Multiple Sclerosis

NOTICE

This policy contains information which is clinical in nature. The policy is not medical advice. The information in this policy is used by Wellmark to make determinations whether medical treatment is covered under the terms of a Wellmark member's health benefit plan. Physicians and other health care providers are responsible for medical advice and treatment. If you have specific health care needs, you should consult an appropriate health care professional. If you would like to request an accessible version of this document, please contact customer service at 800-524-9242.

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, Rebi, Copaxone 40mg, Glatopa 40mg, glatiramer acetate 40mg, 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, Rebi, Copaxone 40mg, Glatopa 40mg, glatiramer acetate 40mg, Gilenya, Tecfidera, Aubagio) before the use of targeted product (Extavia and Vumerity) 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, Tysabri, before the use of the targeted product Lemtrada. Avonex, Ocrevus, Pledridy, Mavenclad, and Mayzent are excluded from the preferred multiple sclerosis product requirements.

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

1. Criteria for initial approval for Extavia will only apply when the following criteria are met:
   a. There is a documented clinical reason that the member must use Extavia over Betaseron.
      (Please note that Extavia and Betaseron are the exact same products with different labels and brand names, which are made in the same manufacturing facility.)
   AND
b. Member has had a documented inadequate response or intolerable adverse effect with at least two of the preferred products other than Betaseron; OR Member is currently receiving therapy with Extavia, excluding when Extavia is obtained as samples or via manufacturer’s patient assistance programs, and experiencing a positive therapeutic outcome.

II. Criteria for initial approval for Vumerity will only apply when at least ONE of the following criteria are met:
   a. Member has had a documented inadequate response or intolerable adverse effect to treatment with at least three of the preferred products
   b. Member is currently receiving therapy with Vumerity, excluding when Vumerity is obtained as samples or via manufacturer’s patient assistance programs, and experiencing a positive therapeutic outcome.

III. Criteria for initial approval for Lemtrada will only apply when at least ONE of the following criteria are met:
   a. Member is currently receiving treatment with Lemtrada, excluding when the Lemtrada is obtained as samples or via manufacturer’s patient assistance programs, and experiencing a positive therapeutic outcome.
   b. Member has experienced a documented inadequate response and/or intolerable adverse event to treatment with Tysabri.
   c. Member has a documented contraindication to therapy with Tysabri or any of its components.

Criteria for Initial Approval

I. **Aubagio** (teriflunomide), **Gilenya** (fingolimod), **Mayzent** (siponimod), **Tecfidera** (dimethyl fumarate), and **Vumerity** (diroximel fumarate) may be considered **medically necessary** for members who have been diagnosed with a relapsing form of multiple sclerosis (including clinically isolated syndrome, relapsing-remitting disease or active secondary progressive disease).

   **Approval** will be for **12 months**.

II. **Avonex** (interferon beta-1α), **Betaseron** (interferon beta-1β), and **Rebif** (interferon beta-1α) may be considered **medically necessary** for members who have been diagnosed with a relapsing form of multiple sclerosis (including clinically isolated syndrome, relapsing-remitting disease or active secondary progressive disease).

   **Approval** will be for **12 months**.

III. **Copaxone 40mg** (glatiramer acetate) and **Glatopa 40mg** (glatiramer acetate) may be considered **medically necessary** for members who have been diagnosed with a relapsing form of multiple sclerosis (including clinically isolated syndrome, relapsing-remitting disease or active secondary progressive disease).

   **Approval** will be for **12 months**.

IV. **Extavia** (interferon beta-1β) may be considered **medically necessary** when ALL the following criteria are met:
   a. Member must have been diagnosed with a relapsing form of multiple sclerosis (including clinically isolated syndrome, relapsing-remitting disease or active secondary progressive disease).

   **Approval** will be for **12 months**.
V. **Plegridy** (peginterferon beta-1α) may be considered **medically necessary** for members who have been diagnosed with a relapsing form of multiple sclerosis (including clinically isolated syndrome, relapsing-remitting disease or active secondary progressive disease).

**Approval** will be for **12 months**.

VI. **Ocrevus** (ocrelizumab) may be considered **medically necessary** for the treatment of relapsing forms of multiple sclerosis (including clinically isolated syndrome, relapsing-remitting disease or active secondary progressive disease).

**Approval** will be for **12 months**.

VII. **Ocrevus** (ocrelizumab) may be considered **medically necessary** for the treatment of primary progressive multiple sclerosis.

**Approval** will be for **12 months**.

VIII. **Vumerity** (diroximel fumarate) may be considered **medically necessary** when ALL the following criteria are met:
   a. Member must have been diagnosed with a relapsing form of multiple sclerosis (including clinically isolated syndrome, relapsing-remitting disease or active secondary progressive disease).

**Approval** will be for **12 months**.

IX. The first course of **Lemtrada** (alemtuzumab) may be considered **medically necessary** for the treatment of relapsing forms of MS when the following criteria is met:
   a. The member has had an inadequate response to two or more drugs indicated for multiple sclerosis;
   **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 **30 days (5 doses)**.

X. **Tysabri** (natalizumab) may be considered **medically necessary** as monotherapy for the treatment of a relapsing form of MS (e.g. relapsing-remitting multiple sclerosis and secondary progressive disease with relapses) when the following criteria is met:
   a. The member has tried and failed two multiple sclerosis therapies. Previous trial of another multiple sclerosis therapy is not required if 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) at least one gadolinium-enhancing MRI lesion or (b) at least nine T2-hyperintensive lesions on cranial MRI

**Approval** will be for **12 months**.
XI. **Tysabri** (natalizumab) may be considered **medically necessary** for the treatment of clinically isolated syndrome of multiple sclerosis. 

**Approval** will be for **12 months**.

*Tysabri (natalizumab) is also considered medically necessary for the treatment of moderate to severe Crohn’s Disease (CD) refractory to other agents. Approval will be for lifetime.

XII. **Mavenclad** (cladribine) may be considered **medically necessary** for the treatment of relapsing forms of multiple sclerosis (including relapsing-remitting and secondary progressive disease for those who continue to experience relapses) when all of the following criteria are met:

a. Member has had an inadequate response, intolerable adverse event, or documented contraindication to ALL of the following:
   - At least one interferon therapy (e.g. Avonex, Betaseron, Plegridy, Rebif)
   - Copaxone, glatiramer acetate, or Glatopa
   - At least two oral therapies indicated for relapsing forms of MS (e.g. Aubagio, Gilenya, Tecfidera, Mayzent)

b. Member does not have clinically isolated syndrome (CIS).

c. Member has obtained a recent complete blood count (CBC) and lymphocytes are within normal limits

d. Member has been screened for tuberculosis and hepatitis B and C

e. Member has not received 2 courses (i.e., 4 cycles) of Mavenclad.

f. Members will not use Mavenclad concomitantly with other medications used for the treatment of multiple sclerosis, excluding Ampyra.

**Approval** will be for **45 days**.

**Continuation of Therapy**

I. The continuation of **Aubagio** (teriflunomide), **Avonex** (interferon beta-1a), **Betaseron** (interferon beta-1β), **Copaxone 40mg** (glatiramer acetate), **Extavia** (interferon beta-1β), **Glatopa 40mg** (glatiramer acetate), **Gilenya** (fingolimod), **Mayzent** (siponimod), **Ocrevus** (ocrelizumab), **Plegridy** (peginterferon beta-1α), **Rebif** (interferon beta-1α), **Tecfidera** (dimethyl fumarate), and **Tysabri** (natalizumab) may be considered **medically necessary** for members who meet initial criteria for approval above and are experiencing disease stability or improvement while receiving the requested medication.

**Approval** will be for **12 months**.

II. Subsequent courses of **Lemtrada** (alemtuzumab) may be considered **medically necessary** for the treatment of relapsing forms of MS when the member meets all of the following criteria:

a. The member has completed at least one previous course of therapy

b. The member must have received the previous course of Lemtrada treatment at least 12 months prior to the planned date of the first dose of Lemtrada course of treatment.

**Approval** will be for **30 days (3 doses)**.

III. The continuation of **Mavenclad** (cladribine) may be considered **medically necessary** for the treatment of relapsing forms of MS (including relapsing-remitting and secondary progressive disease for those who continue to experience relapses) when the member meets all of the following criteria:

a. Member has had an inadequate response or is unable to tolerate ALL alternative drugs indicated for the treatment of relapsing forms of multiple sclerosis.

b. Member has not received 2 courses (i.e., 4 cycles) of Mavenclad.
c. Member has obtained a complete blood count (CBC) with differential including lymphocyte count and lymphocytes are at least 800 cells/μL.
d. The member has not received Mavenclad in the last 43 weeks.

**Approval** will be for 45 days.

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

**Other Criteria**
Members will not use the requested medication concomitantly with other medications used for the treatment of multiple sclerosis, excluding Ampyra, because there is inadequate evidence that use of two or more these drugs in combination results in better clinical outcomes than use of a single drug.

**Dosage and Administration**
Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

**Quantity Limits**

<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® 40 mg Glatopa 40mg</td>
<td>glatiramer acetate</td>
<td>12 syringes per 28 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>Mavenclad</td>
<td>cladribine</td>
<td>20 tablets per 9 months</td>
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</tbody>
</table>
| Mayzent    | siponimod    | Initiation of therapy: 1 starter pack (12 tablets) per first 5 days
Maintenance: 1-2mg per day |
| Ocrevus    | ocrelizumab  | Initiation of therapy: 300 mg infusion on day 1 and 15 Maintenance: 600 mg every 6 months |
| Plegridy™  | peginterferon beta-1α | Initiation of therapy: 1 starter pack per first 28 days
Maintenance: 2 pens per 28 days |
| Rebi®      | interferon beta-1α | 12 vials per 28 days |
| Tecfidera™ | dimethyl fumarate | Initiation of therapy: 1 starter pack per first 28 days
Maintenance: 60 capsules per 30 days |
| Tysabri®   | natalizumab   | 1 vial per 28 days |
**Trade Name | Generic Name | Quantity Limit**
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Vumerity | diroximel fumarate | Initiation of therapy: 1 starter dose bottle (106 capsules) per first 28 days  
Maintenance: 120 capsules per 28 days

**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
- J2350 – Injection, ocrelizumab (Ocrevus), 1mg

**REFERENCES**


*Some content reprinted from CVSHealth*

**POLICY HISTORY**

*Policy #: 05.01.75  
Policy Creation: August 2008  
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