

Satralizumab-mwge (Enspryng®)

Place of Service

Office Administration
Outpatient Facility Infusion Administration
Infusion Center Administration
Self-Administration – *May be covered under the pharmacy benefit*

HCPCS: J3590

NDC:

- 50242-007-01: 120 mg/mL single-dose prefilled syringe

Condition listed in policy (see criteria for details)

- [Neuromyelitis optica spectrum disorder \(NMOSD\)](#)

AHFS therapeutic class: Immunomodulatory agent

Mechanism of action: IL-6 receptor antagonist

(1) Special Instructions and pertinent Information

If member has a Prescription Benefit, please refer cases to Pharmacy Services for prior authorization.

If covered under the Medical Benefit, please submit clinical information for prior authorization review via fax. Please include medical rationale why medication cannot be home self-administered.

(2) Prior Authorization/Medical Review is required for the following condition(s)

All requests for satralizumab-mwge (Enspryng®) must be sent for clinical review and receive authorization prior to drug administration or claim payment.

Neuromyelitis optica spectrum disorder (NMOSD)

1. Prescribed by or in consultation with a neurologist, AND
2. Attestation of anti-aquaporin-4 (AQP4) antibody positivity

Covered Dose

Up to 120 mg SC at Weeks 0, 2, and 4, followed by maintenance of 120 mg SC every 4 weeks

Coverage Period

Indefinite

ICD-10:

G36.0

(3) The following condition(s) DO NOT require Prior Authorization/Preservice

All requests for satralizumab-mwge (Enspryng®) must be sent for clinical review and receive authorization prior to drug administration or claim payment.

(4) This Medication is NOT medically necessary for the following condition(s)

Coverage for a Non-FDA approved indication, requires that criteria outlined in Health and Safety Code § 1367.21, including objective evidence of efficacy and safety are met for the proposed indication.

Please refer to the Provider Manual and User Guide for more information.

(5) Additional Information

How supplied:

- 120 mg/mL single-dose prefilled syringe

(6) References

- AHFS®. Available by subscription at <http://www.lexi.com>
- DrugDex®. Available by subscription at <http://www.micromedexsolutions.com/home/dispatch>
- Enspryng® (satralizumab-mwge) [Prescribing information]. South San Francisco, CA. Genentech Inc.; 5/2021.

(7) Policy Update

Date of last review: 4Q2022

Date of next review: 4Q2023

Changes from previous policy version:

- No clinical change to policy following routine annual review.

*BSC Drug Coverage Criteria to Determine Medical Necessity
Reviewed by P&T Committee*