Field Name	Field Description
Prior Authorization Group Description	**Central Nervous System (CNS) Agents: Multiple Sclerosis* LEGACY CATEGORY**
Drugs	**Preferred Agents:** AVONEX BETASERON COPAXONE BvG dalfampridine dimethyl fumarate fingolimod GILENYA KESIMPTA REBIF Teriflunomide **Non-Preferred Agents:** BAFIERTAM glatiramer glatopa MAVENCLAD MAYZENT OCREVUS PLEGRIDY PONVORY TASCENSO ODT VUMERITY ZEPOSIA
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Tysabri, or Briumvi: • Primary Progressive MS (PPMS) Lemtrada: • PPMS • Clinically Isolated Syndrome (CIS)
Required Medical Information	See "Other Criteria"
Age Restrictions	Patients must be age appropriate per PPI, nationally recognized compendia, or peer-reviewed medical literature
Prescriber Restrictions	Prescriber must be a neurologist
Coverage Duration	If all of the criteria are met, the request will be approved for 12 months.
Other Criteria	**Initial Authorization**

	<u>CIS, Relapsing Remitting MS (RRMS), Secondary Progressive MS (SPMS)</u> • Diagnosis of CIS, RRMS, or SPMS • The medication is being prescribed at a dose consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature • Documented trial of at least TWO preferred agents [dimethyl fumarate, glatiramer, fingolimod (Gilenya)], or a documented medical reason (e.g. contraindication, intolerance, hypersensitivity, etc.) for not utilizing these therapies. OR For patients with "highly active" MS requesting Lemtrada (alemtuzumab), Tysabri (natalizumab), or rituximab, a trial with fingolimod (Gilenya) alone will be acceptable. • If the request is for any medication other the Briumvi (ublituximab) there is a documented trial and failure of Briumvi (ublituximab), or medical reason (e.g., intolerance, hypersensitivity, contraindication) why the patient cannot use Briumvi (ublituximab) • If the request is for Ocrevus (ocrelizumab), Ocrevus Zunovo (ocrelizumab-hyaluronidase-ocsq), Briumvi (ublituximab), or rituximab, documentation of the following: o Attestation that the patient has been screened for and does not have active hepatitis B virus (HBV) • If the request is for Tysabri (natalizumab), documentation of the following o Patient does not have a history of progressive multifocal leukoencephalopathy (PML) o Documentation consistent with pharmacy claims data indicating the patient is not currently using any antineoplastic, immunosuppressant, or immunomodulating medications • If the request is for a rituximab product other than Ruxience (rituximab-pvvr), documented trial and failure of Ruxience (rituximab-pvvr), or medical reason (e.g. intolerance, hypersensitivity, contraindication) why the patient cannot use Ruxience (rituximab-pvvr) <u>Primary Progressive Multiple Sclerosis (PPMS)</u> • Diagnosis of PPMS • The medication is being prescribed at a dose consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature • If the request is for Ocrevus (ocrelizumab), Ocrevus Zunovo (ocrelizumab-hyaluronidase-ocsq), or rituximab, documentation of the following has been submitted

Revision/Review Date 4/2025	o Attestation that the patient has been screened for and does not have active HBV • If the request is for a rituximab product other than Ruxience (rituximab-pvvr), documented trial and failure of Ruxience (rituximab-pvvr), or medical reason (e.g. intolerance, hypersensitivity, contraindication) why the patient cannot use Ruxience (rituximab-pvvr) • If the request is for Rituxan Hycela (rituximab/hyaluronidase), all of the above AND documented medical reason why the patient cannot use Rituxan (rituximab). **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category **ADDITIONAL OCRELIZUMAB (OCREVUS) CRITERIA:** • Must provide documentation of diagnosis of primary progressive multiple sclerosis **OR** must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category **ADDITIONAL SIPONIMOD (MAYZENT) CRITERIA:** • Must provide documentation of CYP2C9 genotype **<u>Reauthorization</u>** <u>CIS</u> • The medication is being prescribed at a dose consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature • Documentation was provided that the prescriber has reviewed the risks and benefits of continuing DMT versus stopping. <u>RRMS, SPMS, or PPMS</u> • Documentation that the prescriber has evaluated the member and recommends continuation of therapy (clinical benefit) • The medication is being prescribed at a dose consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature • If the request is for Lemtrada (alemtuzumab), documentation of the following o At least 12 months has or will have elapsed since previous treatment • If the request is for Tysabri (natalizumab), documentation of the following has been submitted

	o Patient does not have a history of PML o Documentation consistent with pharmacy claims data was submitted indicating the patient is not currently using any antineoplastic, immunosuppressant, or immunomodulating medications **<u>Continuation of Therapy/ Provision:</u>** Members with history (within the past 180 days or past 12 months for Lemtrada [alemtuzumab]) of a non-preferred product are not required to try a preferred agent prior to receiving the non-preferred product. **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**