Satralizumab-mwge (Enspryng™)

Goal(s):

- Restrict use to OHP funded conditions and according to OHP guidelines for use.
- Promote use that is consistent with national clinical practice guidelines and medical evidence.

Length of Authorization:

Up to 12 months

Requires PA:

- Enspryng™ (Satralizumab-mwge) (pharmacy and physician administered claims)

Covered Alternatives:

- Current PMPDP preferred drug list per OAR 410-121-0030 at www.orpdl.org
- Searchable site for Oregon FFS Drug Class listed at www.orpdl.org/drugs/

Approval Criteria		
1. What diagnosis is being treated?	Record ICD10 code.	
2. Is the diagnosis funded by OHP?	**Yes:** Go to #3	**No:** Pass to RPh. Deny; not funded by the OHP.
3. Is this request for continuation of therapy?	**Yes:** Go to **Renewal Criteria**	**No:** Go to # 4
4. Is the request for Neuromyelitis Optica Spectrum Disorder (NMOSD) in an adult who is anti-aquaporin-4 (AQP4) antibody positive?	**Yes:** Go to #5	**No:** Pass to RPh. Deny; medical appropriateness
5. Has the patient been screened for Hepatitis B and tuberculosis infection?	**Yes:** Go to #6	**No:** Pass to RPh. Deny; medical appropriateness
6. Does the patient have active Hepatitis B or untreated latent tuberculosis?	**Yes:** Pass to RPh. Deny; medical appropriateness	**No:** Approve for 12 months

Renewal Criteria		
1. Is there objective documentation of treatment benefit from baseline? Appropriate measures will vary by indication (e.g., hemoglobin stabilization, decreased transfusions, symptom improvement, functional improvement, etc.).	**Yes:** Approve for 12 months Document baseline assessment and physician attestation received.	**No:** Pass to RPh. Deny; medical appropriateness