Texas Prior Authorization Program
Clinical Criteria

Drug/Drug Class

Cytokine and CAM Antagonists

This criteria was recommended for review by the Texas Medicaid Vendor Drug Program to ensure appropriate and safe utilization

Clinical Criteria Information Included in this Document

Enspryng (satralizumab-mwge)

- **Drugs requiring prior authorization**: the list of drugs requiring prior authorization for this clinical criteria
- **Prior authorization criteria logic**: a description of how the prior authorization request will be evaluated against the clinical criteria rules
- **Logic diagram**: a visual depiction of the clinical criteria logic
- **Supporting tables**: a collection of information associated with the steps within the criteria (diagnosis codes, procedure codes, and therapy codes)
- **References**: clinical publications and sources relevant to this clinical criteria

Note: Click the hyperlink to navigate directly to that section.

Revision Notes

Initial publication and presentation to the DUR Board

Enspryng (satralizumab-mwge)

Drugs Requiring Prior Authorization

Enspryng	
Label Name	**GCN**
ENSPRYNG 120 MG/ML SYRINGE	48477

Enspryng (satralizumab-mwge)

Clinical Criteria Logic

1. Is the client greater than or equal to (≥) 18 years of age?
   [] Yes – Go to #2
   [] No – Deny

2. Does the client have a diagnosis of **neuromyelitis optica spectrum disorder (NMOSD)** in the last 730 days?
   [] Yes – Go to #3
   [] No – Deny

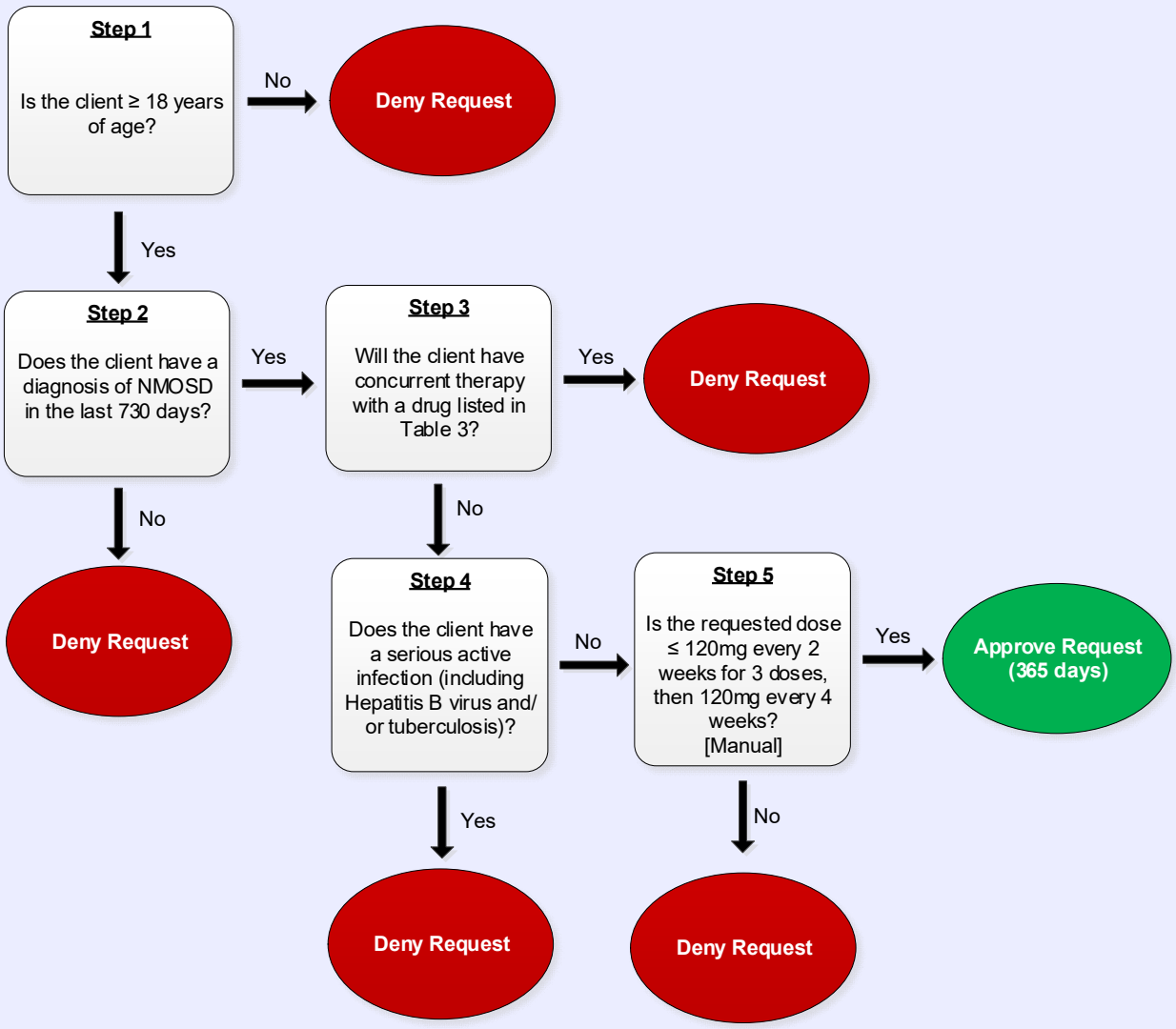
3. Will the client have **concurrent therapy** with a drug listed in Table 3?
   [] Yes – Deny
   [] No – Go to #4

4. Does the client have a **serious active infection** (including Hepatitis B virus and/or tuberculosis) in the last 180 days?
   [] Yes – Deny
   [] No – Go to #5

5. Is the requested dose less than or equal to (≤) 120mg every 2 weeks for 3 doses, then 120mg every 4 weeks? [Manual]
   [] Yes – Approve (365 days)
   [] No - Deny

Enspryng (satralizumab-mwge)

Clinical Criteria Logic Diagram



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Enspryng (satralizumab-mwge)

Clinical Criteria Supporting Tables

Step 2 (diagnosis of NMOSD) Required quantity: *1* Look back timeframe: *730 days*	
ICD-10 Code	**Description**
G360	NEUROMYELITIS OPTICA [DEVIC]

Step 3 (concurrent therapy) Required claims: *1*	
Label Name	**GCN**
ACTEMRA 162MG/0.9ML SYRINGE	35486
ACTEMRA ACTPEN 162 MG/0.9 ML	45082
AUBAGIO 14 MG TABLET	33262
AUBAGIO 7 MG TABLET	33259
AVONEX PEN 30 MCG/0.5 ML KIT	30222
AVONEX PREFILLED SYR 30 MCG KIT	20147
BAFIERTAM DR 95 MG CAPSULE	48156
BETASERON 0.3 MG KIT	98376
COPAXONE 20 MG/ML SYRINGE	17178
COPAXONE 40 MG/ML SYRINGE	35983
DIMETHYL FUMARATE 30D START PK	34433
DIMETHYL FUMARATE DR 120 MG CP	34434
DIMETHYL FUMARATE DR 240 MG CP	34435
EXTAVIA 0.3 MG KIT	98376
GILENYA 0.5 MG CAPSULE	29073
GLATIRAMER 20 MG/ML SYRINGE	17178
GLATIRAMER 40 MG/ML SYRINGE	35983
GLATOPA 20 MG/ML SYRINGE	17178
GLATOPA 40 MG/ML SYRINGE	35983
KESIMPTA 20 MG/0.4 ML PEN	48513
KEVZARA 150 MG/1.14 ML PEN INJ	44269
KEVZARA 150 MG/1.14 ML SYRINGE	43223
KEVZARA 200 MG/1.14 ML PEN INJ	44277
KEVZARA 200 MG/1.14 ML SYRINGE	43224

Step 3 (concurrent therapy) **Required claims:** *1*	
Label Name	**GCN**
MAYZENT 0.25 MG STARTER PACK	46135
MAYZENT 0.25 MG TABLET	46134
MAYZENT 2 MG TABLET	46133
MITOXANTRONE 20 MG/10 ML VL	07544
MITOXANTRONE 25 MG/12.5 ML VL	07544
MITOXANTRONE 30 MG/15 ML VL	07544
PLEGRIDY 125 MCG/0.5 ML PEN	36958
PLEGRIDY 125 MCG/0.5 ML SYRINGE	36948
PLEGRIDY PEN INJ STARTER PACK	36956
PLEGRIDY SYRINGE STARTER PACK	36947
REBIF 22 MCG/0.5 ML SYRINGE	15914
REBIF 44 MCG/0.5 ML SYRINGE	15918
REBIF REBIDOSE 22 MCG/0.5 ML	34167
REBIF REBIDOSE 44 MCG/0.5 ML	34168
REBIF REBIDOSE TITRATION PACK	34166
REBIF TITRATION PACK	24286
RITUXAN 100MG/10ML VIAL	70151
RITUXAN 500MG/50ML VIAL	70151
RUXIENCE 100MG/10ML VIAL	46734
RUXIENCE 500MG/50ML VIAL	46734
SOLIRIS 300MG/30ML VIAL	98255
TECFIDERA DR 120 MG CAPSULE	34434
TECFIDERA DR 240 MG CAPSULE	34435
TECFIDERA STARTER PACK	34433
TRUXIMA 100MG/10ML VIAL	45822
TRUXIMA 500MG/50ML VIAL	45822
UPLIZNA 100MG/10ML VIAL	48233
VUMERITY DR 230 MG CAPSULE	47209
ZEPOSIA 0.23-0.46 MG START PCK	47864
ZEPOSIA 0.23-0.46-0.92 MG KIT	47865
ZEPOSIA 0.92 MG CAPSULE	47863

Step 4 (serious active infection) **Required quantity:** *1* **Look back timeframe:** *180 days*	
ICD-10 Code	**Description**
B160	ACUTE HEPATITIS B WITH DELTA-AGENT WITH HEPATIC COMA

Step 4 (serious active infection) **Required quantity:** *1* **Look back timeframe:** *180 days*	
ICD-10 Code	**Description**
A150	TUBERCULOSIS OF LUNG
A154	TUBERCULOSIS OF INTRATHORACIC LYMPH NODES
A155	TUBERCULOSIS OF LARYNX, TRACHEA AND BRONCHUS
A156	TUBERCULOUS PLEURISY
A157	PRIMARY RESPIRATORY TUBERCULOSIS
A158	OTHER RESPIRATORY TUBERCULOSIS
A159	RESPIRATORY TUBERCULOSIS UNSPECIFIED
A170	TUBERCULOUS MENINGITIS
A171	MENINGEAL TUBERCULOMA
A1781	TUBERCULOMA OF BRAIN AND SPINAL CORD
A1782	TUBERCULOUS MENINGOENCEPHALITIS
A1783	TUBERCULOUS NEURITIS
A1789	OTHER TUBERCULOSIS OF NERVOUS SYSTEM
A179	TUBERCULOSIS OF NERVOUS SYSTEM, UNSPECIFIED
A1801	TUBERCULOSIS OF SPINE
A1802	TUBERCULOUS ARTHRITIS OF OTHER JOINTS
A1803	TUBERCULOSIS OF OTHER BONES
A1809	OTHER MUSCULOSKELETAL TUBERCULOSIS
A1810	TUBERCULOSIS OF GENITOURINARY SYSTEM UNSPECIFIED
A1811	TUBERCULOSIS OF KIDNEY AND URETER
A1812	TUBERCULOSIS OF BLADDER
A1813	TUBERCULOSIS OF OTHER URINARY ORGANS
A1814	TUBERCULOSIS OF PROSTATE
A1815	TUBERCULOSIS OF OTHER MALE GENITAL ORGANS
A1816	TUBERCULOSIS OF CERVIX
A1817	TUBERCULOUS FEMALE PELVIC INFLAMMATORY DISEASE
A1818	TUBERCULOSIS OF OTHER FEMALE GENITAL ORGANS
A182	TUBERCULOUS PERIPHERAL LYMPHADENOPATHY
A1831	TUBERCULOUS PERITONITIS
A1832	TUBERCULOUS ENTERITIS
A1839	RETROPERITONEAL TUBERCULOSIS
A184	TUBERCULOSIS OF SKIN AND SUBCUTANEOUS TISSUE
A1850	TUBERCULOSIS OF EYE UNSPECIFIED
A1851	TUBERCULOUS EPISCLERITIS
A1852	TUBERCULOUS KERATITIS
A1853	TUBERCULOUS CHORIORETINITIS
A1854	TUBERCULOUS IRIDOCYCLITIS

Step 4 (serious active infection) **Required quantity:** *1* **Look back timeframe:** *180 days*	
ICD-10 Code	**Description**
A1859	OTHER TUBERCULOSIS OF EYE
A186	TUBERCULOSIS OF (INNER) (MIDDLE) EAR
A187	TUBERCULOSIS OF ADRENAL GLANDS
A1881	TUBERCULOSIS OF THYROID GLAND
A1882	TUBERCULOSIS OF OTHER ENDOCRINE GLANDS
A1883	TUBERCULOSIS OF DIGESTIVE TRACT ORGANS, NOT ELSEWHERE CLASSIFIED
A1884	TUBERCULOSIS OF HEART
A1885	TUBERCULOSIS OF SPLEEN
A1889	TUBERCULOSIS OF OTHER SITES
A190	ACUTE MILIARY TUBERCULOSIS OF A SINGLE SPECIFIED SITE
A191	ACUTE MILIARY TUBERCULOSIS OF MULTIPLE SITES
A192	ACUTE MILIARY TUBERCULOSIS, UNSPECIFIED
A198	OTHER MILIARY TUBERCULOSIS
A199	MILIARY TUBERCULOSIS, UNSPECIFIED
B161	ACUTE HEPATITIS B WITH DELTA-AGENT WITHOUT HEPATIC COMA
B162	ACUTE HEPATITIS B WITHOUT DELTA-AGENT WITH HEPATIC COMA
B169	ACUTE HEPATITIS B WITHOUT DELTA-AGENT AND WITHOUT HEPATIC COMA
B180	CHRONIC VIRAL HEPATITIS B WITH DELTA-AGENT
B181	CHRONIC VIRAL HEPATITIS B WITHOUT DELTA-AGENT
B1910	UNSPECIFIED VIRAL HEPATITIS B WITHOUT HEPATIC COMA
B1911	UNSPECIFIED VIRAL HEPATITIS B WITH HEPATIC COMA
B440	INVASIVE PULMONARY ASPERGILLOSIS
B441	OTHER PULMONARY ASPERGILLOSIS
B447	DISSEMINATED ASPERGILLOSIS
B449	ASPERGILLOSIS, UNSPECIFIED
B59	PNEUMOCYSTOSIS
Z227	LATENT TUBERCULOSIS

Cytokine and CAM Antagonists

Clinical Criteria References

1. Clinical Pharmacology [online database]. Tampa, FL: Elsevier / Gold Standard, Inc. 2021. Available at http://www.clinicalpharmacology.com. Accessed on October 22, 2021.

2. 2021 ICD-10-CM Diagnosis Codes. Available at **http://www.icd10data.com/**. Accessed on October 222, 2021.

3. Enspryng Prescribing Information. South San Francisco, CA. Genentech, Inc. August 2020.

Publication History

The Publication History records the publication iterations and revisions to this document. Notes for the *most current revision* are also provided in the **Revision Notes** on the first page of this document.

Publication Date	Notes
10/22/2021	Initial publication and presentation to the DUR Board