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), Copaxone® (glatiramer), Extavia® (interferon beta-1b), Gilenya® (Fingolimod), Glatopa™(glatiramer), Kesimpta® (Ofatumumab), Lemtrada® (alemtuzumab), Mavenclad® (cladribine), Mayzent® (siponimod), Ocrevus™ (ocrelizumab), Plegridy®(peginterferon beta-1a), Rebif® (interferonbeta-1a), Tecfidera® (Dimethyl Fumarate), Tysabri® (natalizumab), Vumerity™ (diroximel fumarate), Zeposia® (ozanimod)

GPI Code: 6240003010, 6240407000, 6240306045, 6240306050, 6240307530, 6240702510, 6240501000, 6240502500, 6240552500, 6240506000, 6240505000, 6240705020, 6240555000, 6240553000, 6240707020, 6240101500

Preferred: Avonex® (interferon beta-1a), Betaseron® (interferon beta-1b), Dimethyl Fumarate (generic), Glatiramir (generic), Plegridy® (peginterferon beta-1a), Vumerity™ (diroximel fumarate), Zeposia® (ozanimod)

Non-preferred: Aubagio® (Teriflunomide), Bafiertam™ (Monomethyl Fumarate), Copaxone®(glatiramer), Extavia® (interferon beta-1b), Gilenya® (Fingolimod), Glatopa™ (glatiramer), Kesimpta® (Ofatumumab), Lemtrada® (alemtuzumab), Mavenclad® (cladribine), Mayzent® (siponimod), Ocrevus™(ocrelizumab), Rebif® (interferon beta-1a), Tecfidera® (Dimethyl Fumarate), Tysabri® (natalizumab)

Date of Origin: 5/26/2020

Date Last Reviewed / Revised: 12/4/2020

PRIOR AUTHORIZATION CRITERIA

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

I. Documented diagnosis of a relapsing form of multiple sclerosis, including relapsing-remitting disease (RRMS), or active secondary progressive disease (SPMS), OR an indication noted in the individual medication specific criteria listed in Table 1.

II. The patient meets individual medication 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. Prescribing physician must be a neurologist or a multiple sclerosis physician specialist.

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

EXCLUSION CRITERIA

- Coadministration of any multiple sclerosis agent with any other disease-modifying therapy for the treatment of multiple sclerosis therapy.
- Individual agent 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)	o CIS, RRMS, SPMS o ≥ 18 years	30 mcg IM once per week (4 injections per 28 days)
Betaseron®, Extavia® (Interferon Beta-1b)	o CIS, RRMS, SPMS o ≥ 18 years	0.25 mg SC every other day (14 injections per 28 days)
Copaxone®, Glatopa® (Glatiramer)	o CIS, RRMS, SPMS o ≥ 18 years	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)	o CIS, RRMS, SPMS o ≥ 18 years o Must be screened for Hep B and does not have an active Hepatitis B infection o Must not be pregnant or plan to become pregnant o Serum immunoglobulin screening completed	Loading: 20 mg administered at Week 0, 1, and 2 Maintenance: 20 mg SC monthly
Lemtrada® (Alemtuzumab)	o RRMS, SPMS o ≥ 18 years o Must not be infected with HIV o History of varicella OR has had the varicella-zoster vaccination OR has evidence of immunity (positive antibodies) o CBC and serum creatinine levels o All necessary immunizations administered 6 weeks prior to treatment initiation	12 mg/day IV on 5 consecutive days (total 60 mg) followed 12 months later by 12 mg IV daily for 3 consecutive days (total 36 mg)

Ocrevus™ (Ocrelizumab)	o PPMS, CIS, RRMS, SPMS o ≥ 18 years o Must be screened for Hep B and does not have an active Hepatitis B infection o All necessary immunizations administered 6 weeks prior to treatment initiation	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)
Plegridy® (Peginterferon Beta-1a)	o CIS, RRMS, SPMS o ≥ 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)	o CIS, RRMS, SPMS o ≥ 18 years	44 mcg SC 3 times per week (12 injections per 28 days)
Tysabri® (Natalizumab)	o CIS, RRMS, SPMS o ≥ 18 years o 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® (Teriflunomide)	o CIS, RRMS, SPMS o ≥ 18 years o Must not be pregnant o Must be screened for TB and does not have an active or latent TB o Will not be used with leflunomide o Must not have hepatic impairment (baseline LFT, bilirubin levels, and CBC completed)	14 mg orally once daily (30 tablets per 30 days)
Bafiertam™ (Monomethyl Fumarate)	o CIS, RRMS, SPMS o ≥ 18 years o 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)	o CIS, RRMS, SPMS o ≥ 10 years o Baseline LFT, bilirubin levels, and CBC must be completed o Baseline electrocardiogram (EKG) is completed o Baseline ophthalmic examination is completed o Evidence of varicella-zoster vaccination, history of chickenpox, or evidence of immunity o 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)	o RRMS, SPMS o ≥ 18 years o Must not be pregnant or plan to become pregnant o Patient does not have a current malignancy o Patient does not have clinically isolated syndrome o All necessary immunizations administered 4-6 weeks prior to treatment initiation	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)	o CIS, RRMS, SPMS o ≥ 18 years o Evidence of varicella-zoster vaccination, history of chickenpox, or evidence of immunity o Baseline LFT, bilirubin levels, and CBC must be completed	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

Tecfidera® (Dimethyl Fumarate)	o CIS, RRMS, SPMS o ≥ 18 years	240 mg orally twice daily (60 capsules per 30 days)
Vumerity™ (Diroximel Fumarate)	o CIS, RRMS, SPMS o ≥ 18 years o Baseline LFT, bilirubin levels, and CBC must be completed	462 mg orally twice daily (60 capsules per 30 days)
Zeposia® (ozanimod)	o CIS, RRMS, SPMS o ≥ 18 years o Evidence of varicella-zoster vaccination, history of chickenpox, or evidence of immunity o Baseline LFT, bilirubin levels, and CBC must be completed o Patient has no history of severe sleep apnea o Baseline electrocardiogram (ECG) is completed o Ophthalmologic examination completed	0.92 mg once daily (30 capsules per 30 days)
IV: intravenously. SC: subcutaneously. IM: intramuscularly. LFT: liver function test. CBC: complete blood count CIS: clinically isolated syndrome. RRMS: relapsing-remitting multiple sclerosis. SPMS: secondary progressive multiple sclerosis. PPMS: primary 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 been completed.

APPENDIX

N/A

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