Clinical Policy: Sarilumab (Kevzara)

Reference Number: IL.PHAR.346
Effective Date: 1.142020
Last Review Date: 4.14.25
Line of Business: Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Sarilumab (Kevzara®) is an interleukin-6 (IL-6) receptor antagonist.

FDA Approved Indication(s)

Kevzara is indicated for treatment of:

- Adult patients with moderately to severely active rheumatoid arthritis (RA) who have had an inadequate response or intolerance to one or more disease-modifying natirheumatic drugs (DMARDs).
- Adult patients with polymyalgia rheumatica (PMR) who have had an inadequate response to corticosteroids or who cannot tolerate corticosteroid taper.
- Active polyarticular juvenile idiopathic arthritis (pJIA) in patients who weigh 63 kg or greater.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Kevzara is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Rheumatoid Arthritis (must meet all)**:**

1. Diagnosis of RA per American College of Rheumatology (ACR) criteria (*see Appendix E*);
2. Prescribed by or in consultation with a rheumatologist;
3. Age ≥ 18 years;
4. Member meets one of the following (a or b):
   a. Failure of a ≥ 3 consecutive month trial of methotrexate (MTX) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effect are experienced;
   b. If intolerance or contraindication to MTX (*see Appendix D*), failure of a ≥ 3 consecutive month trial of at least ONE conventional DMARD (e.g., sulfasalazine, leflunomide, hydroxychloroquine) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effect are experienced;

5. Failure of at least TWO of the following, each used for ≥ 3 consecutive months, unless contraindicated or clinically significant adverse effects are experienced: Enbrel®, Adalimumab-adbm or adalimumab-ryvk (Simlandi®) , Cimzia, Xeljanz®/Xeljanz XR®;
   **Prior authorization is required for Enbrel,* Adalimumab-adbm or adalimumab-ryvk (Simlandi®) *, Cimzia, and Xeljanz/Xeljanz XR*
6. Documentation of one of the following baseline assessment scores (a or b):
   a. Clinical disease activity index (CDAI) score (*see Appendix F*);
   b. Routine assessment of patient index data 3 (RAPID3) score (*see Appendix G*);
7. Dose does not exceed 200 mg every two weeks.

Approval duration: 6 months

B. Polymyalgia Rheumatica (must meet all)**:**

1. Diagnosis of PMR per ACR/European Union League Against Rheumatism (EULAR) criteria as evidenced by both of the following (a and b, *see Appendix H*):
   a. Documentation that member presents with symptoms of PMR (e.g., bilateral shoulder aching; symmetrical aching; stiffness in shoulders, hip girdle, neck, and torso; morning stiffness);
   b. Evidence of one of the following (i or ii):
      i. Baseline erythrocyte sedimentation rate (ESR) ≥ 30 mm/hr;
      ii. Baseline c-reactive protein (CRP) ≥ 10 mg/L;
2. Prescribed by or in consultation with a rheumatologist;
3. Age ≥ 50 years;
4. Member meets one of the following (a or b):
   a. Failure of a systemic corticosteroid (e.g., prednisone) at maximally tolerated doses for ≥ 2 weeks, unless contraindicated or clinically significant adverse effects are experienced;
   b. Documentation of one episode of unequivocal PMR flare (e.g., shoulder and/or hip girdle pain associated with inflammatory stiffness) while attempting to taper corticosteroids at a dose ≥ 7.5 mg/day of prednisone equivalent;
5. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
6. Dose does not exceed 200 mg every two weeks.

Approval duration: 6 months

C. Polyarticular Juvenile Idiopathic Arthritis (must meet all)**:**

1. Diagnosis of PJIA* as evidenced by ≥ 5 joints with active arthritis;
   **Overlap of diagnosis exists in children with JIA and non-systemic polyarthritis, which may include children from ILAR JIA categories of enthesitis-related arthritis*
2. Prescribed by or in consultation with a rheumatologist;
3. Age ≥ 2 years;
4. Documentation that member weighs ≥ 63 kg;
5. Documented baseline 10-joint clinical juvenile arthritis disease activity score (cJADAS-10) (*see Appendix I*);
6. Member meets one of the following (a, b, c, or d):

a. Failure of a ≥ 3 consecutive month trial of MTX at up to maximally indicated doses;
b. Member has intolerance or contraindication to MTX (*see Appendix D*), and failure of a ≥ 3 consecutive month trial of leflunomide or sulfasalazine at up to maximally indicated doses, unless clinically significant adverse effects are experienced or both are contraindicated;
c. For sacroiliitis/axial spine involvement (i.e., spine, hip), failure of a ≥ 4 week trial of an NSAID at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
d. Documented presence of high disease activity as evidenced by a cJADAS-10 > 8.5 (*see Appendix I*);

7. Failure of ALL* of the following, each used for ≥ 3 consecutive months, unless clinically significant adverse effects are experienced or both are contraindicated (a, b, and c, *see Appendix D*):
   a. Adalimumab-adbm or adalimumab-ryvk (Simlandi®), unless the member has had a history of failure of two TNF blockers;
   b. If member has not responded or is intolerant to one or more TNF blockers, Xeljanz, unless member has cardiovascular risk and benefits do not outweigh the risk of treatment;

   **Prior authorization may be required for adalimumab products and Xeljanz*
8. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
9. Dose does not exceed 200 mg every two weeks.

Approval duration: 6 months

D. Other diagnoses/indications (must meet 1 or 2):
1. Refer this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**
1. Member meets one of the following (a or b):

a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B)*;

2. Member meets one of the following (a, b, or c):
   a. For RA: member is responding positively to therapy as evidenced by one of the following (i or ii):
      i. A decrease in CDAI (*see Appendix F*) or RAPID3 (*see Appendix G*) score from baseline;
      ii. Medical justification stating inability to conduct CDAI re-assessment, and submission of RAPID3 score associated with disease severity that is similar to initial CDAI assessment or improved;
   b. For PMR: member is responding positively to therapy as evidenced by both of the following (i and ii):
      i. Documentation of decrease in signs and symptoms of PMR (e.g., bilateral shoulder aching; symmetrical aching; stiffness in shoulders, hip girdle, neck, and torso; morning stiffness);
      ii. Evidence of one of the following (1 or 2):
         1. Reduction of CRP from baseline;
         2. Reduction of ESR from baseline;
         3. For pJIA, member is responding positively to therapy as evidenced by a decrease in cJADAS-10 from baseline (*see Appendix I*);
3. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
4. If request is for a dose increase, new dose does not exceed 200 mg every two weeks.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

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III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 for Medicaid or evidence of coverage documents;

B. Combination use with biological disease-modifying antirheumatic drugs (bDMARDs) or potent immunosuppressants, including but not limited to any tumor necrosis factor (TNF) antagonists [e.g., Cimzia®, Enbrel®, Humira® and its biosimilars, Remicade® and its biosimilars (Avsola™, Inflectra™, Renflexis™, Zymfentra®), Simponi®], interleukin agents [e.g., Actemra® (IL-6RA), Arcalyst® (IL-1 blocker), Bimzelx® (IL-17A and F antagonist), Cosentyx® (IL-17A inhibitor), Ilaris® (IL-1 blocker), Ilumya™ (IL-23 inhibitor), Kevzara® (IL-6RA), Kineret® (IL-1RA), Omvoh™ (IL-23 antagonist), Siliq™ (IL-17RA), Skyrizi™ (IL-23 inhibitor), Stelara® (IL-12/23 inhibitor), Taltz® (IL-17A inhibitor), Tofidence™ (IL-6), Tremfya® (IL-23 inhibitor), Wezlana™ (IL-12/23 inhibitor)], Janus kinase inhibitors (JAKi) [e.g., Cibinqo™, Olumiant™, Rinvoq™, Xeljanz®/Xeljanz® XR,], anti-CD20 monoclonal antibodies [Rituxan® and its biosimilars (Riabni™, Ruxience™, Truxima®), Rituxan Hycela®], selective co-stimulation modulators [Orencia®], integrin receptor antagonists [Entyvio®], tyrosine kinase 2 inhibitors [Sotyktu™], and sphingosine 1-phosphate receptor modulator [Velsipity™] because of the additive immunosuppression, increased risk of neutropenia, as well as increased risk of serious infections.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

DMARD: disease-modifying antirheumatic drug
FDA: Food and Drug Administration
IL-6: interleukin-6
MTX: methotrexate
RA: rheumatoid arthritis

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
azathioprine (Azasan®, Imuran®)	**RA** 1 mg/kg/day PO QD or divided BID	2.5 mg/kg/day
systemic corticosteroids (e.g., prednisone)	**PMR** Prednisone: 7.5 mg to 25 mg PO per day	Prednisone: 30 mg/day
Cuprimine® (d-penicillamine)	**RA*** Initial dose: 125 or 250 mg PO QD Maintenance dose: 500 – 750 mg/day PO QD	1,500 mg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
cyclosporine (Sandimmune®, Neoral®)	**RA** 2.5 – 4 mg/kg/day PO divided BID	4 mg/kg/day
hydroxychloroquine (Plaquenil®)	**RA*** Initial dose: 400 – 600 mg/day PO QD Maintenance dose: 200 – 400 mg/day PO QD	600 mg/day
leflunomide (Arava®)	**RA** Initial dose (for low risk hepatotoxicity or myelosuppression): 100 mg PO QD for 3 days Maintenance dose: 20 mg PO QD	20 mg/day
methotrexate (Trexall®, Otrexup™, Rasuvo®, RediTrex®, Xatmep™, Rheumatrex®)	**RA** 7.5 mg/week PO, SC, or IM	30 mg/week
Ridaura® (auranofin)	**RA** 6 mg PO QD or 3 mg PO BID	9 mg/day (3 mg TID)
sulfasalazine (Azulfidine®)	**RA** Initial dose: 500 mg to 1,000 mg PO QD for the first week. Increase the daily dose by 500 mg each week up to a maintenance dose of 2 g/day. Maintenance dose: 2 g/day PO in divided doses	3 g/day
Adalimumab and biosimilars (Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Yuflyma, Yusimry)	**RA** 40 mg SC every other week Some patients with RA not receiving concomitant methotrexate may benefit from increasing the frequency to 40 mg every week or 80 mg every other week.	40 mg/week
Tocilizumab (Actemra)	**RA** IV: 4 mg/kg every 4 weeks followed by an increase to 8 mg/kg every 4 weeks based on clinical response	IV: 800 mg every 4 weeks SC: 162 mg every week

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	SC: Weight < 100 kg: 162 mg SC every other week, followed by an increase to every week based on clinical response Weight ≥ 100 kg: 162 mg SC every week	

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.
**Off-label*

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): known hypersensitivity to sarilumab or any of the inactive ingredients
- Boxed warning(s): risk of serious infections

Appendix D: General Information

- Definition of MTX or DMARD Failure
  - Child-bearing age is not considered a contraindication for use of MTX. Each drug has risks in pregnancy. An educated patient and family planning would allow use of MTX in patients who have no intention of immediate pregnancy.
  - Social use of alcohol is not considered a contraindication for use of MTX. MTX may only be contraindicated if patients choose to drink over 14 units of alcohol per week. However, excessive alcohol drinking can lead to worsening of the condition, so patients who are serious about clinical response to therapy should refrain from excessive alcohol consumption.
- Examples of positive response to therapy may include, but are not limited to:
  - Reduction in joint pain/swelling/tenderness
  - Improvement in ESR/CRP levels
  - Improvements in activities of daily living

Appendix E: The 2010 ACR Classification Criteria for RA

Add score of categories A through D; a score of ≥ 6 out of 10 is needed for classification of a patient as having definite RA.

A	**Joint involvement**	Score
	1 large joint	0
	2-10 large joints	1
	1-3 small joints (with or without involvement of large joints)	2
	4-10 small joints (with or without involvement of large joints)	3
	> 10 joints (at least one small joint)	5
B	**Serology (at least one test result is needed for classification)**	
	Negative rheumatoid factor (RF) *and* negative anti-citrullinated protein antibody (ACPA)	0
	Low positive RF *or* low positive ACPA	2

	* *Low: < 3 x upper limit of normal*	
	High positive RF *or* high positive ACPA * *High: ≥ 3 x upper limit of normal*	3
C	**Acute phase reactants (at least one test result is needed for classification)**	
	Normal C-reactive protein (CRP) and normal erythrocyte sedimentation rate (ESR)	0
	Abnormal CRP or abnormal ESR	1
D	**Duration of symptoms**	
	< 6 weeks	0
	≥ 6 weeks	1

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- *Appendix F: Clinical Disease Activity Index (CDAI) Score*
- The Clinical Disease Activity Index (CDAI) is a composite index for assessing disease activity in RA. CDAI is based on the simple summation of the count of swollen/tender joint count of 28 joints along with patient and physician global assessment on VAS (0–10 cm) Scale for estimating disease activity. The CDAI score ranges from 0 to 76.

CDAI Score	Disease state interpretation
≤ 2.8	Remission
2.8 to ≤ 10	Low disease activity
10 to ≤ 22	Moderate disease activity
> 22	High disease activity

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- *Appendix G: Routine Assessment of Patient Index Data 3 (RAPID3) Score*
- The Routine Assessment of Patient Index Data 3 (RAPID3) is a pooled index of the three patient-reported ACR core data set measures: function, pain, and patient global estimate of status. Each of the individual measures is scored 0 – 10, and the maximum achievable score is 30.

RAPID3 Score	Disease state interpretation
≤ 3	Remission
3.1 to 6	Low disease activity
6.1 to 12	Moderate disease activity
> 12	High disease activity

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
RA	200 mg SC once every two weeks	200 mg every 2 weeks

VI. Product Availability

Single-dose prefilled syringe/pen: 150 mg/1.14 mL, 200 mg/1.14 mL

VII. References

1. Kevzara Prescribing Information. Bridgewater, NJ: Sanofi-Aventis U.S. LLC; June 2024. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/761037s015lbl.pdf. Accessed June 24, 2024.

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3. England BR, Tiong BK, and Bergman MJ, et al. 2019 Update of the American College of Rheumatology Recommended Rheumatoid Arthritis Disease Activity Measures. Arthritis Care Res (Hoboken). 2019 Dec;71(12):1540-1555. doi: 10.1002/acr.24042.
4. Smolen JS, Landewe RB, Dergstra SA, et al. 2022 update of the EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs. Arthritis Rheumatology. 2023 January; 32:3-18. DOI:10.1136/ard-2022-223356.
5. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2024. Available at: https://www.clinicalkey.com/pharmacology/. Accessed June 24, 2024.
6. Dejaco C, Singh YP, and Perel P et al. European League Against Rheumatism; American College of Rheumatology. 2015 recommendations for the management of polymyalgia rheumatica: a European League Against Rheumatism/American College of Rheumatology collaborative initiative. Arthritis Rheumatol. 2015 Oct;67(10):2569-80. doi: 10.1002/art.39333.
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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 and Research. 2019:71(6):717-734. DOI 10.1002/acr.23870.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created, adapted CP.PHAR.346 Sarilumab (Kevzara) for migration to HFS PDL.	1.14.2020	
2Q2021 Review Added criteria for RAPID3 assessment for RA given limited in-person visits during COVID-19 pandemic, updated appendices; added coding implications, References reviewed	4.13.2021	
2Q2022 annual review: references reviewed	4.27.2022	
2Q 2023 annual review: no significant changes; updated off-label dosing for Appendix B; template changes applied to other diagnoses/indications and continued therapy section; references reviewed and updated.	4.15.23	
2Q 2024 annual review: added Bimzelx, Zymfentra, Omvoh, Wezlana, Sotyktu, Tofidence, and Velsipity to section III.B; updated Appendix B; references reviewed and updated.	5.8.24	
2Q 2025 Annual Review: added PMR and newly approved polyarticular juvenile idiopathic arthritis indication; added preferred adalimumab products; references reviewed and updated.	4.14.25	

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.