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 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, Rebif, Copaxone 40mg, Glatopa 40mg, glatiramer acetate 40mg, 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, Plegridy, 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
The criteria will require the use of the health plan’s preferred products for multiple sclerosis (Betaseron, Rebif, Copaxone 40mg, Glatopa 40mg, glatiramer acetate 40mg, Gilenya, Tecfidera, Aubagio) before the use of targeted products (Extavia), unless there are clinical circumstances that exclude the use of the preferred products.

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 40mg** (glatiramer acetate), **Glatopa 40mg** (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**.

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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 (eg, 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

**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 to ALL of the following:
  - a. At least one interferon therapy (e.g. Avonex, Betaseron, Extavia, Plegridy, Rebif)
  - b. Copaxone
  - c. 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**.

**Reauthorization** of Mavenclad for **45 days** may be granted to members requesting continuation of therapy 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/uL
- d. Members will not use Mavenclad concomitantly with other medications used for the treatment of multiple sclerosis, excluding Ampyra.
- e. The member has not received Mavenclad in the last 43 weeks.

*(Effective date for Mavenclad pending)*

**XIII. Mayzent (siponimod)** may be considered medically necessary for the treatment of relapsing forms of multiple sclerosis (including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease).

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

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

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

**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</td>
<td>glatiramer acetate</td>
<td>12 syringes per 28 days</td>
</tr>
<tr>
<td>Glatopa 40mg</td>
<td></td>
<td></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>Plegidy™</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>
<tr>
<td>Mavenclad</td>
<td>cladribine</td>
<td>20 tablets per 9 months</td>
</tr>
<tr>
<td>Mayzent</td>
<td>siponimod</td>
<td>12 per 5 days</td>
</tr>
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### 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

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

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• Mavenclad [package insert]. Rockland, MA; EMD Serono, Inc; April 2019.
• Mayzent [package insert]. East Hanover, NJ; Novartis Pharmaceuticals Corp; March 2019.

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**POLICY HISTORY**

*Policy #: 05.01.75*
*Policy Creation: August 2008*
*Reviewed: July 2019*
*Revised: July 2019*
*Current Effective Date: September 13, 2019*