

**Enspryng (satralizumab-mwge)  
Effective 05/01/2021**

<b>Plan</b>	<input checked="" type="checkbox"/> MassHealth <input checked="" type="checkbox"/> Commercial/Exchange	<b>Program Type</b>	<input checked="" type="checkbox"/> Prior Authorization <input checked="" type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
<b>Benefit</b>	<input checked="" type="checkbox"/> Pharmacy Benefit <input type="checkbox"/> Medical Benefit (NLX)		
<b>Specialty Limitations</b>	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
<b>Contact Information</b>	<b>Specialty Medications</b>		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	<b>Non-Specialty Medications</b>		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	<b>Medical Specialty Medications (NLX)</b>		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
<b>Exceptions</b>	N/A		

### Overview

Neuromyelitis optica spectrum disorder (NMOSD) is a chronic disorder of the brain and spinal cord dominated by inflammation of the optic nerve (optic neuritis) and inflammation of the spinal cord (myelitis)

Enspryng 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.

### Coverage Guidelines

Authorization may be reviewed for members new to AllWays Health Partners who are currently receiving treatment with Enspryng, excluding when the product is obtained as samples or via manufacturer’s patient assistance programs

#### OR

Authorization may be granted for members when ALL the following criteria are met, and documentation is provided:

1. The member has a diagnosis of neuromyelitis optica spectrum disorder
2. The member has a diagnosis is anti-aquaporin-4 (AQP4) antibody positive
3. The member exhibits at least one of the following core characteristics of NMOSD
  - a. Optic Neuritis
  - b. Acute myelitis
  - c. Area postrema syndrome (episode of otherwise unexplained hiccups or nausea and vomiting)
  - d. Acute brainstem syndrome
  - e. Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions



4. The member will not receive the requested drug concomitantly with other biologics for the treatment of NMOSD
5. The member is  $\geq 18$  years of age

**Continuation of Therapy**

Reauthorizations may be granted when patient demonstrates a positive response to therapy and the member will not receive Enspryng in combination with other biologics for the treatment of NMOSD.

**Limitations**

1. Initial approvals and reauthorizations will be for 12 months.
2. The following quantity limits apply:

Enspryng 120mg/mL (1mL)	1mL per 28 days
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**References**

1. Enspryng (satralizumab-mwge) [prescribing information]. South San Francisco, CA: Genentech, Inc.; August 2020.
2. Weinshenker B. In *NORD Guide to Rare Disorders*. Philadelphia, PA: Lippincott, Williams & Wilkins; 2003:567.

**Review History**

3/17/2021 – Created and Reviewed at March P&T. Effective 05/01/2021

**Disclaimer**

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