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 products (Avonex, Extavia and Plegridy), unless there are clinical circumstances that exclude the use of the preferred products. Lemtrada, Ocrevus, and Tysabri are excluded from the preferred multiple sclerosis product requirement.

**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>Avonex</td>
<td>interferon beta-1a</td>
<td>Relapsing forms of MS, First clinical episode of MS</td>
</tr>
<tr>
<td>Extavia</td>
<td>interferon beta-1b</td>
<td>Relapsing forms of MS, First clinical episode of MS</td>
</tr>
<tr>
<td>Plegridy</td>
<td>peginterferon beta-1a</td>
<td>Relapsing forms of MS</td>
</tr>
<tr>
<td>Zinbryta</td>
<td>daclizumab</td>
<td>Relapsing forms of MS</td>
</tr>
</tbody>
</table>

MS = multiple sclerosis
POLICY

Must meet BOTH the Preferred Drug Plan Design 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 (Avonex, Extavia and Plegridy), 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. Lemtrada, Ocrevus, and Tysabri are excluded from the preferred multiple sclerosis product requirement.

Criteria for Initial Approval

I. Aubagio (teriflunomide) may be considered medically necessary for members who have been diagnosed with ANY of the following relapsing forms of multiple sclerosis:
   a. Progressive-relapsing multiple sclerosis (PRMS)
   b. Relapsing-remitting multiple sclerosis (RRMS)
   c. Secondary progressive multiple sclerosis (SPMS) with documented relapses

   AND
   a. Pregnancy has been excluded

   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:
      • Progressive-relapsing multiple sclerosis (PRMS)
      • Relapsing-remitting multiple sclerosis (RRMS)
      • Secondary progressive multiple sclerosis (SPMS) with documented relapses
      • First clinical episode of multiple sclerosis and have magnetic resonance imaging (MRI) features consistent with 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 Avonex (interferon beta-1α); 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 Avonex (interferon beta-1α)

   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. Members who have been diagnosed with ANY of the following relapsing forms of multiple sclerosis:
      • Progressive-relapsing multiple sclerosis (PRMS)
- Relapsing-remitting multiple sclerosis (RRMS)
- Secondary progressive multiple sclerosis (SPMS) with documented relapses

**OR**

a. Members who have experienced a first clinical episode of multiple sclerosis and have magnetic resonance imaging (MRI) features consistent with 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:
   - Progressive-relapsing multiple sclerosis (PRMS)
   - Relapsing-remitting multiple sclerosis (RRMS)
   - Secondary progressive multiple sclerosis (SPMS) with documented relapses
   - First clinical episode of multiple sclerosis and have magnetic resonance imaging (MRI) features consistent with 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 ANY of the following relapsing forms of multiple sclerosis:

a. Progressive-relapsing multiple sclerosis (PRMS)

b. Relapsing-remitting multiple sclerosis (RRMS)

c. Secondary progressive multiple sclerosis (SPMS) with documented relapses

AND

a. Baseline QTc interval is NOT ≥ 500 msec.

**Approval will be for 24 months.**

VI. **Plegridy** (peginterferon beta-1α) may be considered **medically necessary** for members who have been diagnosed with ANY of the following relapsing forms of multiple sclerosis:

a. Progressive-relapsing multiple sclerosis (PRMS)

b. Relapsing-remitting multiple sclerosis (RRMS)

c. Secondary progressive multiple sclerosis (SPMS) with documented relapses

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 Plegridy (peginterferon beta-1α); 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 Plegridy (peginterferon beta-1α)

**Approval will be for 24 months.**
VII. **Tecfidera** (dimethyl fumarate) may be considered **medically necessary** for members who have been diagnosed with ANY of the following relapsing forms of multiple sclerosis:
   a. Progressive-relapsing multiple sclerosis (PRMS)
   b. Relapsing-remitting multiple sclerosis (RRMS)
   c. Secondary progressive multiple sclerosis (SPMS) with documented relapses

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

VIII. **Zinbryta** (daclizumab) may be considered **medically necessary** for members who have been diagnosed with ANY of the following relapsing forms of multiple sclerosis:
   a. Progressive-relapsing multiple sclerosis (PRMS)
   b. Relapsing-remitting multiple sclerosis (RRMS)
   c. Secondary progressive multiple sclerosis (SPMS) with documented relapses

**AND**
   a. Must have had an inadequate response or tried and was intolerant to or had confirmed adverse event to TWO or more Preferred Formulary Products despite adequate duration of treatment

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

IX. **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 **12 months**.

Reauthorization of 12 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.

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

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

Reauthorization of 12 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.

XI. **Lemtrada (alemtuzumab) and 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 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></td>
<td>Glatopa™ 20mg</td>
<td></td>
</tr>
<tr>
<td>Copaxone® 40 mg</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>Plegridy™</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>Zinbryta™</td>
<td>daclizumab</td>
<td>1 syringe 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
• J3490 Unclassified drugs

REFERENCES


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