



Drug and Coverage Policy

Effective Date 5/1/2026

Coverage Policy NumberIP0078

Policy Title.....Enspryng

Enspryng

- Enspryng® (satralizumab-mwge subcutaneous injection – Genentech)

INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer’s particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer’s benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer’s benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see “Coding Information” below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

OVERVIEW

Enspryng, an interleukin-6 receptor antagonist, is indicated for the treatment of **neuromyelitis optica spectrum disorder** (NMOSD) in adults who are anti-aquaporin-4 antibody positive.¹

Disease Overview

NMOSD is a rare, relapsing, autoimmune disorder of the brain and spinal cord with optic neuritis and/or myelitis as predominant characteristic symptoms.² NMOSD often causes significant, permanent damage to vision and/or spinal cord function resulting in blindness or impaired mobility.³ Patients may experience pain, paralysis, loss of bowel and bladder control, loss of visual acuity, and uncontrolled motor functions. Complications can lead to death.

Recommendations

The Neuromyelitis Optica Study Group (NEMOS) published revised recommendations for the treatment of NMOSD in 2024.⁴ The standard of care for the treatment of NMOSD attacks (for both AQP4-IgG-positive and double-negative cases) are high-dose glucocorticoids and/or apheresis therapy. Long-term immunotherapy is recommended for patients with AQP4-IgG-positive NMOSD. NEMOS notes the first-choice therapies for the treatment of AQP4-IgG-positive NMOSD are Enspryng, eculizumab intravenous infusion (Soliris[®], biosimilars), Ultomiris[®] (ravulizumab-cwyz intravenous infusion), Uplizna[®] (inebilizumab-cdon intravenous infusion), and rituximab. The order of preference for these therapies is unclear and further comparative trials and real-world data are needed. The choice of treatment is dependent on several factors, including disease activity and severity, mode and onset of action, possibility to combine it with immunosuppressive drugs, effect on autoimmune and other comorbidities, gender (family planning issues), frequency and route of administration, side effect profile as well as patient and physician preference. In general, if a patient fails a first-choice treatment, another first-choice treatment should be tried; other options include use of a second-choice treatment (azathioprine, mycophenolate mofetil, low-dose oral glucocorticoids) or the addition of a second-choice treatment to the regimen.

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Enspryng. All approvals are provided for the duration noted below. Because of the specialized skills required for evaluation and diagnosis of patients treated with Enspryng as well as the monitoring required for adverse events and long-term efficacy, approval requires Enspryng to be prescribed by or in consultation with a physician who specializes in the condition being treated.

Coverage Policy

POLICY STATEMENT

Prior Authorization is required for benefit coverage of Enspryng. All approvals are provided for the duration noted below. Because of the specialized skills required for evaluation and diagnosis of patients treated with Enspryng as well as the monitoring required for adverse events and long-term efficacy, approval requires Enspryng to be prescribed by or in consultation with a physician who specializes in the condition being treated.

Documentation: Documentation is required where noted in the criteria as [**documentation required**]. Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information.

Enspryng is considered medically necessary when the following are met:

FDA-Approved Indication

- 1. Neuromyelitis Optica Spectrum Disorder.** Approve for the duration noted if the patient meets ONE of the following (A or B):
 - A) Initial Therapy.** Approve for 1 year if the patient meets ALL of the following (i, ii, and iii):
 - i.** Patient is \geq 18 years of age; AND

- ii. Diagnosis was confirmed by a positive blood serum test for anti-aquaporin-4 antibody **[documentation required]**; AND
 - iii. The medication is being prescribed by or in consultation with a neurologist.
- B) Patient is Currently Receiving Enspryng.** Approve for 1 year if the patient meets ALL of the following (i, ii, iii, and iv):
- i. Patient is \geq 18 years of age; AND
 - ii. Diagnosis was confirmed by a positive blood serum test for anti-aquaporin-4 antibody; AND
 - iii. According to the prescriber, patient has had clinical benefit from the use of Enspryng; AND
Note: Examples of clinical benefit include reduction in relapse rate, reduction in symptoms (e.g., pain, fatigue, motor function), and a slowing in progression of symptoms.
 - iv. The medication is being prescribed by or in consultation with a neurologist.

Conditions Not Covered

Enspryng for any other use is considered not medically necessary, including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

1. **Concomitant Use with a Rituximab Product, eculizumab intravenous infusion (Soliris, biosimilars), Ultomiris (ravulizumab-cwvz intravenous infusion), or Uplizna (inebilizumab-cdon intravenous infusion).** There is no evidence to support concomitant use of Enspryng with rituximab, eculizimab, Ultomiris, or Uplizna.

References

1. Enspryng® subcutaneous injection [prescribing information]. South San Francisco, CA: Genentech; March 2022.
2. National Organization for Rare Disorders. Neuromyelitis Optica Spectrum Disorder. Updated July 2022. Available at: <https://rarediseases.org/rare-diseases/neuromyelitis-optica/>. Accessed April 1, 2026.
3. Wingerchuk DM, Banwell B, Bennett JL, et al. International consensus diagnostic criteria for neuromyelitis optica spectrum disorders. *Neurology*. 2015;85(2):177-189.
4. K umpfel T, Giglhuber K, Aktas O, et al. Update on the diagnosis and treatment of neuromyelitis optica spectrum disorders (NMOSD) – revised recommendations of the Neuromyelitis Optica Study Group (NEMOS). Part II: Attack therapy and long-term management. *J Neurol*. 2024;271:141-176.

Revision Details

Summary of Changes	Review Date	Effective Date
Neuromyelitis Optica Spectrum Disorder. Added criteria for 'Patient is Currently Receiving Enspryng'	5/23/2024	8/1/2024
Conditions Not Covered. Added Ultomiris to no concomitant use statement as 'Concomitant Use with a Rituximab Product, Soliris		

(eculizumab intravenous infusion), Ultomiris (ravulizumab-cwvz intravenous infusion), or Uplizna (inebilizumab-cdon intravenous infusion) Title change from Satralizumab-mwge.		
No change to criteria.	4/17/2025	7/1/2025
Added "<u>Documentation</u>:" Documentation is required where noted in the criteria as [documentation required] . Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information." Added "[documentation required]" to the following criteria: Diagnosis was confirmed by a positive blood serum test for anti-aquaporin-4 antibody	6/12/2025	8/15/2025
Updated policy template.	10/2/2025	11/1/2025
No criteria changes.	4/16/2026	5/1/2026

The policy effective date is in force until updated or retired.

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