Commercial PA Criteria

Effective: January 1, 2019

Prior Authorization: Kevzara

Products Affected: Kevzara (sarilumab) subcutaneous solution

Medication Description: Kevzara is an interleukin-6 (IL-6) receptor antagonist indicated for the treatment of rheumatoid arthritis that is moderate to severe in adults who have had an inadequate response or intolerance to 1 or more disease modifying antirheumatic drugs (DMARDs). It may be used as monotherapy or in combination with a traditional DMARD.

Covered Uses:

1. Rheumatoid Arthritis - moderately to severely active rheumatoid arthritis (RA) who have had an inadequate response or intolerance to one or more disease-modifying antirheumatic drugs (DMARDs).
2. Polymyalgia Rheumatica - indicated for treatment of adult patients with polymyalgia rheumatica who have had an inadequate response to corticosteroids or who cannot tolerate corticosteroid taper.

Exclusion Criteria:

1. Ankylosing Spondylitis
2. Concurrent used with a Biologic or DMARD

Required Medical Information:

1. Diagnosis
2. Previous medications tried/failed

Age Restrictions: 18 years of age or older

Prescriber Restrictions: Prescribed by or in consultation with a rheumatologist.

Coverage Duration:
Initial: 6 months.
Continuation: 12 months

Other Criteria:

Rheumatoid Arthritis
Initial Therapy: Approve Kevzara if the patient meets the following criteria (A, **AND** B)

A. Patient has tried ONE conventional synthetic disease-modifying antirheumatic drug (DMARD) for at least 3 months; **AND**
Note: Examples of conventional synthetic DMARDs include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine. An exception to the requirement for a trial of one conventional synthetic DMARD can be made if the patient has already had a 3-month trial of at least one biologic other than the

requested drug. A biosimilar of the requested biologic does not count. Refer to Appendix for examples of biologics used for rheumatoid arthritis. A patient who has already

B. Patient must have a trail and documented failure of, or intolerance to, **TWO** of the following medications:
Note: A trial of multiple adalimumab products counts as ONE product. A trial of either or both Xeljanz products (Xeljanz and Xeljanz XR) collectively counts as ONE product. A trial of Actemra intravenous, Cimzia, an infliximab product (e.g., Remicade, biosimilars), Orencia (intravenous or subcutaneous), or Simponi (Aria or subcutaneous) also counts
    a. Enbrel
    b. Adalimumab product
    c. Xeljanz/Xeljanz XR
    d. Rinvoq
    e. Actemra SC

Polymyalgia Rheumatica

Initial Therapy: Approve Kevzara if the patient meets the following criteria (A **AND** B)

A. Patient has clinically diagnosed polymyalgia rheumatica diagnosed by or in consultation with rheumatologist **AND**

B. Patient has tried one systemic corticosteroid
    Note: An example of a systemic corticosteroid is prednisone.

Continuation

A. Patient meets all initial authorization criteria; **AND**

B. Patient achieves or maintains a positive clinical response after at least 6 months of therapy with Kevzara as evidenced by low disease activity or improvement in signs and symptoms of the condition

References:

1. Kevzara® subcutaneous injection [prescribing information]. Bridgewater, NJ: Regeneron/Sanofi-Aventis; February 2023.

Policy Revision history

Rev #	Type of Change	Summary of Change	Sections Affected	Date
1	New Policy	New Policy	All	01/01/2019
2	Policy Update	Added Rinvoq as a preferred product for RA	Other Criteria	10/18/2019
3	Policy Update	Removed Actemra SQ as a preferred product for RA	Other Criteria	01/01/2021
4	Policy Update	Added Actemra SQ as a preferred product for RA	Other Criteria	02/22/2022
5	Policy Update	Other Criteria: Updated “Humira” to “adalimumab”	Other Criteria	05/11/2023

6	Policy Update	Added to Covered uses: Polymyalgia Rheumatica - indicated for treatment of adult patients with polymyalgia rheumatica who have had an inadequate response to corticosteroids or who cannot tolerate corticosteroid taper. Added criteria for Polymyalgia Rheumatica. Substituted "RA" for "the condition" for continuation therapy. Added Dosing Limitation: to FDA Label Subcutaneous Adult Dosage Regimen 1. The recommended dosage is 200 mg once every two weeks.	Covered uses Criteria Continuation	6/13/2023
7	Policy Update	Removal of Dosage Limitation Initial coverage updated 3 months to 6 months Removed current criteria for RA and replaced with Select criteria for implementation to label	Coverage Duration Other Criteria	12/18/2023