Clinical Policy: Multiple Sclerosis Agents

Reference Number: PHW.PDL.043
Effective Date: 01/01/2020
Last Review Date: 11/2025

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 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.
   See the Preferred Drug List (PDL) for the list of preferred Multiple Sclerosis Agents at: https://papdl.com/preferred-drug-list.

2. A Multiple Sclerosis Agent with a prescribed quantity that exceeds the quantity limit.

3. A prescription for Ampyra (dalfampridine ER), Aubagio (teriflunomide), Briumvi (ublituximab-xiiy), Gilenya (fingolimod), Kesimpta (ofatumumab), Ocrevus (ocrelizumab), Ocrevus Zunovo (ocrelizumab and hyaluronidase-ocsq), Tysabri (natalizumab), or Tecfidera (dimethyl fumarate DR).

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 member:

1. For a natalizumab product see PHW.PDL.043.01 Natalizumab (Tysabri); **OR**

2. For Zeposia (ozanimod) for the treatment of ulcerative colitis, see PHW.PDL.010 Ulcerative Colitis Agents; **OR**

3. 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**

4. Is age-appropriate according to FDA-approved package labeling, nationally

recognized compendia, or peer-reviewed medical literature; **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 prescribed the Multiple Sclerosis Agent by **one** of the following:

   a. For Ampyra (dalfampridine ER), a neurologist or physical medicine and rehabilitation (PM&R) specialist
   b. For all other Multiple Sclerosis Agents, a neurologist;

   AND

7. Does not have a contraindication to the prescribed Multiple Sclerosis Agent; **AND**

8. For a non-preferred Multiple Sclerosis Agent, **one** of the following:

   a. Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Multiple Sclerosis Agents approved or medically accepted for the member's diagnosis

   b. **One** of the following:

      i. Has a current prescription (within the past 90 days) for the same non-preferred Multiple Sclerosis Agent (does not apply to non-preferred Multiple Sclerosis Agents when a therapeutically equivalent brand/generic or corresponding biosimilar/brand biologic/unbranded biologic is preferred)
      ii. For a non-preferred Multiple Sclerosis Agent with a dosing interval exceeding 90 days (e.g., Lemtrada, Mavenclad), is receiving treatment with the same non-preferred Multiple Sclerosis Agent and will continue therapy at a dosing interval supported by FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature;

   AND

9. For Ampyra (dalfampridine ER), has motor dysfunction on a continuous basis that impairs the ability to complete instrumental activities of daily living or activities of daily living; **AND**

10. For Mavenclad (cladribine), has documentation of a recent lymphocyte count within recommended limits according to FDA-approved package labeling before initiating the first treatment course; **AND**

11. 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 member 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 member, 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 member:

1. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

2. Is prescribed the Multiple Sclerosis Agent by **one** of the following:

    a. For Ampyra (dalfampridine ER), a neurologist or PM&R specialist
    b. For all other Multiple Sclerosis Agents, a neurologist;

    AND

3. Does not have a contraindication to the prescribed Multiple Sclerosis Agent; **AND**

4. **One** of the following:

    a. For Ampyra (dalfampridine ER), has a documented improvement in motor function

    b. For all other Multiple Sclerosis Agents, **one** of the following:

        i. For a Multiple Sclerosis Agent prescribed for a diagnosis of a relapsing form of multiple sclerosis, has documented improvement or stabilization of the multiple sclerosis disease course
        ii. For a Multiple Sclerosis Agent prescribed for a diagnosis of primary progressive multiple sclerosis or a non-relapsing form of secondary progressive multiple sclerosis, continues to benefit from the prescribed Multiple Sclerosis Agent based on the prescriber's assessment;

    AND

5. For Lemtrada (alemtuzumab), received the previous treatment course at least 12 months prior to the requested treatment course with Lemtrada (alemtuzumab); **AND**

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

    a. Has documentation of a recent lymphocyte count within recommended limits

according to FDA-approved package labeling before initiating the second treatment course

b. Has not exceeded the recommended total number of treatment courses according to FDA-approved package labeling;

AND

7. For a non-preferred Multiple Sclerosis Agent with a therapeutically equivalent brand/generic or corresponding biosimilar/brand biologic/unbranded biologic that is preferred on the PDL, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred therapeutically equivalent brand/generic or corresponding biosimilar/brand biologic/unbranded biologic that would not be expected to occur with the requested drug;

AND

8. 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 member 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 member, 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 member.

D. Dose and Duration of Therapy

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

1. For Ampyra (dalfampridine ER):

   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 up to 3 days.

3. For Mavenclad (cladribine):

   a. Requests for prior authorization will be approved for a duration of therapy consistent with FDA-approved package labeling.

4. For all other agents:
   - New Request: 6 months
   - Renewal Request: 12 months

E. References:

1. Ampyra Package Insert. Pearl River, NY: Acorda Therapeutics, Inc.; June 2022.
2. Aubagio Package Insert. Cambridge, MA: Genzyme Corporation; June 2024.
3. Bafiertam Package Insert. High Point, NC: Banner Life Sciences; March 2024.
4. Briumvi Package Insert. Morrisville, NC:TG Therapeutics, Inc.; November 2024.
5. Clinical Resource, Multiple Sclerosis Treatments, The Pharmacists Letter/Prescriber's Letter. September 2017.
6. Gilenya Package Insert. East Hanover, New Jersey: Novartis Pharmaceuticals Corporation; June 2024.
7. 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.
8. Kesimpta Package Insert. East Hanover, NJ: Novartis Pharmaceuticals Corporation; April 2024.
9. Lemtrada Package Insert. Cambridge, MA: Genzyme Corporation; May 2024.
10. Mavenclad Package Insert. Rockland, MA: EMD Serono, Inc.; May 2024.
11. Mayzent Package Insert. East Hanover, NJ: Novartis Pharmaceuticals Corporation; June 2024.
12. 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.
13. Ocrevus (ocrelizumab) Package Insert. South San Francisco, CA: Genetech, Inc.; June 2024.
14. Ocrevus Zunovo Package Insert. South San Francisco, CA: Genetech, Inc.; September 2024.
15. Olek MJ, Mowry E. Overview of disease-modifying therapies for multiple sclerosis. Gonzalez-Scarano F, Dashe JF, eds. Waltham, MA: UpToDate Inc. Updated April 28, 2025. Accessed August 19, 2025.

16. Olek MJ, Mowry E. Initial disease-modifying therapy for relapsing-remitting multiple sclerosis in adults. Gonzalez-Scarano F, Dashe JF, eds. Waltham, MA: UpToDate Inc. Updated January 10, 2025. Accessed August 19, 2025.
17. Olek MJ, Mowry E. Treatment of primary progressive multiple sclerosis in adults. Gonzalez-Scarano F, Dashe JF, eds. Waltham, MA: UpToDate Inc. Updated January 10, 2025. Accessed August 19, 2025.
18. Olek MJ, Mowry E. Treatment of secondary progressive multiple sclerosis in adults. Gonzalez-Scarano F, Dashe JF, eds. Waltham, MA: UpToDate Inc. Updated May 05, 2025. Accessed August 19, 2025.
19. Ponvory Package Insert. Titusville, NJ: Janssen Pharmaceuticals, Inc.; August 2023.
20. Rae-Grant A, Day GS, Marrie RA, et al. Practice guideline recommendations summary: Disease-modifying therapies for adults with multiple sclerosis: Report of the Guideline Development, Dissemination, and Implementation Subcommittee of the American Academy of Neurology. Neurology 2018; 90:777.
21. Tascenso ODT Package Insert. Swindon, United Kingdom: Catalent Pharmaceuticals Ltd; January 2025.
22. Tecfidera Package Insert. Cambridge, MA: Biogen Inc.; March 2024.
23. Vumerity Package Insert. Cambridge, MA: Biogen Inc.; September 2024.
24. Zeposia Package Insert. Princeton, NJ: Bristol-Myers Squibb Company; August 2024.

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Q3 2020 annual review: no changes.	07/2020
Q1 2021: policy revised according to DHS revisions effective 01/05/2021	11/2020
Q1 2022: policy revised according to DHS revisions effective 01/03/2022	10/2021
Q1 2023 annual review: no changes.	11/2022
Q1 2024: policy revised according to DHS revisions effective 01/08/2024	11/2023
Q1 2025: policy revised according to DHS revisions effective 01/06/2025	11/2024
Q1 2026: policy revised according to DHS revisions effective 01/05/2026.	11/2025