VENTURA COUNTY
HEALTH CARE PLAN

PRIOR AUTHORIZATION POLICY

POLICY: Inflammatory Conditions – Kevzara Prior Authorization Policy
- Kevzara® (sarilumab subcutaneous injection – Regeneron/Sanofi-Aventis)

REVIEW DATE: 03/27/2024; selected revision 06/19/2024

OVERVIEW

Kevzara, an interleukin-6 receptor inhibitor, is indicated for the treatment of the following conditions:[1]

- **Rheumatoid arthritis**, in adults with moderate to severe active disease who have had an inadequate response or intolerance to one or more disease-modifying antirheumatic drugs (DMARDs).
- **Polyarticular juvenile idiopathic arthritis**, for the treatment of active disease in patients who weigh ≥ 63 kg.
- **Polymyalgia rheumatica**, in adults who have had an inadequate response to corticosteroids or who cannot tolerate corticosteroid taper.

Guidelines

Kevzara is addressed in the following guidelines:

- **Rheumatoid Arthritis:** Guidelines from the American College of Rheumatology (ACR) [2021] recommend addition of a biologic or a targeted synthetic DMARD for a patient taking the maximum tolerated dose of methotrexate who is not at target.[2]
- **Polyarticular Juvenile Idiopathic Arthritis**: Guidelines specific to juvenile non-systemic polyarthritis, sacroiliitis, and enthesitis (2019) were published prior to approval of Kevzara for PJIA.[8] For patients without risk factors, initial therapy with a DMARD is conditionally recommended over a biologic. Biologics are conditionally recommended as initial treatment when combined with a DMARD over biologic monotherapy.
- **Polymyalgia Rheumatica:** Guidelines from the European League Against Rheumatism (EULAR)/ACR (2015) were published prior to approval of Kevzara for this condition.[7] The minimum effective individualized duration of glucocorticosteroid therapy is strongly recommended.

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Kevzara. All approvals are provided for the approval duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days. Because of the specialized skills required for evaluation and diagnosis of patients treated with Kevzara as well as the monitoring required for adverse events and long-term efficacy, initial approval requires Kevzara to be prescribed by or in consultation with a physician who specializes in the condition being treated.

All reviews for use of Kevzara for Coronavirus Disease 2019 **(**COVID-19) and/or cytokine release syndrome associated with COVID-19 will be forwarded to the Medical Director.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Kevzara is recommended in those who meet the following criteria:

FDA-Approved Indication

1. **Rheumatoid Arthritis.** Approve for the duration noted if the patient meets ONE of the following (A or B):
   - **A)** Initial Therapy. Approve for 6 months if the patient meets BOTH of the following (i and ii):
     - **i.** 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 tried a biologic is not required to "step back" and try a conventional synthetic DMARD.
     - **ii.** The medication is prescribed by or in consultation with a rheumatologist.
   - **B)** Patient is Currently Receiving Kevzara. Approve for 1 year if the patient meets BOTH of the following (i and ii):
     - **i.** Patient has been established on therapy for at least 6 months; AND
       Note: A patient who has received < 6 months of therapy or who is restarting therapy is reviewed under criterion A (Initial Therapy).
     - **ii.** Patient meets at least ONE of the following (a or b):
       - **a)** Patient experienced a beneficial clinical response when assessed by at least one objective measure; OR
         Note: Examples of objective measures of disease activity include Clinical Disease Activity Index (CDAI), Disease Activity Score (DAS) 28 using erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP), Patient Activity Scale (PAS)-II, Rapid Assessment of Patient Index Data 3 (RAPID-3), and/or Simplified Disease Activity Index (SDAI).
       - **b)** Patient experienced an improvement in at least one symptom, such as decreased joint pain, morning stiffness, or fatigue; improved function or activities of daily living; decreased soft tissue swelling in joints or tendon sheaths.

2. **Polyarticular Juvenile Idiopathic Arthritis.** Approve for the duration noted if the patient meets ONE of the following (A or B):
   - **A)** Initial Therapy. Approve for 6 months if the patient meets ALL of the following (i, ii, and iii):
     - **i.** Patient weighs ≥ 63 kg; AND
     - **ii.** Patient meets ONE of the following (a, b, c, or d):
       - **a)** Patient has tried one other systemic therapy for this condition; OR
         Note: Examples of other systemic therapies include methotrexate, sulfasalazine, leflunomide, or a nonsteroidal anti-inflammatory drug (NSAID). A previous trial of one biologic other than the requested drug also counts as a trial of one systemic therapy for Juvenile Idiopathic Arthritis. A biosimilar of the requested drug does not count. Refer to Appendix for examples of biologics used for Juvenile Idiopathic Arthritis.
       - **b)** Patient will be starting on Kevzara concurrently with methotrexate, sulfasalazine, or leflunomide; OR
       - **c)** Patient has an absolute contraindication to methotrexate, sulfasalazine, or leflunomide; OR

Note: Examples of absolute contraindications to methotrexate include pregnancy, breastfeeding, alcoholic liver disease, immunodeficiency syndrome, and blood dyscrasias; OR

d) Patient has aggressive disease, as determined by the prescriber; AND

iii. The medication is prescribed by or in consultation with a rheumatologist.

B) Patient is Currently Receiving Kevzara. Approve for 1 year if the patient meets BOTH of the following (i and ii):

i. Patient has been established on therapy for at least 6 months; AND
Note: A patient who has received < 6 months of therapy or who is restarting therapy with this medication is reviewed under criterion A (Initial Therapy).

ii. Patient meets at least ONE of the following (a or b):

a) When assessed by at least one objective measure, patient experienced a beneficial clinical response from baseline (prior to initiating the requested medication); OR
Note: Examples of objective measures include Physician Global Assessment (MD global), Parent/Patient Global Assessment of Overall Well-Being (PGA), Parent/Patient Global Assessment of Disease Activity (PDA), Juvenile Arthritis Disease Activity Score (JDAS), Clinical Juvenile Arthritis Disease Activity Score (cJDAS), Juvenile Spondyloarthritis Disease Activity Index (JSpADA), serum markers (e.g., C-reactive protein, erythrocyte sedimentation rate), and/or reduced dosage of corticosteroids.

b) Compared with baseline (prior to initiating the requested medication), patient experienced an improvement in at least one symptom, such as improvement in limitation of motion, less joint pain or tenderness, decreased duration of morning stiffness or fatigue, improved function or activities of daily living.

3. Polymyalgia Rheumatica. Approve for the duration noted if the patient meets ONE of the following (A or B):

A) Initial Therapy. Approve for 6 months if the patient meets BOTH of the following (i and ii):

i. Patient has tried one systemic corticosteroid; AND
Note: An example of a systemic corticosteroid is prednisone.

ii. The medication is prescribed by or in consultation with a rheumatologist.

B) Patient is Currently Receiving Kevzara. Approve for 1 year if the patient meets BOTH of the following (i and ii):

i. Patient has been established on therapy for at least 6 months; AND
Note: A patient who has received < 6 months of therapy or who is restarting therapy is reviewed under criterion A (Initial Therapy).

ii. Patient meets at least ONE of the following (a or b):

a) When assessed by at least one objective measure, patient experienced a beneficial clinical response from baseline (prior to initiating Kevzara); OR
Note: Examples of objective measures are serum markers (e.g., C-reactive protein, erythrocyte sedimentation rate), resolution of fever, and/or reduced dosage of corticosteroids.

b) Compared with baseline (prior to initiating Kevzara), patient experienced an improvement in at least one symptom, such as decreased shoulder, neck, upper arm, hip, or thigh pain or stiffness; improved range of motion; and/or decreased fatigue.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Kevzara is not recommended in the following situations:

1. **Ankylosing Spondylitis.** In a Phase II study, Kevzara did not demonstrate efficacy in patients with ankylosing spondylitis.[3]

2. **Concurrent Use with a Biologic or with a Targeted Synthetic Disease-Modifying Antirheumatic Drug (DMARD).** Kevzara should not be administered in combination with another biologic or with a targeted synthetic DMARD used for an inflammatory condition (see Appendix for examples). Combination therapy is generally not recommended due to a potential for a higher rate of adverse effects with combinations and lack of evidence for additive efficacy.
   Note: This does NOT exclude the use of conventional synthetic DMARDs (e.g., methotrexate, leflunomide, hydroxychloroquine, and sulfasalazine) in combination with Kevzara.

3. **COVID-19 (Coronavirus Disease 2019).** Forward all requests to the Medical Director.[4-6]
   Note: This includes requests for cytokine release syndrome associated with COVID-19.

4. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

1. Kevzara® subcutaneous injection [prescribing information]. Bridgewater, NJ: Regeneron/Sanofi-Aventis; June 2024.
2. Fraenkel L, Bathon JM, England BR, et al. 2021 American College of Rheumatology guideline for the treatment of rheumatoid arthritis. *Arthritis Rheumatol*. 2021;73(7):1108-1123.
3. Sieper J, Braun J, Kay J, et al. Sarilumab for the treatment of ankylosing spondylitis: results of a Phase II, randomised, double-blind, placebo-controlled study (ALIGN). *Ann Rheum Dis*. 2015;74(6):1051-1057.
4. COVID-19 Treatment Guidelines Panel. Coronavirus Disease 2019 (COVID-19) Treatment Guidelines. National Institutes of Health. Updated January 26, 2023. Available at https://www.covid19treatmentguidelines.nih.gov/. Accessed March 7, 2023.
5. US National Institutes of Health. In: ClinicalTrials.gov [Internet]. Bethesda (MD): National Library of Medicine (US). 2000- [cited 2024 June 17]. Available from: https://clinicaltrials.gov/. Search terms: coronavirus, sarilumab.
6. Rochwerg B, Siemieniuk R, Jacobs M, et al. Therapeutics and COVID-19: living guideline [version 14.1]. Updated November 9, 2023. Available at: https://app.magicapp.org/#/guideline/nBkO1E. Accessed on June 17, 2024.
7. Dejaco C, Singh YP, Perel P, et al. 2015 Recommendations for the management of polymyalgia rheumatica: a European League Against Rheumatism/American College of Rheumatology collaborative initiative. *Ann Rheum Dis*. 2015;74(10):1799-807.
8. Ringold S, Angeles-Han ST, Beukelman T, et al. 2019 American College of Rheumatology/Arthritis Foundation guideline for the treatment of juvenile idiopathic arthritis: therapeutic approaches for non-systemic polyarthritis, sacroiliitis, and enthesitis. *Arthritis Care Res (Hoboken)*. 2019;71(6):717-734.

HISTORY

Type of Revision	Summary of Changes	Review Date
Early Annual Revision	**Polymyalgia Rheumatica:** This newly approved condition was added to the policy.	03/08/2023
Annual Revision	No criteria changes.	03/27/2024
Selected Revision	**Polyarticular Juvenile Idiopathic Arthritis:** This newly approved indication was added to the policy.	06/19/2024

APPENDIX

	Mechanism of Action	Examples of Inflammatory Indications*
Biologics		
Adalimumab SC Products (Humira®, biosimilars)	Inhibition of TNF	AS, CD, JIA, PsO, PsA, RA, UC
Cimzia® (certolizumab pegol SC injection)	Inhibition of TNF	AS, CD, nr-axSpA, PsO, PsA, RA
Etanercept SC Products (Enbrel®, biosimilars)	Inhibition of TNF	AS, JIA, PsO, PsA
Zymfentra® (infliximab-dyyb SC injection)	Inhibition of TNF	CD, UC
Infliximab IV Products (Remicade®, biosimilars)	Inhibition of TNF	AS, CD, PsO, PsA, RA, UC
Simponi®, Simponi® Aria™ (golimumab SC injection, golimumab IV infusion)	Inhibition of TNF	SC formulation: AS, PsA, RA, UC
		IV formulation: AS, PJIA, PsA, RA
Tocilizumab Products (Actemra® IV infusion, biosimilar; Actemra SC injection, biosimilar)	Inhibition of IL-6	SC formulation: PJIA, RA, SJIA
		IV formulation: PJIA, RA, SJIA
Kevzara® (sarilumab SC injection)	Inhibition of IL-6	RA, PJIA, PMR
Orencia® (abatacept IV infusion, abatacept SC injection)	T-cell costimulation modulator	SC formulation: JIA, PSA, RA
		IV formulation: JIA, PsA, RA
Rituximab IV Products (Rituxan®, biosimilars)	CD20-directed cytolytic antibody	RA
Kineret® (anakinra SC injection)	Inhibition of IL-1	JIA^, RA
Stelara® (ustekinumab SC injection, ustekinumab IV infusion)	Inhibition of IL-12/23	SC formulation: CD, PsO, PsA, UC
		IV formulation: CD, UC
Siliq® (brodalumab SC injection)	Inhibition of IL-17RA	PsO
Bimzelx® (bimekizumab-bkzx SC injection)	Inhibition of IL-17A and IL-17F	PsO
Cosentyx® (secukinumab SC injection, secukinumab IV infusion)	Inhibition of IL-17A	SC formulation: AS, ERA, nr-axSpA, PsO, PsA
		IV formulation: AS, nr-axSpA, PsA
Taltz® (ixekizumab SC injection)	Inhibition of IL-17A	AS, nr-axSpA, PsO, PsA
Ilumya™ (tildrakizumab-asmn SC injection)	Inhibition of IL-23	PsO
Skyrizi® (risankizumab-rzaa SC injection, risankizumab-rzaa IV infusion)	Inhibition of IL-23	SC formulation: CD, PSA, PsO
		IV formulation: CD
Tremfya™ (guselkumab SC injection)	Inhibition of IL-23	PsO
Entyvio™ (vedolizumab IV infusion, vedolizimab SC injection)	Integrin receptor antagonist	SC formulation: UC
		IV formulation: CD, UC
Oral Therapies/Targeted Synthetic DMARDs		
Otezla® (apremilast tablets)	Inhibition of PDE4	PsO, PsA
Cibinqo™ (abrocitinib tablets)	Inhibition of JAK pathways	AD
Olumiant® (baricitinib tablets)	Inhibition of JAK pathways	RA
Rinvoq® (upadacitinib extended-release tablets)	Inhibition of JAK pathways	AD, AS, nr-axSpA, RA, PsA, UC
Sotyktu™ (deucravacitinib tablets)	Inhibition of TYK2	PsO
Xeljanz® (tofacitinib tablets)	Inhibition of JAK pathways	RA, PJIA, PsA, UC
Xeljanz® XR (tofacitinib extended-release tablets)	Inhibition of JAK pathways	RA, PsA, UC

* Not an all-inclusive list of indications (e.g., oncology indications and rare inflammatory conditions are not listed). Refer to the prescribing information for the respective agent for FDA-approved indications; SC – Subcutaneous; TNF – Tumor necrosis factor; AS – Ankylosing spondylitis; CD – Crohn's disease; JIA – Juvenile idiopathic arthritis; PsO – Plaque psoriasis; PsA – Psoriatic arthritis; RA – Rheumatoid arthritis; UC – Ulcerative colitis; nr-axSpA – Non-radiographic axial spondyloarthritis; IV – Intravenous, PJIA – Polyarticular juvenile idiopathic arthritis; IL – Interleukin; SJIA – Systemic juvenile idiopathic arthritis; PMR – Polymyalgia rheumatic; ^ Off-label use of Kineret in JIA supported in guidelines; ERA – Enthesitis-related arthritis; DMARD – Disease-modifying antirheumatic drug; PDE4 – Phosphodiesterase 4; JAK – Janus kinase; AD – Atopic dermatitis; TYK2 – Tyrosine kinase 2.