BlueCross BlueShield Federal Employee Program

KEVZARA
(sarilumab)

Pre - PA Allowance

None

Prior-Approval Requirements

Diagnoses

Patient must have **ONE** of the following:

1. Moderate to severe active rheumatoid arthritis (RA)
   a. 18 years of age or older
   b. Inadequate treatment response, intolerance, or contraindication to a 3-month trial of at least **ONE** conventional disease-modifying antirheumatic drug (DMARD) (see Appendix 2)
   c. Inadequate treatment response, intolerance, or contraindication to at least **ONE** biologic or targeted synthetic (DMARD) (see Appendix 2) if adjudicated through the pharmacy benefit
   d. Patient **MUST** have tried the preferred product(s) (see Appendix 3) if adjudicated through the pharmacy benefit unless the patient has a valid medical exception (e.g., inadequate treatment response, intolerance, contraindication)

2. Polymyalgia rheumatica (PMR)
   a. 18 years of age or older
   b. Inadequate treatment response, intolerance, or contraindication to corticosteroids **OR** patient cannot tolerate corticosteroid taper

3. Active polyarticular juvenile idiopathic arthritis (pJIA)
   a. 2 years of age or older
   b. Weight ≥ 63 kg
   c. Inadequate treatment response, intolerance, or contraindication to a 3-month trial of at least **ONE** conventional (DMARD) (see Appendix 2)
   d. Patient **MUST** have tried the preferred product(s) (see Appendix 3) if adjudicated through the pharmacy benefit unless the patient has a valid medical exception (e.g., inadequate treatment response, intolerance, contraindication)

AND ALL of the following for **ALL** diagnoses:

a. **NOT** to be used in combination with any other biologic DMARD or targeted synthetic DMARD (see Appendix 2)
b. Result for latent TB infection is negative **OR** result was positive for latent TB and patient completed treatment (or is receiving treatment) for latent TB
c. Absence of active infection (i.e., bacterial, fungal, TB)
d. **NOT** given concurrently with live vaccines
e. Documented ALT level less than 5 times upper limit of normal (ULN)
f. Prescriber agrees to monitor neutrophil count and platelet count prior to initiation and 4 to 8 weeks after start of therapy and every 3 months as clinically indicated

Prior - Approval Limits

Quantity 6 syringes/pens per 84 days

Duration 12 months

Prior – Approval *Renewal* Requirements

Diagnoses

Patient must have **ONE** of the following:

1. Rheumatoid arthritis (RA)
    a. 18 years of age or older
    b. Patient **MUST** have tried the preferred product(s) (see Appendix 3) if adjudicated through the pharmacy benefit unless the patient has a valid medical exception (e.g., inadequate treatment response, intolerance, contraindication)

2. Polymyalgia rheumatica (PMR)
    a. 18 years of age or older

3. Polyarticular juvenile idiopathic arthritis (pJIA)
    a. 2 years of age or older
    b. Weight ≥ 63 kg
    c. Patient **MUST** have tried the preferred product(s) (see Appendix 3) if adjudicated through the pharmacy benefit unless the patient has a valid medical exception (e.g., inadequate treatment response, intolerance, contraindication)

AND ALL of the following for **ALL** diagnoses:

1. Condition has improved or stabilized with therapy
2. **NOT** to be used in combination with any other biologic DMARD or targeted synthetic DMARD (see Appendix 2)
3. **NOT** given concurrently with live vaccines
4. Documented ALT level less than 5 times upper limit of normal (ULN)
5. Prescriber agrees to monitor neutrophil count and platelet count every 3 months as clinically indicated

Prior - Approval Limits

Quantity 6 syringes/pens per 84 days

Duration 18 months

Appendix 1 – Examples of Contraindications to Methotrexate

Contraindications to Methotrexate
1. Alcoholism, alcoholic liver disease or other chronic liver disease
2. Breastfeeding
3. Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
4. Elevated liver transaminases
5. History of intolerance or adverse event
6. Hypersensitivity
7. Interstitial pneumonitis or clinically significant pulmonary fibrosis
8. Myelodysplasia
9. Pregnancy or planning pregnancy (male or female)
10. Renal impairment
11. Significant drug interaction

Appendix 2 - List of DMARDS

Conventional disease-modifying antirheumatic drugs (DMARDs)

Generic Name	Brand Name
azathioprine	Azasan, Imuran
cyclophosphamide	Cytoxan
cyclosporine	Neoral, Gengraf, Sandimmune
hydroxychloroquine	Plaquenil
leflunomide	Arava

methotrexate	Rheumatrex, Trexall
mycophenolate	Cellcept
sulfasalazine	Azulfidine, Sulfazine

Biological disease-modifying antirheumatic drugs (DMARDs)

Generic Name	Brand Name
abatacept	Orencia
adalimumab	Humira
anakinra	Kineret
bimekizumab-bkzx	Bimzelx
brodalumab	Siliq
certolizumab	Cimzia
etanercept	Enbrel
golimumab	Simponi/Simponi Aria
guselkumab	Tremfya
infliximab	Remicade
ixekizumab	Taltz
risankizumab-rzaa	Skyrizi
rituximab	Rituxan
sarilumab	Kevzara
secukinumab	Cosentyx
spesolimab-sbzo	Spevigo
tildrakizumab-asmn	Ilumya
tocilizumab	Actemra
ustekinumab	Stelara
vedolizumab	Entyvio

Targeted synthetic disease-modifying antirheumatic drugs (DMARDs)

Generic Name	Brand Name
apremilast	Otezla
baricitinib	Olumiant
deucravacitinib	Sotyktu
tofacitinib	Xeljanz/XR
upadactinib	Rinvoq

Appendix 3 - List of Preferred Products

Diagnosis	Standard Option/Basic Option Preferred Products	Blue Focus Preferred Products
Polyarticular Juvenile Idiopathic Arthritis (PJIA)	*must try **TWO** preferred products: Actemra SC	*must try **ONE** preferred product: Enbrel

	Enbrel Humira** Rinvoq Xeljanz	Humira**
Rheumatoid Arthritis (RA)	*must try **TWO** preferred products: Actemra (SC) Enbrel Humira** Rinvoq Xeljanz/XR	*must try **ONE** preferred product: Enbrel Humira**

**Including all preferred biosimilars (see reference product criteria)