Pharmacy Medical Necessity Guidelines: Multiple Sclerosis Agents

Effective: January 1, 2021

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	Oral: RX IV: MED	Department to Review	RxUM/ MM

These pharmacy medical necessity guidelines apply to the following:

Commercial Products

☐ Tufts Health Plan Commercial products – large group plans
☐ Tufts Health Plan Commercial products – small group and individual plans
☐ Tufts Health Freedom Plan products – large group plans
☐ Tufts Health Freedom Plan products – small group plans
- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Tufts Health Public Plans Products

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
☐ Tufts Health RITogether – A Rhode Island Medicaid Plan

Fax Numbers:
Intravenous medications:
MM: 888.415.9055

Self-administered formulations (oral):
RxUM:617.673.0988

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

FOOD AND DRUG ADMISTRATION-APPROVED INDICATIONS

Aubagio (teriflunomide) is indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.

Gilenya (fingolimod) is indicated for the treatment of relapsing forms of MS, to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in patients 10 years of age and older.

Glatopa (glatiramer) is indicated for the treatment of relapsing forms of MS, to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.

Lemtrada (alemtuzumab) is indicated for the treatment of patients with relapsing forms of MS. Because of its safety profile, the use of Lemtrada should generally be reserved for patients who have had an inadequate response to two or more drugs indicated for the treatment of MS.

Mavenclad (cladribine) is indicated for the treatment of relapsing forms of MS, to include relapsing-remitting disease and active secondary progressive disease, in adults. Because of its safety profile, use of Mavenclad (cladribine) is generally recommended for patients who have had an inadequate response to, or are unable to tolerate, an alternate drug indicated for treatment of MS.

Mayzent (siponimod) is indicated for the treatment of relapsing forms of MS, to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.

Ocrevus (ocrelizumab) is indicated for the treatment of patients with relapsing or primary progressive forms of multiple sclerosis.

Tecfidera (dimethyl fumarate) is indicated for the treatment of relapsing forms of MS, to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.

Zeposia (ozanimod) is indicated for the treatment of relapsing forms of MS, to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.

COVERAGE GUIDELINES

Aubagio (teriflunomide), Gilenya (fingolimod), and Tecfidera (dimethyl fumarate)

The plan may authorize coverage of Aubagio, Gilenya, or Tecfidera for Members, when the following criteria are met:

1. Documented diagnosis of **one (1)** of the following:
    a. Clinically isolated syndrome
    b. Relapse-remitting multiple sclerosis
    c. Active secondary-progressive multiple sclerosis

AND

2. Prescribed by or in consultation with a neurologist

Glatopa (glatiramer)

The plan may authorized coverage of Glatopa for Members, when the following criteria are met:

1. Documentation of **one (1)** of the following:
    a. Previous trial of Copaxone
    b. Clinical rationale for prescribing Glatopa

Lemtrada (alemtuzumab)

The plan may authorize coverage of Lemtrada for Members, when the following criteria are met:

1. Documented diagnosis of relapsing multiple sclerosis

AND

2. Prescribed by or in consultation with a neurologist

AND

3. Documentation of **one (1)** of the following:
    a. Inadequate response or adverse reaction to **two (2)** or contraindication to all of the following:
        i. Aubagio
        ii. Gilenya
        iii. glatiramer acetate therapy
        iv. interferon therapy
        v. Ocrevus
        vi. Tecfidera
    b. Member is new to the plan and stable on Lemtrada

Mavenclad (cladribine)

The plan may authorize coverage of Mavenclad for Members, when the following criteria are met:

1. Documented diagnosis of relapsing multiple sclerosis

AND

2. Prescribed by or in consultation with a neurologist

AND

3. The Member is at least 18 years of age

AND

4. Documentation of **one (1)** of the following:
    a. Inadequate response or adverse reaction to **two (2)** or contraindication to all of the following:
        i. Aubagio
        ii. Gilenya
        iii. glatiramer acetate therapy
        iv. interferon therapy
        v. Ocrevus
        vi. Tecfidera
    b. Member is new to the plan and stable on Mavenclad

Mayzent (siponimod) and Zeposia (ozanimod)

The plan may authorize coverage of Mayzent or Zeposia for Members, when the following criteria are met:

1. Documented diagnosis of **one (1)** of the following:
    a. Clinically isolated syndrome

b. Relapse-remitting multiple sclerosis
c. Active secondary-progressive multiple sclerosis

AND

2. Prescribed by or in consultation with a neurologist

AND

3. Documentation of one (1) of the following:
    a. Inadequate response or adverse reaction to **two (2)** or contraindication to **all** the following:
        i. Aubagio
        ii. Gilenya
        iii. glatiramer acetate therapy
        iv. interferon therapy
        v. Ocrevus
        vi. Tecfidera
    b. Member is new to the plan and stable on Mayzent/Zeposia

AND

4. If the request is for Mayzent, documentation of genetic testing confirming Member does not have a CYP2C9 *3/*3 genotype

Ocrevus (ocrelizumab)

The plan may authorize coverage of Ocrevus for Members, when the following criteria are met:

1. Documented diagnosis of **one (1)** of the following:
    a. Primary progressive multiple sclerosis
    b. Relapsing multiple sclerosis

AND

2. Prescribed by or in consultation with a neurologist

LIMITATIONS

1. Aubagio and Gilenya have a quantity limit of 30 units per 30 days.
2. Mavenclad has a quantity limit of 10 units per month.
3. Mayzent has a quantity limit of 120 units per 30 days for 0.25 mg tablet and 30 units per 30 days for 2 mg tablet.
4. Tecfidera has a quantity limit of 60 units per 30 days.
5. The plan does not cover the following medications: Bafiertam, dimethyl fumarate, fingolimod, glatiramer acetate and Vumerity. Refer to the Pharmacy Medical Necessity Guidelines for Non-covered Pharmacy Products.

CODES

The following HCPCS/CPT code(s) are:

Code	Description
J0202	Injection, alemtuzumab, 1 mg
J2350	Injection, ocrelizumab, 1 mg

REFERENCES

1. Aubagio (teriflunomide) [prescribing information]. Cambridge, MA: Genzyme Corporation; February 2020.
2. Gilenya (fingolimod) [prescribing information]. Stein, Switzerland: Novartis Pharma Stein AG; December 2019.
3. Glatopa (glatiramer) [prescribing information]. Princeton, NJ: Sandoz Inc.; July 2020.
4. Goodin DS, Frohman EM, Garman GP et al. Disease-modifying therapies in multiple sclerosis: report of the therapeutics and technology assessment subcommittee of the American Academy of Neurology and the MS Council for Clinical Practice Guidelines. *Neurology*. 2002; 58:169-78.
5. Harrison DM. In the clinic. Multiple sclerosis. *Ann Intern Med*. 2014; 160(7):ITC4-2-ITC4-18.
6. Lublin FD, Reingold SC, Cohen JA et al. Defining the clinical course of multiple sclerosis: the 2013 revisions. *Neurology*. 2014; 83: 278-86.
7. Mavenclad (cladribine) [prescribing information]. Rockland, MA: EMD Serono, Inc.; 2019 March.
8. Mayzent (siponimod) [prescribing information]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; July 2020.
9. National Institute for Health and Care Excellence (NICE). Ocrelizumab for treating primary progressive multiple sclerosis [ID938]. 2017a January. URL:

nice.org.uk/guidance/indevelopment/gid-ta10153. Available from Internet. Accessed 2017 March 16.
10. National Institute for Health and Care Excellence (NICE). Ocrelizumab for treating relapsing multiple sclerosis [ID937]. 2017b January. URL: nice.org.uk/guidance/indevelopment/gid-ta10152. Available from Internet. Accessed 2017 March 16.
11. National Multiple Sclerosis Society. Changing therapy in relapsing multiple sclerosis: considerations and recommendations of a task force of the National Multiple Sclerosis Society. 2004. Available on the Internet. URL: nationalmssociety.org/NationalMSSociety/media/MSNationalFiles/Brochures/Clinical_Bulletin_Changing-Therapy-in-Relapsing-MS.pdf. Accessed 2018 December 24.
12. Ocrevus (ocrelizumab) [prescribing information]. South San Francisco, CA: Genentech Inc.; 2018 November.
13. Rae-Grant A, Day GS, Marrie RA, et al. Practice guideline recommendations summary: Disease-modifying therapies for adults with multiple sclerosis. Neurology. 2018 April;90(17):777-88.
14. Ryan M, Deno S, Zwibel HL. Review of the clinical debate regarding interventions for multiple sclerosis. *JMCP*. 2009; 15(1):S2-17.
15. Scolding N, Barnes D, Cader S et al. Association of British neurologists: revised (2015) guidelines for prescribing disease-modifying treatments in multiple sclerosis. *Pract Neurol.* 2015; 15(4):273-9.
16. Tecfidera (dimethyl fumarate) [prescribing information]. Cambridge, MA: Biogen Inc.; February 2020.
17. Wingerchuk DM, Weinshenker BG. Disease modifying therapies for relapsing multiple sclerosis. *BMJ.* 2016; 354: i3518.
18. Zeposia (ozanimod) [prescribing information]. Summit, NJ: Celgene Corporation; March 2020.

APPROVAL HISTORY

September 12, 2017: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

1. October 1, 2017: Administrative update: Added new C code (C9494) to Medical Necessity Guideline.
2. January 1, 2018: Administrative update: Added new J code J2350 to the Medical Necessity Guideline and removed expired C code C9494.
3. January 9, 2018: Added exception language for Members new to the plan and stable on Ocrevus (ocrelizumab) prior to enrollment.
4. August 7, 2018: For relapsing multiple sclerosis, removed the requirement of a documented inadequate response, contraindication or inability to tolerate an appropriate trial with at least two other disease modifying therapies. Updated relapsing multiple sclerosis criteria to require at least one of the following: The Member is newly diagnosed with relapsing multiple sclerosis; the Member is disease modifying therapy naïve; the Member's current, or previous, disease modifying therapy does not adequately control the disease as evidenced by disease progression or the Member is experiencing intolerable adverse events; or the Member is new to the plan and stable on Ocrevus (ocrelizumab).
5. January 8, 2019: No changes.
6. April 14, 2020: Effective May 1, 2020, retire Medical Necessity Guideline for Tufts Health Plan Commercial Products (including Tufts Health Freedom) and Tufts Health Direct. Effective May 1, 2020, removed limited duration of approval rules and, for relapsing forms of multiple sclerosis, removed documentation of one of the following: The Member is newly diagnosed with relapsing multiple sclerosis; the Member is disease modifying therapy naïve; the Member's current, or previous, disease modifying therapy does not adequately control the disease as evidenced by disease progression or the Member is experiencing intolerable adverse events; or the Member is new to the plan and stable on Ocrevus (ocrelizumab). Removed the following Limitation: "Tufts Health Commercial Plans, Tufts Health Freedom Plan products, Tufts Health Direct, and Tufts Health RITogether do not consider Ocrevus (ocrelizumab) to be a self-administered medication. Ocrevus (ocrelizumab) may be covered under the medical benefit only.
7. November 24, 2020: Effective January 1, 2021, updated Medical Necessity Guideline to therapeutic class "Multiple Sclerosis Agents" for implementation of MassHealth ACPP/MCO Partial Unified Formulary. Added Aubagio, Gilenya, Glatopa, Mayzent, Tecfidera, and Zeposia to the Medical Necessity Guideline with new coverage criteria. Existing coverage criteria for Mavenclad added to Medical Necessity guideline (previous ID: 2295438) and updated to remove reauthorization criteria, added the Multiple Sclerosis Agents prerequisite criteria, and updated the

stability language to "Member is new to the plan and stable on Mavenclad", and removed the Limitation "The plan will not authorize Mavenclad (cladribine) for the treatment of clinically isolated syndrome." Existing coverage criteria for Lemtrada added to Medical Necessity Guideline (previous ID: 2295438) and updated to remove Tysabri from prerequisite options and updated the stability language to "Member is new to the plan and stable on Lemtrada." Removed the following Limitation for Lemtrada and Ocrevus "The plan will not approve Lemtrada/Ocrevus when used in conjunction with other disease-modifying medications for the treatment of multiple sclerosis." Updated provider specialty requirements to "Prescribed by or in consultation with a neurologist" for all Multiple Sclerosis Agents. Removed Tufts Health RITogether from Medical Necessity Guideline, Lemtrada and Ocrevus coverage criteria moved to Multiple Sclerosis Agents (ID: 2295438).

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.