UnitedHealthcare Community Plan

# Clinical Pharmacy Program Guidelines for Enspryng

| | |
|---|---|
| Program | Prior Authorization- Enspryng |
| Medication | Enspryng™ (satralizumab) |
| Markets in Scope | Arizona, California, Colorado, Hawaii, Maryland, Nevada, New Jersey, New York, New York EPP, Pennsylvania-CHIP, Rhode Island, South Carolina |
| Issue Date | 10/2020 |
| Pharmacy and Therapeutics Approval Date | 10/2020 |
| Effective Date | 12/2020 |

## 1. Background:

Enspryng (satralizumab) is an interleukin-6 (IL-6) receptor antagonist indicated for the treatment of neuromyelitis optica spectrum disorder (NMOSD) in adult patients who are anti-aquaporin-4 (AQP4) antibody positive.

## 2. Coverage Criteria:

**A. Initial Authorization**

1. **Enspryng** will be approved based on **all** of the following criteria:

   a. Diagnosis of neuromyelitis optica spectrum disorder (NMOSD)

   **-AND-**

   b. Patient has a positive serologic test for anti-aquaporin-4 (AQP4) antibodies

   **-AND-**

   c. Patient is not receiving Enspryng in combination with any of the following:

      (1) Disease modifying therapies for the treatment of multiple sclerosis [e.g., Gilenya (fingolimod), Tecfidera (dimethyl fumarate), Ocrevus (ocrelizumab), etc.]
      (2) Complement inhibitors [e.g., Soliris (eculizumab)]
      (3) Anti-IL6 therapy [e.g., Actemra (tocilizumab)];
      (4) B-cell depletion therapy [e.g. rituximab, Uplizna (inebilizumb)]

**Authorization will be issued for 12 months.**

**B. Reauthorization**

1. **Enspryng** will be approved based on **both** of the following criteria:

   a. Documentation of positive clinical response to Enspryng therapy

   **-AND-**

   b. Patient is not receiving Enspryng in combination with any of the following:

      (1) Disease modifying therapies for the treatment of multiple sclerosis [e.g., Gilenya (fingolimod), Tecfidera (dimethyl fumarate), Ocrevus (ocrelizumab), etc.]
      (2) Complement inhibitors [e.g., Soliris (eculizumab)]
      (3) Anti-IL6 therapy [e.g., Actemra (tocilizumab)];
      (4) B-cell depletion therapy [e.g. rituximab, Uplizna (inebilizumb)]

**Authorization will be issued for 12 months.**

**3. Additional Clinical Rules:**

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

**4. References:**

Enspryng [package insert]. South San Francisco, CA: Genentech, Inc.; August 2020.

| Program | Prior Authorization– Enspryng (satralizumab) |
|---|---|
| **Change Control** | |
| Date | Change |
| 10/2020 | New program |