Generic Name: N/A

Therapeutic Class or Brand Name: Multiple Sclerosis Agents

Applicable Drugs (if Therapeutic Class): Avonex® (interferon beta-1a), Aubagio® (teriflunomide), Bafiertam™ (monomethyl fumarate), Betaseron®(interferon beta-1b), Briumvi®(Ublituximab), Copaxone® (glatiramer), Extavia® (interferon beta-1b), Gilenya® (fingolimod), Glatopa™(glatiramer), Kesimpta® (ofatumumab), Lemtrada® (alemtuzumab), Mavenclad® (cladribine), Mayzent® (siponimod), Ocrevus™ (ocrelizumab), Ocrevus Zunovo (ocrelizumab and hyaluronidase injection), Plegridy®(peginterferon beta-1a), Ponvory® (ponesimod), Rebif® (interferon beta-1a), Tecfidera® (dimethyl fumarate), Tysabri® (natalizumab), Vumerity™ (diroximel fumarate), Zeposia® (ozanimod)

Preferred: Avonex® (interferon beta-1a), Betaseron® (interferon beta-1b), dimethyl fumarate (generic), fingolimod (generic), glatiramer (generic), Kesimpta® (ofatumumab), Mayzent® (siponimod), Plegridy® (peginterferon beta-1a), teriflunomide (generic), Vumerity™ (diroximel fumarate), Zeposia® (ozanimod)

Non-preferred: Aubagio® (teriflunomide), Bafiertam™ (monomethyl fumarate), Briumvi®(Ublituximab), Copaxone®(glatiramer), Extavia® (interferon beta-1b), Gilenya® (fingolimod), Glatopa™ (glatiramer), Lemtrada® (alemtuzumab), Mavenclad® (cladribine), Ocrevus™(ocrelizumab), Ocrevus Zunovo (ocrelizumab and hyaluronidase injection), Ponvory® (ponesimod), Rebif® (interferon beta-1a), Tecfidera® (dimethyl Fumarate), Tysabri® (natalizumab)

Date of Origin: 5/26/2020

Date Last Reviewed / Revised: 10/15/2024

PRIOR AUTHORIZATION CRITERIA

(May be considered medically necessary when criteria I-VI are met)

I. Documented diagnosis of multiple sclerosis AND the requested medication is used for an FDA-approved indication, or use is supported by current clinical practice guidelines. Refer to Table 1 for medication specific criteria.

II. The patient meets specific criteria listed for the requested medication in Table 1.

III. If request is for a non-preferred agent, must have a documented trial and failure of, intolerance, or contraindication to two preferred products (refer to plan document for the list of preferred products).

IV. Treatment must be prescribed by or in consultation with a neurologist or a multiple sclerosis physician specialist.

V. The patient has no known contraindication to the requested agent.

VI. Refer to the plan document for the list of preferred products. If the request is for a brand medication for which a generic is available, there must be a documented treatment failure or contraindication to the generic medication.

EXCLUSION CRITERIA

- Coadministration of any multiple sclerosis agent with any other disease-modifying therapy for the treatment of multiple sclerosis therapy.
- For Gilenya, Mayzent, Ponvory and Zeposia, the patient has no myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III or IV heart failure in the last 6 months.
- Medication specific treatment exclusion as noted in Table 1.

OTHER CRITERIA

- Table 1

Agents	Medication Specific Criteria	Dosing Limits
Injectable and Infusions Agents		
Avonex® (interferon beta-1a)	○ CIS, RRMS, SPMS ○ ≥ 18 years	30 mcg IM once per week (4 injections per 28 days)
Betaseron®, Extavia® (interferon beta-1b)	○ CIS, RRMS, SPMS ○ ≥ 18 years	0.25 mg SC every other day (14 injections per 28 days)
Briumvi®(Ublituximab)	○ CIS, RRMS, SPMS ○ ≥ 18 years ○ Must be screened for Hep B and does not have an active Hepatitis B infection ○ All necessary immunizations administered 6 weeks prior to treatment initiation ○ Serum immunoglobulin screening completed	150mg on day 1, followed by 450mg two weeks later, subsequent dose of 450mg administered once every 24 weeks thereafter
Copaxone®, Glatopa® (glatiramer)	○ CIS, RRMS, SPMS ○ ≥ 18 years ○ Baseline ophthalmic examination is completed ○	20 mg SC once daily (30 injections per 30 days) or 40 mg SC 3 times per week (12 injections per 28 days)
Kesimpta® (ofatumumab)	○ CIS, RRMS, SPMS ○ ≥ 18 years	Loading: 20 mg administered at Week 0, 1, and 2

	○ Must be screened for Hepatitis B and does not have an active Hepatitis B infection ○ Serum immunoglobulin screening completed ○ Must not be pregnant or plan to become pregnant	Maintenance: 20 mg SC monthly starting at week 4
Lemtrada® (alemtuzumab)	○ RRMS, SPMS ○ ≥ 18 years ○ Must not be infected with HIV ○ CBC and serum creatinine levels ○ History of varicella OR has had the varicella-zoster vaccination OR has evidence of immunity (positive antibodies) ○ All necessary immunizations administered 6 weeks prior to treatment initiation	12 mg/day IV on 5 consecutive days (total 60 mg) then 12 mg IV daily for 3 consecutive days (total 36 mg)12 months later
Ocrevus™ (ocrelizumab), Ocrevus Zunovo™ (ocrelizumab and hyaluronidase injection)	○ PPMS, CIS, RRMS, SPMS ○ ≥ 18 years ○ Must be screened for Hep B and does not have an active Hepatitis B infection ○ All necessary immunizations administered 6 weeks prior to treatment initiation ○ Serum immunoglobulin screening completed	Ocrevus™: 300 mg IV on day 1, followed by 300 mg IV 2 weeks later, subsequent doses of 600 mg IV are administered once every 6 months (beginning 6 months after the first 300 mg dose) Ocrevus Zunovo™: 920 mg/23,000 units (920 mg ocrelizumab and 23,000 units of hyaluronidase) subcutaneous in the abdomen every 6 months.
Plegridy® (peginterferon beta-1a)	○ CIS, RRMS, SPMS ○ ≥ 18 years	Loading: 63 mcg SC on day 1, 94 mcg SC on day 15, then 125 mcg SC on day 29 Maintenance: 2 injections per 28 days.

Rebif® (interferon beta-1a)	○ CIS, RRMS, SPMS ○ ≥ 18 years	44 mcg SC 3 times per week (12 injections per 28 days)
Tysabri® (natalizumab)	○ CIS, RRMS, SPMS ○ ≥ 18 years ○ Must be evaluated for anti-JCV (John Cunningham virus) antibody test (ELISA [enzyme-linked immunosorbent assay])	300 mg IV infusion every 4 weeks
Oral Agents		
Aubagio® (neriflunomide)	○ CIS, RRMS, SPMS ○ ≥ 18 years ○ Must not be pregnant ○ Must be screened for TB and does not have an active or latent TB ○ Will not be used with leflunomide ○ Must not have hepatic impairment (baseline LFT, bilirubin levels), and CBC completed	7 or 14 mg orally once daily (30 tablets per 30 days)
Bafiertam™ (monomethyl fumarate)	○ CIS, RRMS, SPMS ○ ≥ 18 years ○ Must not have hepatic impairment (baseline LFT, bilirubin levels) ○ Lymphocyte count, and CBC completed	190 mg twice a day (120 capsules of 95 mg capsule per 30 days)
Gilenya® (fingolimod)	○ CIS, RRMS, SPMS ○ ≥ 10 years ○ Baseline LFT, bilirubin levels, and CBC must be completed ○ Must be screened for TB and does not have an active or latent TB ○ Baseline EKG is completed ○ Baseline ophthalmic examination is completed ○ Evidence of varicella-zoster vaccination, history of chickenpox, or evidence of immunity ○ There is no acute or chronic infection ○ Must not be pregnant or plan to become pregnant	30 capsules per 30 days Adults: 0.5 mg orally once daily Pediatric: ≥10 years of age and ≤40 kg: 0.25 mg orally once daily ≥10 years of age and >40 kg: 0.5 mg orally once daily

Mavenclad® (cladribine)	○ RRMS, SPMS ○ ≥ 18 years ○ Patient does not have a current malignancy ○ Patient does not have clinically isolated syndrome ○ Must not be pregnant or plan to become pregnant ○ All necessary immunizations administered 4-6 weeks prior to treatment initiation ○ Must have documented treatment failure or contraindication to all the preferred product(s) ○	3.5 mg/kg orally over a 2-year treatment course, administered as 1.75 mg/kg in each year, no more than 20 mg per day
Mayzent® (siponimod)	○ CIS, RRMS, SPMS ○ ≥ 18 years ○ Baseline LFT, bilirubin levels, and CBC must be completed ○ Must be screened for TB and does not have an active or latent TB ○ Baseline ECG is completed ○ Baseline ophthalmic examination is completed ○ Evidence of varicella-zoster vaccination, history of chickenpox, or evidence of immunity ○ There is no acute or chronic infection ○ Must not be pregnant or plan to become pregnant	CYP2C9 Genotype *1/*1, *1/*2, or *2/*2: 0.25 mg orally once daily on Days 1 and 2, then 0.5 mg once daily on Day 3, then 0.75 mg once daily on Day 4, then 1.25 mg once daily on Day 5, then 2 mg once daily, beginning on Day 6 CYP2C9 Genotype *1/*3 or *2/*3: 0.25 mg orally once daily on Days 1 and 2, then 0.5 mg once daily on Day 3, then 0.75 mg once daily on Day 4, then 1 mg once daily, beginning on Day 5
Ponvory® (ponesimod)	○ CIS, RRMS, SPMS ○ ≥ 18 years ○ Baseline LFT, bilirubin levels, and CBC must be completed ○ Must be screened for TB and does not have an active or latent TB ○ Baseline ECG is completed ○ Baseline ophthalmic examination is completed	Initial Dosage: One Ponvory® Starter Pack (14 tablets per 14 days) Maintenance: 20 mg once daily (30 tablets per 30 days)

	○ Evidence of varicella-zoster vaccination, history of chickenpox, or evidence of immunity ○ There is no acute or chronic infection ○ Must not be pregnant or plan to become pregnant	
Tecfidera® (dimethyl fumarate)	○ CIS, RRMS, SPMS ○ ≥ 18 years	240 mg orally twice daily (60 capsules per 30 days)
Vumerity™ (diroximel fumarate)	○ CIS, RRMS, SPMS ○ ≥ 18 years ○ Baseline LFT, bilirubin levels, and CBC must be completed ○ Treatment failure or contraindication to generic Tecfidera (dimethyl fumarate)	462 mg orally twice daily (120 capsules per 30 days)
Zeposia® (ozanimod)	○ CIS, RRMS, SPMS ○ ≥ 18 years ○ Baseline LFT, bilirubin levels, and CBC must be completed ○ Must be screened for TB and does not have an active or latent TB ○ Baseline ECG is completed ○ Baseline ophthalmic examination is completed ○ Evidence of varicella-zoster vaccination, history of chickenpox, or evidence of immunity ○ There is no acute or chronic infection ○ Must not be pregnant or plan to become pregnant ○ Patient has no history of severe sleep apnea	0.92 mg once daily (30 capsules per 30 days)

IV: intravenously. SC: subcutaneously. IM: intramuscularly. LFT: liver function test. CBC: complete blood count. ECG: electrocardiogram. TB: tuberculosis.
CIS: clinically isolated syndrome.
PPMS: primary progressive multiple sclerosis.
RRMS: relapsing-remitting multiple sclerosis. SPMS: secondary progressive multiple sclerosis.

Quantity / Days Supply Restrictions

- Requested quantities not exceeding dosing limits listed in Table 1.

Approval Length

- **Authorization:** 1 year.
- **Re-Authorization:** An updated letter of medical necessity or progress notes showing that current medical necessity criteria are met and that the medication is effective. NOTE: Lemtrada® will not be authorized for more than a total of 2 treatment courses.
    - All required drug safety monitoring for the requested medication listed in Table 1 has been completed.

Appendix

N/A

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