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|---|---------------------------------|------------------------|
| <br><b>KMTSJ, Inc.</b> | DEPARTMENT:                     | Utilization Management |
|   | SUBJECT:                        | Multiple Sclerosis     |
|   | PRODUCT LINE:                   | All                    |
|   | POLICY NUMBER:                  | UM119                  |
|   | ORIGINAL POLICY EFFECTIVE DATE: | 12/21/2021             |
|   | LAST REVISED DATE:              | 12/16/2022             |
|   | LAST REVIEWED DATE:             | 12/15/2023             |

**SCOPE:**

To ensure Group Health Cooperative of Eau Claire consistently and correctly administers benefits to all members according to their policy benefits.

**POLICY:**

It is the policy of Group Health Cooperative of Eau Claire to review requests for multiple sclerosis treatments according to member policy and evidence-based medical criteria through the prior authorization process.

**PROCEDURE: Prior Authorization Required: YES**

**Coverage Criteria for Relapsing-Remitting MS (RRMS)**

**First Line treatments:**

First line treatment for RRMS includes the following conventional therapies:

**Oral**

- Fingolimod (Gilenya)
- Teriflunomide (Aubagio)
- Dimethyl fumarate (Tecfidera) \*
- Monomethyl fumarate (Bafiertam)
- Siponimod (Mayzent)
- Diroximel fumarate (Vumerity)
- Ozanimod (Zeposia)
- dalfampridine (Ampyra)

**Subcutaneous**

- Glatiramer acetate (Copaxone) \*

**Second line treatments:**


Member must have a diagnosis of moderate-severe RRMS and had an insufficient response to at least 3 of the conventional therapies listed under the first line treatments including Copaxone and Tecfidera.

**Oral**

- Cladribine (Mavenclad)

**Subcutaneous**

- Ofatumumab (Kesimpta)
- Interferon beta -1a (Avonex)
- Interferon beta -1a (Rebif)
- Peginterferon beta-1a (Plegridy)
- Interferon beta -1b (Betaseron)
- Interferon beta -1b (Extavia)

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**Third line treatments:**

Member must have a diagnosis of moderate-severe RRMS and had an insufficient response to at least 2 of the conventional therapies listed under the second line treatments.

**Intravenous**

Natalizumab (Tysabri)  
 Mitoxantrone hydrochloride  
 Ocrelizumab (Ocrevus)

**Coverage Criteria for Secondary Progressive MS (SPMS)**

**First Line treatments:**

First line treatment for SPMS includes the following conventional therapies:

**Oral**

Fingolimod (Gilenya)  
 Teriflunomide (Aubagio)  
 Dimethyl fumarate (Tecfidera) \*  
 Monomethyl fumarate (Bafiertam)  
 Siponimod (Mayzent)  
 Diroximel fumarate (Vumerity)  
 Ozanimod (Zeposia)  
 dalfampridine (Ampyra)

**Subcutaneous**

Glatiramer acetate (Copaxone) \*

**Second line treatments:**


Member must have a diagnosis of moderate-severe SPMS and had an insufficient response to at least 3 of the conventional therapies listed under the first line treatments including Copaxone and Tecfidera.

**Oral**

Cladribine (Mavenclad)

**Subcutaneous**

Ofatumumab (Kesimpta)  
 Interferon beta -1a (Avonex)  
 Interferon beta -1a (Rebif)  
 Peginterferon beta-1a (Plegridy)  
 Interferon beta -1b (Betaseron)  
 Interferon beta -1b (Extavia)

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**Third line treatments:**

Member must have a diagnosis of moderate-severe SPMS and had an insufficient response to at least 2 of the conventional therapies listed under the second line treatments.

**Intravenous**

Natalizumab (Tysabri)  
 Mitoxantrone hydrochloride  
 Ocrelizumab (Ocrevus)

**Coverage Criteria for Primary Progressive MS (PPMS)**

**First Line treatments:**

First line treatment for those diagnosed with PPMS meeting the following criteria:

1. One year of disease progression (worsening of neurological function without remission)
2. Two of the following
  - a. A type of lesion in the brain that is recognized by experts in as being typical of MS
  - b. Two or more lesions of a similar type in the spinal cord
  - c. Evidence in the spinal fluid of oligoclonal band or an elevated IgG index, both of which are indicative of immune system activity in the central nervous system.

**Subcutaneous**

Glatiramer acetate (Copaxone) (Glatopa)

**Intravenous**

Ocrelizumab (Ocrevus)

APPROVED: 

DATE: 12/15/2023

**REVISION HISTORY:**

| Rev. Date  | Revised By/Title   | Summary of Revision                 |
|------------|--------------------|-------------------------------------|
| 12/21/2021 | Dakota Rau, PharmD | No changes                          |
| 12/16/2022 | Dakota Rau, PharmD | Updated criteria for PPMS diagnosis |
| 12/15/2023 | Dakota Rau, PharmD | No changes                          |
|            |                    |                                     |



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