Sarilumab (Kevzara®)

Place of Service
Self Administration

HCPC: J3590

NDCs:
- 0024-5908-01: two single-dose 150mg/1.14 mL prefilled syringes per pack
- 0024-5910-01: two single-dose 200mg/1.14 mL prefilled syringes per pack

Condition(s) listed in policy (*see criteria for details*)
- Rheumatoid arthritis, moderate to severe

AHFS therapeutic class: Antirheumatic

Mechanism of action: Interleukin-6 (IL-6) receptor antagonist

(1) Special Instructions and Pertinent Information

Kevzara is managed under the Outpatient Pharmacy Benefit. If the patient has a prescription drug benefit, please contact Blue Shield Pharmacy Services to obtain a prior authorization.

To submit a request to the medical benefit, please submit clinical information for prior authorization review via fax, including medical rationale why the patient cannot self-administer Kevzara in the home.

(2) Prior Authorization/Medical Review is required for the following condition(s)
All requests for Kevzara® (sarilumab) must be sent for clinical review and receive authorization prior to drug administration or claim payment.

Rheumatoid arthritis, moderate to severe
- Diagnosed or recommended by a rheumatologist, AND
- Patient is at least18 years of age or older, AND
- Not being used in combination with other targeted therapies for rheumatoid arthritis, AND
- Medical rationale why Enbrel, Humira and Remicade cannot be used with any conventional DMARDs

Covered dose: up to 200 mg SC every two weeks
Coverage period: Yearly based on continued response to therapy.

ICD-10:
M05.40-M06.9

(3) The following condition(s) DO NOT require Prior Authorization/Preservice
All requests for Kevzara® (sarilumab) must be sent for clinical review and receive authorization prior to drug administration or claim payment.

(4) This Medication is NOT medically necessary for the following condition(s)

Blue Shield's research indicates there is inadequate clinical evidence to support off-label use of this drug for the following conditions (Health and Safety Code 1367.21):

Coverage for a Non-FDA approved indication, requires that criteria outlined in Health and Safety Code § 1367.21, including objective evidence of efficacy and safety are met for the proposed indication.

Please refer to the Provider Manual and User Guide for more information.

(5) Additional Information

How supplied:

- 150 mg (single-dose syringe): NDC 0024-5908-01
- 200 mg (single-dose syringe): NDC 0024-5910-01
- 150 mg (single-dose pen): NDC 0024-5920-01
- 200 mg (single-dose pen): NDC 0024-5922-01

(6) References

- Kevzara® Prescribing Information. Sanofi & Regeneron. 2017.
- AHFS®. Available by subscription at http://www.lexi.com
- DrugDex®. Available by subscription at http://www.micromedexsolutions.com/home/dispatch

(7) Policy Update

Date of last review: 3Q2018

Date of next review: 2Q2019

Changes from previous policy version:

- No clinical changes to policy following routine annual review

BSC Drug Coverage Criteria to Determine Medical Necessity
Reviewed by P&T Committee