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, Avonex, Betaseron, generic dimethyl fumarate, generic fingolimod, glatiramer acetate, Glatopa, Kesimpta, Mayzent, Plegridy, Ponvory, Rebif, generic teriflunomide, Vumerity, and Zeposia** are the preferred products. The criteria will require the use of the health plan's preferred products for multiple sclerosis (Betaseron, generic dimethyl fumarate, generic fingolimod, glatiramer acetate, Glatopa, Kesimpta, Mayzent, Ponvory, Rebif, generic teriflunomide, Vumerity, and Zeposia**) before the use of a targeted product (brand Aubagio, Bafiertam, brand Copaxone, Extavia, brand Gilenya, Mavenclad, Tascenso ODT, and brand Tecfidera) unless there are clinical circumstances that exclude the use of the preferred products. The program also considers Briumvi, Ocrevus, Ocrevus Zunovo, and Tyruko preferred products. The criteria will require the use of the health plan's preferred products for multiple sclerosis, Briumvi, Ocrevus, Ocrevus Zunovo, and Tyruko, before the use of the targeted products, Lemtrada or Tysabri*.

*For Tysabri, please refer to the Tysabri (natalizumab) policy.
**For Zeposia, please refer to the Zeposia policy.

POLICY

Required Documentation

Submission of the following information is necessary to initiate the prior authorization review:

I. Initial Requests

a. Submission of chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy is necessary to initiate the prior authorization review. If therapy is not advisable, documentation of clinical reason to avoid therapy is necessary.

II. Continuation Requests
   a. Submission of chart notes or medical record documentation supporting positive clinical response to therapy or remission.

Prescriber Specialties

Medication must be prescribed by or in consultation with a neurologist or other prescriber specializing in the treatment of multiple sclerosis.

Preferred Drug Plan Design

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

I. Criteria for initial approval for brand **Aubagio** 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 brand **Aubagio**, excluding when brand **Aubagio** is obtained as samples or via manufacturer's patient assistance programs, and is experiencing a positive therapeutic outcome

II. Criteria for initial approval for brand **Copaxone** 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 brand **Copaxone**, excluding when brand **Copaxone** is obtained as samples or via manufacturer's patient assistance programs, and is experiencing a positive therapeutic outcome

III. 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 is experiencing a positive therapeutic outcome.

IV. Criteria for initial approval for **Bafiertam** 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 **Bafiertam**, excluding when **Bafiertam** is obtained as samples or via manufacturer's patient assistance programs, and is experiencing a positive therapeutic outcome

V. Criteria for initial approval for brand **Gilenya** 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 brand **Gilenya**, excluding when brand **Gilenya** is obtained as samples or via manufacturer's patient assistance programs, and is experiencing a positive therapeutic outcome

VI. Criteria for initial approval for **Mavenclad** 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 one of the preferred products
   b. Member is currently receiving therapy with **Mavenclad**, excluding when **Mavenclad** is obtained as samples or via manufacturer's patient assistance programs, and is experiencing a positive therapeutic outcome

VII. Criteria for initial approval for **Tascenso ODT** 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 **Tascenso ODT**, excluding when **Tascenso ODT** is obtained as samples or via manufacturer's patient assistance programs, and is experiencing a positive therapeutic outcome

VIII. Criteria for initial approval for brand **Tecfidera** 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 brand **Tecfidera**, excluding when brand **Tecfidera** is obtained as samples or via manufacturer's patient assistance programs, and is experiencing a positive therapeutic outcome

IX. 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 is experiencing a positive therapeutic outcome
   b. Member has experienced a documented inadequate response and/or intolerable adverse event to treatment with Briumvi, Ocrevus, Ocrevus Zunovo, and Tyruko
   c. Member has a documented contraindication to therapy with Briumvi, Ocrevus, Ocrevus Zunovo, and Tyruko or any of their components

<u>Criteria for Initial Approval</u>

I. Brand and generic **Aubagio** (teriflunomide), **Avonex** (interferon beta-1α), **Bafiertam** (monomethyl fumarate), **Betaseron** (interferon beta-1β), **Briumvi** (ublituximab-xiiy), brand and generic **Copaxone** (glatiramer acetate), **Extavia** (interferon beta-1β), brand and generic **Gilenya** (fingolimod), glatiramer acetate, **Glatopa** (glatiramer acetate), **Kesimpta** (ofatumumab), **Mayzent** (siponimod), **Plegridy** (peginterferon beta-1α), **Ponvory** (ponesimod), **Rebif** (interferon beta-1α), **Tascenso ODT** (fingolimod), brand and generic **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 relapsing-remitting and secondary progressive disease for those who continue to experience relapse).

Approval will be for **12 months.**

II. Brand and generic **Aubagio** (teriflunomide), **Avonex** (interferon beta-1α), **Bafiertam** (monomethyl fumarate), **Betaseron** (interferon beta-1β), **Briumvi** (ublituximab-xiiy), brand and generic **Copaxone** (glatiramer acetate), **Extavia** (interferon beta-1β), brand and generic **Gilenya** (fingolimod), glatiramer acetate, **Glatopa** (glatiramer acetate), **Kesimpta** (ofatumumab), **Mayzent** (siponimod), **Plegridy** (peginterferon beta-1α), **Ponvory** (ponesimod), **Rebif** (interferon beta-1α), **Tascenso ODT** (fingolimod), brand and generic **Tecfidera** (dimethyl fumarate), and **Vumerity** (diroximel fumarate) may be considered **medically necessary** for the treatment of clinically isolated syndrome of multiple sclerosis.

Approval will be for **12 months.**

III. **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 or is unable to tolerate an alternative drug indicated for the treatment of multiple sclerosis
   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, hepatitis B, and hepatitis 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 and Nuedexta.

Approval will be for **90 days**.

IV. **Ocrevus** (ocrelizumab) and Ocrevus Zunovo (ocrelizumab and hyaluronidase-ocsq) may be considered **medically necessary** for members who have been diagnosed with a relapsing form of multiple sclerosis (including relapsing-remitting and secondary progressive disease for those who continue to experience relapse).

Approval will be for **12 months.**

V. **Ocrevus** (ocrelizumab) and Ocrevus Zunovo (ocrelizumab and hyaluronidase-ocsq) may be considered **medically necessary** for the treatment of clinically isolated syndrome of multiple sclerosis.

Approval will be for **12 months.**

VI. **Ocrevus** (ocrelizumab) and Ocrevus Zunovo (ocrelizumab and hyaluronidase-ocsq) may be considered **medically necessary** for the treatment of primary progressive multiple sclerosis.

Approval will be for **12 months.**

VII. 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

   Approval will be for **30 days (5 doses).**

Continuation of Therapy

I. The continuation of brand and generic **Aubagio** (teriflunomide), **Avonex** (interferon beta-1α), **Bafiertam** (monomethyl fumarate), **Betaseron** (interferon beta-1β), **Briumvi** (ublituximab-xiiy), brand and generic **Copaxone** (glatiramer acetate), **Extavia** (interferon beta-1β), brand and generic **Gilenya** (fingolimod), glatiramer acetate, **Glatopa** (glatiramer acetate), **Kesimpta** (ofatumumab), **Mayzent** (siponimod), **Ocrevus** (ocrelizumab), Ocrevus Zunovo (ocrelizumab and hyaluronidase-ocsq), **Plegridy** (peginterferon beta-1α), **Ponvory** (ponesimod), **Rebif** (interferon beta-1α), **Tascenso ODT** (fingolimod), brand and generic **Tecfidera** (dimethyl fumarate), and **Vumerity** (diroximel fumarate) may be considered **medically necessary** for members who meet Criteria for Initial Approval above and are experiencing disease stability or improvement while receiving the requested medication.

   Approval will be for **12 months.**

II. The continuation of **Mavenclad** (cladribine) may be considered **medically necessary** for members who meet initial criteria for approval above and meet ALL of the following:
   a. Member has not received 2 courses (i.e., 4 cycles) of Mavenclad.
   b. Member has obtained a complete blood count (CBC) with differential including lymphocyte count and lymphocytes are at least 800 cells/μL
   c. The member has not received Mavenclad in the last 43 weeks.

   Approval will be for **90 days.**

III. Subsequent courses of **Lemtrada** (alemtuzumab) may be considered **medically necessary** for the treatment of relapsing forms of multiple sclerosis 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 last dose of the prior treatment course at least 12 months prior to the planned date of the first dose of subsequent Lemtrada course of treatment.

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

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 disease modifying multiple sclerosis agents (Note: Ampyra and Nuedexta are not disease modifying).

Members currently receiving the requested medication as samples or via the manufacturer's patient assistance program will be required to meet the criteria for initial approval. This ensures that members are treated equally regardless of their provider's ability to access medication samples.

Non-Formulary Exception Criteria

Non-Formulary Exception Criteria applies to formularies which do not include the requested product(s) on the formulary drug list. Meeting the criteria above may satisfy some, or all, portions of the Non-Formulary Exception Criteria. A medication that is non-formulary may be covered when the Criteria for Approval AND the following criteria are met:

1. The requested drug must be used for an FDA-approved indication, or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines). Diagnostic testing/lab results required when applicable.
2. The prescribed dose/quantity must fall within the FDA-approved labeling or dosing guidelines found in the compendia of current literature.
3. All covered formulary alternative drugs on any tier will be ineffective, have been ineffective, would not be as effective as the non-formulary drug, or would have adverse effects. Documentation is required and must include chart note(s) or other documentation indicating prior treatment failure, severity of the adverse event (if any), and dosage and duration of the prior treatment, or contraindication to formulary alternatives.

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

Trade Name	Generic Name	Quantity Limit
Aubagio	teriflunomide	30 tablets per 30 days
Avonex	interferon beta-1α	4 vials, syringes, or pens per 28 days
Betaseron	interferon beta-1β	14 vials/syringes per 28 days
Bafiertam	monomethyl fumarate	120 capsules per 30 days
Briumvi	ublituximab-xiiy	Initiation of therapy: 150 mg on day 1 Maintenance: 450 mg on day 15, then 450 mg every 6 months
Copaxone 40mg Glatopa 40mg Glatiramer acetate 40mg	glatiramer acetate	12 syringes per 28 days
Copaxone 20mg Glatopa 20mg Glatiramer acetate 20mg	glatiramer acetate	30 syringes per 30 days
Extavia	interferon beta-1β	15 vials/syringes per 30 days
Gilenya	fingolimod	30 capsules per 30 days

Trade Name	Generic Name	Quantity Limit
Kesimpta	ofatumumab	Initiation of therapy: 3 pens per 15 days Maintenance: 1 pen per 28 days
Mavenclad	cladribine	20 tablets per 9 months
Mayzent	siponimod	Initiation of therapy: 1 starter pack per first 4-5 days Maintenance 0.25mg: 120 tablets per 30 days Maintenance 1mg or 2mg: 30 tablets per 30 days
Ocrevus	ocrelizumab	Initiation of therapy: 300 mg infusion on day 1 and 15 Maintenance: 600 mg every 6 months
Ocrevus Zunovo	ocrelizumab and hyaluronidase-ocsq	1 vial per 180 days
Plegridy	peginterferon beta-1α	Initiation of therapy: 1 starter pack per first 28 days Maintenance: 2 pens per 28 days
Ponvory	Ponesimod	Initiation of therapy: 1 starter pack per first 14 days Maintenance: 30 tablets per 30 days
Rebif	interferon beta-1α	12 prefilled syringes or autoinjectors per 28 days
Tascenso ODT	fingolimod	30 orally disintegrating tablets per 30 days
Tecfidera	dimethyl fumarate	Initiation of therapy: 1 starter pack per first 28 days Maintenance: 60 capsules per 30 days
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 – Injection, natalizumab, 1 mg
- J2350 – Injection, ocrelizumab, 1mg
- J2351 – Injection, ocrelizumab, 1 mg and hyaluronidase-ocsq (effective 4/1/2025)
- J2329 – Injection, ublituximab-xiiy, 1 mg
- Q5134 - Inj, tyruko, 1 mg
- J3590 – Unclassified biologicals
- C9399 – Unclassified drugs or biologicals

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POLICY HISTORY

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