JOHNS HOPKINS MEDICINE JOHNS HOPKINS HEALTHCARE	Johns Hopkins HealthCare LLC **Pharmacy Public** **Pharmacy Management Drug Policies**	*Policy Number*	MEDS052
		Effective Date	07/17/2013
		Review Date	10/19/2022
	Subject **Multiple Sclerosis Agents (Subcutaneous Injectable: Betaseron, Extavia, Avonex, Rebif, Plegridy, Copaxone, and Kesimpta; Oral: Tecfidera, Bafiertam, Gilenya, Tascenso ODT, Aubagio, Mavenclad, Mayzent, Vumerity, Ponvory)**	*Revision Date*	10/19/2022
		Page	1 of 6

This document applies to the following Participating Organizations:

Priority Partners

Keywords: Aubagio, Avonex, Betaseon, Copaxone, Extavia, Gilenya, Mavenclad, Mayzent, Plegridy, Ponvory, Rebif, Tascenso ODT, Tecfidera, Vumerity

Table of Contents		Page Number

I. POLICY

A. Self-administered injectable and oral medications for the treatment of multiple sclerosis (MS) will require prior authorization for appropriate use. The process for initiating a prior authorization request can be found in policy PHARM 20.
   1. PPMCO members are subject to the Priority Partners formulary, available at www.ppmco.org.
   2. USFHP members are subject to prior authorization criteria, step-edits and days-supply limits outlined in the Tricare Policy Manual. Tricare Policy supersedes JHHC Medical/Pharmacy Policies. Tricare limits may be accessed at: http://pec.ha.osd.mil/formulary_search.php?submenuheader=1

II. POLICY CRITERIA

A. *Subcutaneous Injectable Therapy*:
   1. **Extavia (interferon-1b), Plegridy (peginterferon-1a), or interferon-1a products (Avonex, Rebif)** may be approved for patients who meet the following:
      a. Patient is 18 years of age or older
      b. Documentation has been submitted showing ONE of the following:
         1. History of clinically isolated syndrome (CIS) confirmed by MRI
         2. Diagnosis of relapsing-remitting multiple sclerosis (RRMS) confirmed by MRI
         3. Diagnosis of secondary progressive multiple sclerosis (SPMS) with a current relapse
   2. **Betaseron (interferon-1b)** may be approved for patients who meet the following:
      a. Patient is 18 years of age or older
      b. Documentation has been submitted showing ONE of the following:
         1. History of clinically isolated syndrome (CIS) confirmed by MRI
         2. Diagnosis of relapsing-remitting multiple sclerosis (RRMS) confirmed by MRI
         3. Diagnosis of secondary progressive multiple sclerosis (SPMS) with a current relapse
      c. Documentation has been submitted showing trial and inadequate response to Extavia
   3. **Glatiramir acetate (generic of Copaxone)** may be approved for patients who meet the following:
      a. Patient is 18 years of age or older
      b. Documentation has been submitted showing ONE of the following:

1. History of clinically isolated syndrome (CIS) confirmed by MRI
2. Diagnosis of relapsing-remitting multiple sclerosis (RRMS) confirmed by MRI
3. Diagnosis of secondary progressive multiple sclerosis (SPMS) with a current relapse

c. *Requirements for **Brand Copaxone**:
1. Patient has met the criteria for coverage of the generic glatiramir acetate (noted above)
2. Documentation has been submitted showing trial and inadequate response to generic glatiramir acetate

4. **Kesimpta (ofatumumab)** may be approved for patients who meet the following:
a. Patient is 18 years of age or older
b. Documentation has been submitted showing ONE of the following:
1. History of clinically isolated syndrome (CIS) confirmed by MRI
2. Diagnosis of relapsing-remitting multiple sclerosis (RRMS) confirmed by MRI
3. Diagnosis of secondary progressive multiple sclerosis (SPMS) with a current relapse

B. *Oral Therapy*:
1. **Dimethyl fumarate (generic of Tecfidera)** may be approved for patients who meet the following:
a. Patient is 18 years of age or older
b. Documentation has been submitted showing ONE of the following:
1. History of clinically isolated syndrome (CIS) confirmed by MRI
2. Diagnosis of relapsing-remitting multiple sclerosis (RRMS) confirmed by MRI
3. Diagnosis of secondary progressive multiple sclerosis (SPMS) with a current relapse
c. Documentation has been submitted showing trial and inadequate response to injectable therapy, evidenced by frequent relapses, increasing MRI disease activity, or progressive disability
d. *Requirements for **Brand Tecfidera**:
1. Patient has met the criteria for coverage of the generic dimethyl fumarate (noted above)
2. Documentation has been submitted showing trial and inadequate response to generic dimethyl fumarate

2. **Bafiertam (monomethyl fumarate)** may be approved for patients who meet the following:
a. Patient is 18 years of age or older
b. Documentation has been submitted showing ONE of the following:
1. History of clinically isolated syndrome (CIS) confirmed by MRI
2. Diagnosis of relapsing-remitting multiple sclerosis (RRMS) confirmed by MRI
3. Diagnosis of secondary progressive multiple sclerosis (SPMS) with a current relapse
c. Documentation has been submitted showing trial and inadequate response to injectable therapy, evidenced by frequent relapses, increasing MRI disease activity, or progressive disability
d. Documentation has benen submitted showing trial and inadequate response to generic dimethyl fumarate

3. **Fingolimod (generic of Gilenya)** may be approved for patients who meet the following:
a. Pediatric patients:
1. Patient is 10 to 17 years of age
2. Documentation has been submitted showing ONE of the following:
i. History of clinically isolated syndrome (CIS) confirmed by MRI
ii. Diagnosis of relapsing-remitting multiple sclerosis (RRMS) confirmed by MRI
iii. Diagnosis of secondary progressive multiple sclerosis (SPMS) with a current relapse
b. Adult patients:
1. Patient is 18 years of age or older
2. Documentation has been submitted showing ONE of the following:
i. History of clinically isolated syndrome (CIS) confirmed by MRI

ii. Diagnosis of relapsing-remitting multiple sclerosis (RRMS) confirmed by MRI
iii. Diagnosis of secondary progressive multiple sclerosis (SPMS) with a current relapse

3. Documented trial and inadequate response to injectable therapy, evidenced by frequent relapses, increasing MRI disease activity, or progressive disability

c. *Requirements for **Brand Gilenya**:
1. Patient has met the criteria for coverage of the generic fingolimod (noted above)
2. Documentation has been submitted showing trial and inadequate response to generic fingolimod

4. **Tascenso ODT (fingolimod)** may be approved for patients who meet the following:
1. Pediatric patient is 10 years of age or older and weighing less than or equal to 40 kg (88.2 lbs)
2. Documentation has been submitted showing ONE of the following:
i. History of clinically isolated syndrome (CIS) confirmed by MRI
ii. Diagnosis of relapsing-remitting multiple sclerosis (RRMS) confirmed by MRI
iii. Diagnosis of secondary progressive multiple sclerosis (SPMS) with a current relapse

5. **Aubagio (teriflunomide), Vumerity (diroximel fumarate), or Ponvory (ponesimod)** may be approved for patients who meet the following:
a. Patient is 18 years of age or older
b. Documentation has been submitted showing ONE of the following:
1. History of clinically isolated syndrome (CIS) confirmed by MRI
2. Diagnosis of relapsing-remitting multiple sclerosis (RRMS) confirmed by MRI
3. Diagnosis of secondary progressive multiple sclerosis (SPMS) with a current relapse
c. Documentation has been submitted showing trial and inadequate response to injectable therapy, evidenced by frequent relapses, increasing MRI disease activity, or progressive disability
d. Documentation has been submitted showing trial and inadequate response to either generic dimethyl fumarate or fingolimod

6. **Zeposia (ozanimod):** * Please see policy MEDS140 for clinical criteria for coverage of Zeposia*

7. **Mavenclad (cladribine)** may be approved for patients who meet the following:
a. Patient is 18 years of age or older
b. Documentation has been submitted showing ONE of the following:
1. Diagnosis of relapsing-remitting multiple sclerosis (RRMS) confirmed by MRI
2. Diagnosis of secondary progressive multiple sclerosis (SPMS) with a current relapse
c. Documentation has been submitted showing trial and inadequate response to injectable therapy, evidenced by frequent relapses, increasing MRI disease activity, or progressive disability
d. Documentation has been submitted showing trial and inadequate response to either generic dimethyl fumarate or fingolimod

8. **Mayzent (Siponimod)** may be approved for patients who meet the following:
a. Patient is 18 years of age or older
b. Documentation has been submitted showing showing ONE of the following:
1. History of clinically isolated syndrome (CIS) confirmed by MRI
2. Diagnosis of relapsing-remitting multiple sclerosis (RRMS) confirmed by MRI
3. Diagnosis of secondary progressive multiple sclerosis (SPMS) with a current relapse
c. Documentation has been submitted showing one of the following CYP2C9 genotype test results:
1. Patient has genotype *1/*1, *1/*2, or *2/*2
2. Patient has genotype *1/*3 or *2/*3 (dosing adjustment required)

d. Documentation has been submitted showing trial and inadequate response to injectable therapy, evidenced by frequent relapses, increasing MRI disease activity, or progressive disability
e. Documentation has been submitted showing trial and inadequate response to either generic dimethyl fumarate or fingolimod

III. AUTHORIZATION PERIOD/LIMITATIONS

A. Initial approval will be up to 12 months of therapy.
B. Approval for continuation of therapy may be extended in up to 12-month intervals with documentation showing the patient's clinical improvement from treatment as supported by one of the following:
   1. Reduction in clinical relapses
   2. Lack of new or enlarging lesion per MRI evaluation
C. Limitations:
   1. Mavenclad may be approved for two cycles per 12-month period. Following two years (4 cycles) of treatment, Mavenclad will not be eligible for continuation.
   2. Continuation of therapy with Tascenso ODT is limited to current users that meet the continuation criteria and still have a weight less than or equal to 40 kg. If a patient's weight exceeds 40 kg after treatment initiation, the patient should be switched to an alternative product approved for use in the patient's current weight group.

IV. EXCLUSIONS

A. The Multiple Sclerosis agents will not be approved for the following:
   1. Concurrent therapy with more than one disease-modifying MS therapy
   2. Any indications that are not FDA-approved, or guideline-supported
   3. Additional drug-specific exclusions include:
      a. Mayzent will not be approved for the following:
         i. Patients with CYP2C9 *3/*3 genotype
         ii. Patients who have experienced myocardial infarction, unstable angina, stroke, TIA, decompensated heart failure requiring hospitalization, or Class III/IV heart failure within 6 months of the prior authorization request
         iii. Patients with Mobitz type II second-degree, third-degree AV block, or sick sinus syndrome, without a functioning pacemaker
      b. Mavenclad will not be approved for the following:
         i. Patients with clinically isolated syndrome because of its safety profile
         ii. More than two treatment courses (4 cycles over a 2-year total duration)
      c. Tascenso ODT will not be approved for the following:
         i. Pediatric patients younger than 10 years of age
         ii. Patients that weigh more than 40kg
         iii. Adult patients
         iv. Concurrent use with another fingolimod product
B. The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.

V. RECOMMENDED DOSE AND DOSAGE FORMS

All FDA approved dosage(s) and dosing interval(s) for the FDA approved indication(s).

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		Page	5 of 6

VI. REFERENCES

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VII. APPROVALS

Signature on file at JHHC

DATE OF REVISION	SUMMARY OF CHANGE
07/02/2013	Addition of Oral MS medications: Tecfidera, Gilenya, Aubagio
12/12/2014	Addition of Plegridy, removal of PA for EHP members for Copaxone, Avonex, and Rebif
04/15/2015	Made Gilenya Par with Tecfidera
03/28/2016	Removed background information
10/19/2016	Addition of criteria for Zinbryta
07/27/2017	Updated Exclusions section regarding physician samples
10/18/2017	Removal of medical injectable drugs (Tysabri & Novantrone) from pharmacy coverage policy
05/01/2018	Removal of Zinbryta due to its market withdrawal
07/01/2018	Removal of EHP as an applicable Line of Business
07/17/2019	Updated criteria layout, and added criteria for Mavenclad

09/17/2019	Added criteria for Mayzent
11/13/2019	Updated Copaxone criteria using Prescribing Information
01/15/2020	Added criteria for Vumerity and updated layout
07/15/2020	Added criteria for Zeposia
10/21/2020	Added additional criteria for Betaseron to reflect non-formulary status
11/12/2020	Clarified criteria for brand Copaxone, pediatric use of Gilenya, and continuation therapy for Mavenclad
01/20/2021	Added criteria for Kesimpta and Bafiertam; clarified criteria for brand Tecifidera
07/21/2021	Added criteria for Ponvory
10/20/2021	Moved Zeposia to its own drug-specific policy; clarified continuation of therapy criteria
10/19/2022	Added criteria for Tascenso ODT, a new formulation of fingolimod (generic of Gilenya

Review/Revision Dates: 07/02/2013, 12/12/2014, 03/1/2014, 04/15/2015, 3/28/2016, 10/19/2016, 07/27/2017, 10/18/2017, 05/01/2018, 07/01/2018, 07/17/2019, 09/17/2019, 10/16/2019, 11/13/2019, 01/15/2020, 07/15/2020, 10/21/2020, 11/12/2020, 01/20/2021, 07/21/2021, 10/20/2021, 10/19/2022