacy Medical Necessity Guidelines: Enspryng™ (satralizumab-mwge)

Effective: November 10, 2020

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	RX	Department to Review	RxUM
<p>These pharmacy medical necessity guidelines apply to the following:</p> <p>Commercial Products</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Tufts Health Plan Commercial products – large group plans <input checked="" type="checkbox"/> Tufts Health Plan Commercial products – small group and individual plans <input checked="" type="checkbox"/> Tufts Health Freedom Plan products – large group plans <input checked="" type="checkbox"/> Tufts Health Freedom Plan products – small group plans • CareLinkSM – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization <p>Tufts Health Public Plans Products</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product) <input checked="" type="checkbox"/> Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans <input checked="" type="checkbox"/> Tufts Health RITogether – A Rhode Island Medicaid Plan 		<p>Fax Numbers:</p> <p>RXUM: 617.673.0988</p>	

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

FOOD AND DRUG ADMINISTRATION-APPROVED INDICATIONS

Enspryng (satralizumab-mwge) is an interleukin-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

The plan may authorize coverage of Enspryng (satralizumab-mwge) for Members when all of the following criteria are met:

1. Documented diagnosis of neuromyelitis optica spectrum disorder
AND
2. Documentation of a positive serologic test for anti-aquaporin-4 antibodies
AND
3. The prescribing physician is a neurologist or an ophthalmologist

LIMITATIONS

1. Combination therapy with other NMOSD disease modifying treatments will not be authorized.

CODES

None

REFERENCES

1. Enspryng (satralizumab-mwge) [prescribing information]. South San Francisco, CA: Genentech, Inc.; August 2020.
2. Traboulsee A, Greenberg BM, Bennett JL et al. Safety and efficacy of satralizumab monotherapy in neuromyelitis optica spectrum disorder: a randomised, double-blind, multicentre, placebo-controlled phase 3 trial. *Lancet Neurol.* 2020; 19(5):402-12. Uplizna prescribing information. Gaithersburg, MD: Viela Bio, Inc.; 2020 June. Yamamura T, Kleiter I, Fujihara K et al. Trial of satralizumab in neuromyelitis optica spectrum disorder. *N Engl J Med.* 2019; 381(22):2114-24.

APPROVAL HISTORY

November 10, 2020: Reviewed by Pharmacy & Therapeutics Committee.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined

population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.

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