



## Clinical Policy: Multiple Sclerosis Agents

Reference Number: PHW.PDL.043

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[Revision Log](#)

### Policy/Criteria

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of health plans affiliated with PA Health and Wellness® that Multiple Sclerosis Agents are **medically necessary** when the following criteria are met:

### I. Requirements for Prior Authorization of Multiple Sclerosis Agents

#### A. Prescriptions That Require Prior Authorization

Prescriptions for Multiple Sclerosis Agents that meet any of the following conditions must be prior authorized:

1. A non-preferred Multiple Sclerosis Agent.
2. A prescription for Ampyra (dalfampridine), Aubagio (teriflunomide), Gilenya (fingolimod), Tysabri (natalizumab), or Tecfidera (dimethyl fumarate).
3. A Multiple Sclerosis Agent with a prescribed quantity that exceeds the quantity limit.

#### B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Multiple Sclerosis Agent, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. For Tysabri (natalizumab), see **PHW.PDL.043.01 Natalizumab (Tysabri); OR**
2. Is being treated for a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication;  
**AND**
3. Is prescribed the Multiple Sclerosis Agent by **one** of the following:
  - a. For Ampyra (dalfampridine), a neurologist or physical medicine and rehabilitation (PM&R) specialist
  - b. For all other Multiple Sclerosis Agents, a neurologist;

**AND**

4. Does not have a history of a contraindication to the prescribed Multiple Sclerosis Agent; **AND**
5. Is prescribed a dose that is consistent with the FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**
6. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed literature; **AND**
7. Had all potential drug interactions addressed by the prescriber (such as discontinuation of the interacting drug, dose reduction of the interacting drug, or counseling of the beneficiary of the risks associated with the use of both medications when they interact); **AND**
8. For a non-preferred Multiple Sclerosis Agent, **one** of the following:
  - a. Has a history of therapeutic failure, contraindication, or intolerance to the preferred Multiple Sclerosis Agents approved for the beneficiary's diagnosis,
  - b. Has a current prescription (within the past 90 days) for the same non-preferred Multiple Sclerosis Agent,
  - c. For Lemtrada (alemtuzumab), has received a previous treatment course at least 12 months prior to the current request,
  - d. For Mavenclad (cladribine), has completed an initial treatment course at least 43 weeks prior to the current request;

**AND**

9. For Lemtrada (alemtuzumab), **all** of the following:
  - a. Has documented positive antibodies for varicella zoster virus (VZV), documentation of vaccination for VZV, or a healthcare professional confirmed history of chickenpox,
  - b. Did not receive a VZV vaccination in the previous six weeks,
  - c. Has documentation of a recent negative purified protein derivative (PPD) test or blood test for tuberculosis;

**AND**

10. For Ampyra (dalfampridine), has motor dysfunction on a continuous basis that impairs the ability to complete instrumental activities of daily living (IADL's) or activities of daily living (ADL's); **AND**
11. For Aubagio (teriflunomide), **both** of the following:
  - a. Does not have a diagnosis of severe immunodeficiency, bone marrow disease, or severe, uncontrolled infection

- b. Has documentation of a recent negative purified protein derivative (PPD) test or blood test for tuberculosis;

**AND**

- 12. For Gilenya (fingolimod), **both** of the following:

- a. Has documented positive antibodies to VZV, documentation of vaccination for VZV, or a healthcare professional confirmed history of chickenpox
- b. Did not receive a VZV vaccination in the previous one month;

**AND**

- 13. For Ocrevus (ocrelizumab), does not have evidence of significant active infection;

**AND**

- 14. For Mavenclad (cladribine), **both** of the following:

- a. Has documentation of recent lymphocyte count within recommended limits according to FDA-approved package labeling before initiating the first treatment course
- b. Has documented positive antibodies to VZV, documentation of vaccination for VZV, or a healthcare professional confirmed history of chickenpox;

**AND**

- 15. For Mayzent (siponimod), **both** of the following:

- a. Has documented positive antibodies to VZV, documentation of vaccination for VZV, or a healthcare professional confirmed history of chickenpox
- b. Has documentation of prescriber consultation with a cardiologist if recommended in the FDA-approved package labeling;

**AND**

- 16. If a prescription for a Multiple Sclerosis Agent is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override.

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

**FOR RENEWALS OF PRIOR AUTHORIZATION FOR MULTIPLE SCLEROSIS**

**AGENTS:** The determination of medical necessity of a request for renewal of a prior authorization for a Multiple Sclerosis Agent that was previously approved will take into account whether the beneficiary:

1. Is prescribed the Multiple Sclerosis Agent by **one** of the following:
  - a. For Ampyra (dalfampridine), a neurologist or physical medicine and rehabilitation (PM&R) specialist
  - b. For all other Multiple Sclerosis Agents, a neurologist;

**AND**

2. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**
3. Does not have a history of a contraindication to the prescribed Multiple Sclerosis Agent; **AND**
4. Had all potential drug interactions addressed by the prescriber (such as discontinuation of the interacting drug, dose reduction of the interacting drug, or counseling of the beneficiary of the risks associated with the use of both medications when they interact); **AND**
5. For Lemtrada (alemtuzumab), **all** of the following:
  - a. Received the previous treatment course at least 12 months prior to the requested treatment course with Lemtrada (alemtuzumab),
  - b. Has documented improvement or stabilization of the multiple sclerosis disease course,
  - c. Does not have signs of malignancy or autoimmune disorder;

**AND**

6. For Ampyra (dalfampridine), has a documented improvement in motor function; **AND**
7. For Tecfidera (dimethyl fumarate), has documented improvement or stabilization of the multiple sclerosis disease course; **AND**
8. For Aubagio (teriflunomide), **both** of the following:
  - a. Has documented improvement or stabilization of the multiple sclerosis disease course
  - b. Does not have a diagnosis of severe immunodeficiency, bone marrow disease, or severe, uncontrolled infection;

**AND**

9. For Gilenya (fingolimod), has documented improvement or stabilization of the multiple sclerosis disease course; **AND**
10. For Ocrevus (ocrelizumab), **both** of the following:
  - a. **One** of the following:
    - i. Has documented improvement or stabilization of the multiple sclerosis disease course
    - ii. Based on the prescriber's professional judgement, continues to benefit from Ocrevus (ocrelizumab)
  - b. Does not have evidence of significant active infection;

**AND**

11. For Mavenclad (cladribine), **all** of the following:
  - a. Has documented improvement or stabilization of the multiple sclerosis disease course,
  - b. Has documentation of recent lymphocyte count within recommended limits according to FDA-approved package labeling before initiating the second treatment course,
  - c. Has not exceeded the recommended total number of treatment courses according to FDA-approved package labeling;

**AND**

12. For Mayzent (siponimod), **both** of the following:
  - a. Has documented improvement or stabilization of the multiple sclerosis disease course
  - b. Has documentation of prescriber consultation with a cardiologist if recommended in the FDA-approved package labeling;

**AND**

13. If a prescription for a Multiple Sclerosis Agent is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override.

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically

necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

**C. Clinical Review Process**

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for a Multiple Sclerosis Agent. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

**D. Dose and Duration of Therapy**

Requests for prior authorization of Multiple Sclerosis Agents will be approved as follows:

1. For Ampyra (dalfampridine) or Aubagio (teriflunomide):
  - a. Initial requests will be approved for 3 months.
  - b. Renewal requests will be approved for 6 months.
2. For Lemtrada (alemtuzumab):
  - a. Requests for an **initial** treatment course will be approved for 5 days.
  - b. Requests for **subsequent** treatment courses will be approved for 3 days.
3. For Mavenclad (cladribine):
  - a. PA Health & Wellness will limit authorizations consistent with FDA-approved package labeling.
4. For all other agents:
  - o New Request: 6 months
  - o Renewal Request: 12 months

**E. References:**

1. Ampyra Package Insert. Ardsley, NY: Acorda Therapeutics, Inc.; September 2017.
2. Aubagio Package Insert. Cambridge, MA: Genzyme Corporation; November 2016.
3. Clinical Resource, Multiple Sclerosis Treatments, The Pharmacists Letter/Prescriber's Letter. September 2017.
4. Gilenya Package Insert. East Hanover, New Jersey: Novartis Pharmaceuticals

- Corporation; January 2019.
5. Hauser SL, Bar-Or A, Comi G, et al. Ocrelizumab versus Interferon Beta-1a in Relapsing Multiple Sclerosis. *New England Journal of Medicine*. January 19, 2017; 376:221-234.
  6. Lemtrada Package Insert. Cambridge, MA: Genzyme Corporation; January 2019.
  7. Mavenclad Package Insert. Rockland, MA: EMD Serono, Inc.; March 2019.
  8. Mayzent Package Insert. East Hanover, NJ: Novartis Pharmaceuticals Corporation; March 2019.
  9. MedWatch FDA Safety Information and Adverse Event Reporting Program, Gilenya (fingolimod): Drug Safety Communication - Safety Review of a Reported Death After the First Dose, May 2012.
  10. Montalban X, Hauser SL, Kappos L, et al. Ocrelizumab versus Placebo in Primary Progressive Multiple Sclerosis. *New England Journal of Medicine*. January 19, 2017. 376:209-220.
  11. Ocrevus (ocrelizumab) Package Insert. South San Francisco, CA: Genetech, Inc.; November 2018.
  12. Olek MJ, Mowry E. Disease-modifying treatment of relapsing-remitting multiple sclerosis in adults. Gonzalez-Scarano F, Dashe JF, eds. Waltham, MA: UpToDate Inc. Updated April 24, 2019. Accessed May 14, 2019.
  13. Olek MJ, Mowry E. Treatment of progressive multiple sclerosis in adults. Gonzalez-Scarano F, Dashe JF, eds. Waltham, MA: UpToDate Inc. Updated April 24, 2019. Accessed May 14, 2019.
  14. Tecfidera Package Insert. Cambridge, MA: Biogen Inc.; December 2017.
  15. Treatment of relapsing-remitting multiple sclerosis in adults. Up To Date. Accessed February 5, 2015.

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Q3 2020 annual review: no changes.	07/2020