Multiple Sclerosis

**BENEFIT APPLICATION**

Benefit determinations are based on the applicable contract language in effect at the time the services were rendered. Exclusions, limitations or exceptions may apply. Benefits may vary based on contract, and individual member benefits must be verified. Wellmark determines medical necessity only if the benefit exists and no contract exclusions are applicable. This policy may not apply to FEP. Benefits are determined by the Federal Employee Program.

**DESCRIPTION**

The intent of the Multiple Sclerosis drug policy is to ensure appropriate selection of patients for therapy based on product labeling, clinical guidelines and clinical studies while steering utilization to the most cost-effective medication within the therapeutic class. For this program, Betaseron, Rebif, Copaxone, Glatopa, Gilenya, Tecfidera and Aubagio are the preferred products. The criteria will require the use of the health plan’s preferred products for multiple sclerosis (Betaseron, Rebif, Copaxone, Glatopa, Gilenya, Tecfidera, Aubagio) before the use of targeted product (Extavia) unless there are clinical circumstances that exclude the use of the preferred products. The program also considers Tysabri a preferred product. The criteria will require the use of the health plan’s preferred product for multiple sclerosis before the use of the targeted product Lemtrada. Avonex, Ocrevus, and Plegridy are excluded from the preferred multiple sclerosis product requirements.

**Targeted Multiple Sclerosis Products**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Generic Name</th>
<th>FDA-Approved Indications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preferred Products:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Betaseron</td>
<td>interferon beta-1b</td>
<td>Relapsing forms of MS, First clinical episode of MS</td>
</tr>
<tr>
<td>Rebif</td>
<td>interferon beta-1a</td>
<td>Relapsing forms of MS</td>
</tr>
<tr>
<td>Copaxone/Glatopa</td>
<td>glatiramer</td>
<td>Relapsing forms of MS</td>
</tr>
<tr>
<td>Gilenya</td>
<td>fingolimod</td>
<td>Relapsing forms of MS</td>
</tr>
<tr>
<td>Tecfidera</td>
<td>dimethyl fumarate</td>
<td>Relapsing forms of MS</td>
</tr>
<tr>
<td>Aubagio</td>
<td>teriflunomide</td>
<td>Relapsing forms of MS</td>
</tr>
<tr>
<td><strong>Targeted Products:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extavia</td>
<td>interferon beta-1b</td>
<td>Relapsing forms of MS, First clinical episode of MS</td>
</tr>
</tbody>
</table>

MS = multiple sclerosis
<table>
<thead>
<tr>
<th>Medication</th>
<th>Generic Name</th>
<th>FDA-Approved Indications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preferred Products:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tysabri</td>
<td>natalizumab</td>
<td>Relapsing forms of MS</td>
</tr>
<tr>
<td><strong>Targeted Products:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lemtrada</td>
<td>alemtuzumab</td>
<td>Relapsing forms of MS</td>
</tr>
</tbody>
</table>

**POLICY**

Must meet BOTH the Preferred Drug Plan Design (for the specific drug) and Criteria for Initial Approval/Continuation of Therapy when both are applicable.

**Preferred Drug Plan Design**

The criteria will require the use of the health plan’s preferred products for multiple sclerosis (Betaseron, Rebif, Copaxone, Glatopa, Gilenya, Tecfidera, Aubagio) before the use of targeted products (Extavia), unless there are clinical circumstances that exclude the use of the preferred products. TWO Preferred Formulary Products are required in members who are naïve to treatment with the requested targeted product. ONE Preferred Formulary Product is required in members who are treatment-experienced with the requested targeted product.

The criteria will also require the use of the health plan’s preferred product Tysabri before the use of the targeted product Lemtrada, unless there are clinical circumstances that exclude the use of the preferred products.

Ocrevus is excluded from the preferred multiple sclerosis product requirements.

**Criteria for Initial Approval**

I. **Aubagio** (teriflunomide) may be considered medically necessary for members who have been diagnosed with a relapsing form of multiple sclerosis.

   Approval will be for 24 months.

II. **Avonex** (interferon beta-1α) may be considered medically necessary when the following criteria are met:

   a. Must have ONE of the following diagnoses:

   - A relapsing form of multiple sclerosis
   - First clinical episode of multiple sclerosis

   Approval will be for 24 months.

III. **Betaseron** (interferon beta-1β), **Copaxone** (glatiramer acetate), **Glatopa** (glatiramer acetate), and **Rebif** (interferon beta-1α) may be considered medically necessary when the following criteria are met:

   a. Must have ONE of the following diagnoses:

   - A relapsing form of multiple sclerosis
   - First clinical episode of multiple sclerosis
Approval will be for 24 months.

IV. Extavia (interferon beta-1β) may be considered medically necessary when the following criteria are met:
   a. Must have ONE of the following diagnoses:
      • A relapsing form of multiple sclerosis
      • First clinical episode of multiple sclerosis
   AND
   a. Must have had an inadequate response or tried and was intolerant to or had confirmed adverse event to TWO Preferred Formulary Products if naïve to treatment with Extavia (interferon beta-1β); OR
   b. Must have had an inadequate response to or tried and was intolerant to or had confirmed adverse event to ONE Preferred Formulary Product if treatment-experienced with Extavia (interferon beta-1β)

Approval will be for 24 months.

V. Gilenya (fingolimod) may be considered medically necessary for members who have been diagnosed with a relapsing form of multiple sclerosis.

Approval will be for 24 months.

VI. Plegridy (peginterferon beta-1α) may be considered medically necessary for members who have been diagnosed with a relapsing form of multiple sclerosis.

Approval will be for 24 months.

VII. Tecfidera (dimethyl fumarate) may be considered medically necessary for members who have been diagnosed with a relapsing form of multiple sclerosis.

Approval will be for 24 months.

VIII. Ocrevus (ocrelizumab) may be considered medically necessary for the treatment of relapsing forms of multiple sclerosis in patients 18 years of age or older when the following criteria are met:
   a. Must be prescribed by or in consultation with a neurologist.
   AND
   b. Must meet ONE of the following
      • The member is newly diagnosed with MS.
      • The member is new to treatment with disease modifying therapy.
      • For members who have previously received or are currently receiving disease modifying therapy: The member’s disease is not currently stabilized on existing disease modifying therapy as evidenced by disease progression or occurrence of an intolerable adverse event.

Approval will be for 24 months.

Reauthorization of 24 months may be granted to members requesting continuation of therapy for the treatment of relapsing forms of MS when the member has experienced disease improvement or slowing of disease progression (eg, decrease in the number of relapses, improvement or no decline in Kurtzke Expanded Disability Status Scale [EDSS] or in MRI findings) since initiating Ocrevus therapy.
IX. **Ocrevus (ocrelizumab)** may be considered medically necessary for the treatment of primary progressive multiple sclerosis in members 18 years of age or older when the following criteria are met:
   a. Must be prescribed by or in consultation with a neurologist.

   **Approval** will be for **24 months**.

Reauthorization of 24 months may be granted to members requesting continuation of therapy for the treatment of primary progressive MS when the member has experienced slowing of disease progression (e.g., no decline in EDSS or MRI findings) since initiating Ocrevus therapy.

X. **Lemtrada (alemtuzumab)** may be considered medically necessary as monotherapy for the treatment of relapsing forms of MS when the following criteria is met:
   a. The member has tried and failed two multiple sclerosis therapies;
   OR
   The member has evidence of highly active disease despite glatiramer or interferon-β as demonstrated by 1 relapse in the previous year and either a) ≥ 1 gadolinium-enhancing MRI lesion or (b) at least 9 T2-hyperintensive lesions on cranial MRI.
   AND
   b. The member must meet one of the following exclusion criteria:
   • Member is currently receiving treatment with Lemtrada, excluding when the Lemtrada is obtained as samples or via manufacturer’s patient assistance programs.
   • Member has experienced a documented inadequate response and/or intolerable adverse event to treatment with Tysabri.
   • Member has a documented contraindication to therapy with Tysabri or any of its components.

   **Approval** will be for **24 months** (total duration of therapy is 24 months).

XI. **Tysabri (natalizumab)** may be considered medically necessary as monotherapy for the treatment of relapsing forms of MS when the patient has tried and failed two multiple sclerosis therapies, or when the patient has evidence of highly active disease despite glatiramer or interferon-β as demonstrated by 1 relapse in the previous year and either a) ≥ 1 gadolinium-enhancing MRI lesion or (b) at least 9 T2-hyperintensive lesions on cranial MRI.

   **Approval** will be for **lifetime**

   *Tysabri is also considered medically necessary for the treatment of Crohn’s Disease (CD) refractory to other agents

**Continuation of Therapy**

All members (including new members) requesting authorization for continuation of therapy must meet ALL initial authorization criteria except for Ocrevus. Reauthorization criteria for Ocrevus is listed above.

The aforementioned drugs are considered **not medically necessary** for patients who do not meet the criteria set forth above.

**Quantity limits apply:**
<table>
<thead>
<tr>
<th>Trade Name</th>
<th>Generic Name</th>
<th>Quantity Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aubagio®</td>
<td>teriflunomide</td>
<td>30 tablets per 30 days</td>
</tr>
<tr>
<td>Avonex®</td>
<td>interferon beta-1α</td>
<td>4 vials per 28 days</td>
</tr>
<tr>
<td>Betaseron®</td>
<td>interferon beta-1β</td>
<td>15 vials per 30 days</td>
</tr>
<tr>
<td>Copaxone® 20 mg</td>
<td>glatiramer acetate</td>
<td>30 syringes (1 kit) per 30 days</td>
</tr>
<tr>
<td>Extavia®</td>
<td>interferon beta-1β</td>
<td>15 vials per 30 days</td>
</tr>
<tr>
<td>Gilenya™</td>
<td>fingolimod</td>
<td>30 capsules per 30 days</td>
</tr>
<tr>
<td>Plegidry™</td>
<td>peginterferon beta-1α</td>
<td>Initiation of therapy: 1 starter pack per first 28 days Maintenance: 2 pens per 28 days</td>
</tr>
<tr>
<td>Rebif®</td>
<td>interferon beta-1α</td>
<td>12 vials per 28 days</td>
</tr>
<tr>
<td>Tecfidera™</td>
<td>dimethyl fumarate</td>
<td>Initiation of therapy: 1 starter pack per first 28 days Maintenance: 60 capsules per 30 days</td>
</tr>
<tr>
<td>Tysabri®</td>
<td>natalizumab</td>
<td>1 vial per 28 days</td>
</tr>
</tbody>
</table>

**PROCEDURES AND BILLING CODES**

*To report provider services, use appropriate CPT* codes, *Alpha Numeric (HCPCS level 2) codes, Revenue codes, and/or ICD-CM diagnostic codes.*

- J0202 - Injection, alemtuzumab, 1 mg
- J2323 - natalizumab, 1 mg
- C9494 – Injection, ocrelizumab, 1 mg (Cancelled as of 1-1-18)
- J2350 – Injection, ocrelizumab (Ocrevus), 1mg (eff 1-1-18)
- J3490 Unclassified drugs

**REFERENCES**

- Gilenya [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; August 2015.


*Some content reprinted insert from CVSHealth