CARE VALUE POLICY

POLICY: Multiple Sclerosis Care Value Policy

- Aubagio® (teriflunomide tablets – Genzyme/Sanofi)
- Avonex® (interferon beta-1a injection [intramuscular] – Biogen Idec)
- Bafiertam™ (monomethyl fumarate delayed-release capsules – Banner Life Sciences)
- Betaseron® (interferon beta-1b injection [subcutaneous] – Bayer)
- Copaxone® (glatiramer acetate injection [subcutaneous] – Teva, generic)
- Extavia® (interferon beta-1b injection [subcutaneous] – Novartis)
- Gilenya® (fingolimod capsules – Novartis)
- Glatopa® (glatiramer acetate injection [subcutaneous] – Sandoz, generic)
- Kesimpta (ofatumumab injection [subcutaneous] – Novartis)
- Mavenclad® (cladribine tablets – EMD Serono)
- Mayzent® (siponimod tablets – Novartis)
- Plegridy® (peginterferon beta-1a injection [subcutaneous] – Biogen Idec)
- Ponvory™ (ponesimod tablets – Janssen)
- Rebif® (interferon beta-1a injection [subcutaneous] – Serono)
- Tecfidera® (dimethyl fumarate delayed-release capsules – Biogen, generic)
- Vumerity® (diroximel fumarate delayed-release capsules – Biogen/Alkermes)
- Zeposia® (ozanimod capsules – Celgene)

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OVERVIEW

This Care Value policy involves the use of self-administered injectable products and oral disease-modifying agents used in **multiple sclerosis**.[1-19] All products are indicated for use in adults. Of note, Gilenya is the only agent specifically indicated for children ≥ 10 to < 18 years of age for the treatment of relapsing forms of multiple sclerosis.[10] Mayzent has an indication for use in active secondary progressive multiple sclerosis and its pivotal data involved this patient population.[13] Glatiramer injection and Tecfidera only have limited data in this patient subset. Zeposia is also indicated for use in adults with moderately to severely active ulcerative colitis.[16] A practice guideline recommendation regarding disease-modifying agents for adults with multiple sclerosis from the American Academy of Neurology (2018) includes Gilenya as one of the agents to consider for patients with multiple sclerosis who have highly active disease.

POLICY STATEMENT

The **Multiple Sclerosis Care Value Program** has been developed to encourage the use of the Preferred Product(s) (generic glatiramer injection and generic dimethyl fumarate delayed-release capsules). For all Non-Preferred Products the patient is required to meet the respective standard *Prior Authorization Policy* criteria. Requests for the Preferred Products do not have to meet standard *Prior Authorization Policy* criteria. The Program also directs the patient to try one Preferred Product (generic glatiramer injection or generic dimethyl fumarate delayed-release capsules) prior to the approval of a Non-Preferred Product. Requests for Non-Preferred Products will also be reviewed using the exception criteria (below). All approvals are provided for 1 year.

The **Tecfidera (Brand) Care Value Program** has been developed to encourage the use of both Preferred Products (generic glatiramer injection and generic dimethyl fumarate delayed-release capsules). For the Non-Preferred Product, the patient is required to meet the respective standard *Prior Authorization Policy*

criteria. Requests for the Preferred Products do not have to meet standard *Prior Authorization Policy* criteria. Requests for the Non-Preferred Product will also be reviewed using the exception criteria (below). All approvals are provided for 1 year.

Automation: None.

Documentation: Documentation is required for use of Gilenya as noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to, chart notes, prescription claims records, and magnetic resonance imaging (MRI) reports and/or other information.

Multiple Sclerosis Care Value Program

Preferred Products:	generic glatiramer injection, generic dimethyl fumarate delayed-release capsules
Non-Preferred Products:	Aubagio, Avonex, Bafiertam, Betaseron, Copaxone, Extavia, Gilenya, Glatopa, Kesimpta, Mavenclad, Mayzent, Plegridy, Ponvory, Rebif, Vumerity, Zeposia

Tecfidera (Brand) Care Value Program

Preferred Products:	generic glatiramer injection and generic dimethyl fumarate delayed-release capsules
Non-Preferred Product:	Tecfidera (brand)

RECOMMENDED EXCEPTION CRITERIA

I. Multiple Sclerosis Care Value Program

Non-Preferred Product	Exception Criteria
Aubagio	**1.** Approve if the patient meets the following criteria (A and B): **A)** Patient meets the standard *Multiple Sclerosis – Aubagio Prior Authorization Policy* criteria; AND **B)** Patient meets one of the following (i, ii, or iii): **i.** Patient has been established on Aubagio for ≥ 120 days; OR **ii.** Patient meets both of the following (a and b): **a)** Patient has tried generic dimethyl fumarate delayed-release capsules; AND **b)** Patient has experienced inadequate efficacy or significant intolerance according to the prescriber; OR Note: Prior use of Tecfidera with inadequate efficacy or significant intolerance (according to the prescriber) also counts. **iii.** Patient meets both of the following (a and b): **a)** Patient has tried generic glatiramer injection; AND **b)** Patient has experienced inadequate efficacy or significant intolerance, according to the prescriber. Note: Prior use of Copaxone or Glatopa with inadequate efficacy or significant intolerance (according to the prescriber) also counts.

Non-Preferred Product	Exception Criteria
Avonex	**1.** Approve if the patient meets the following criteria (A and B): **A)** Patient meets the standard *Multiple Sclerosis – Avonex Prior Authorization Policy* criteria; AND **B)** Patient meets one of the following (i, ii, or iii): **i.** Patient has been established on Avonex for ≥ 120 days; OR **ii.** Patient meets both of the following (a and b): **a)** Patient has tried generic dimethyl fumarate delayed-release capsules; AND **b)** Patient has experienced inadequate efficacy or significant intolerance according to the prescriber; OR Note: Prior use of Tecfidera with inadequate efficacy or significant intolerance (according to the prescriber) also counts. **iii.** Patient meets both of the following (a and b): **a)** Patient has tried generic glatiramer injection; AND **b)** Patient has experienced inadequate efficacy or significant intolerance, according to the prescriber. Note: Prior use of Copaxone or Glatopa with inadequate efficacy or significant intolerance (according to the prescriber) also counts.
Bafiertam	**1.** Approve if the patient meets the following criteria (A and B): **A)** Patient meets the standard *Multiple Sclerosis – Bafiertam Prior Authorization Policy* criteria; AND **B)** Patient meets one of the following (i ii, or iii): **i.** Patient has been established on Bafiertam for ≥ 120 days; OR **ii.** Patient meets both of the following (a and b): **a)** Patient has tried generic dimethyl fumarate delayed-release capsules; AND **b)** Patient has experienced inadequate efficacy or significant intolerance, according to the prescriber; OR Note: Prior use of Tecfidera with inadequate efficacy or significant intolerance (according to the prescriber) also counts. **iii.** Patient meets both of the following (a and b): **a)** Patient has tried generic glatiramer injection; AND **b)** Patient has experienced inadequate efficacy or significant intolerance, according to the prescriber. Note: Prior use of Copaxone or Glatopa with inadequate efficacy or significant intolerance (according to the prescriber) also counts.

Non-Preferred Product	Exception Criteria
Betaseron	**1.** Approve if the patient meets the following criteria (A and B): **A)** Patient meets the standard *Multiple Sclerosis – Betaseron/Extavia Prior Authorization Policy* criteria; AND **B)** Patient meets one of the following (i, ii, or iii): **i.** Patient has been established on Betaseron for ≥ 120 days; OR **ii.** Patient meets both of the following (i, ii, or iii): **a)** Patient has tried generic dimethyl fumarate delayed-release capsules; AND **b)** Patient has experienced inadequate efficacy or significant intolerance according to the prescriber; OR Note: Prior use of Tecifera with inadequate efficacy or significant intolerance (according to the prescriber) also counts. **iii.** Patient meets both of the following (a and b): **a)** Patient has tried generic glatiramer injection; AND **b)** Patient has experienced inadequate efficacy or significant intolerance, according to the prescriber. Note: Prior use of Copaxone or Glatopa with inadequate efficacy or significant intolerance (according to the prescriber) also counts.
Copaxone 20 mg/mL and 40 mg/mL	**1.** Approve if the patient meets the following criteria (A and B): **A)** Patient meets the standard *Multiple Sclerosis – Glatiramer Products Prior Authorization Policy* criteria; AND **B)** Patient meets one of the following (i or ii): **i.** Patient meets both of the following criteria (a and b): **a)** Patient has tried generic dimethyl fumarate delayed-release capsules; AND **b)** Patient has experienced inadequate efficacy or significant intolerance, according to the prescriber; OR Note: Prior use of Tecfidera with inadequate efficacy or significant intolerance (according to the prescriber) also counts. **ii.** Patient meets both of the following (a and b): **a)** Patient has tried generic glatiramer injection; AND **b)** Copaxone is being requested due to a formulation difference in the inactive ingredient(s) [e.g., preservatives] between the brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction.

Non-Preferred Product	Exception Criteria
Extavia	**1.** Approve if the patient meets the following criteria (A and B): **A)** Patient meets the standard *Multiple Sclerosis – Betaseron/Extavia Prior Authorization Policy* criteria; AND **B)** Patient meets one of the following (i, ii, or ii): **i.** Patient has been established on Extavia for ≥ 120 days; OR **ii.** Patient meets both of the following (a and b): **a)** Patient has tried generic dimethyl fumarate delayed-release capsules; AND **b)** Patient has experienced inadequate efficacy or significant intolerance according to the prescriber; OR Note: Prior use of Tecfidera with inadequate efficacy or significant intolerance (according to the prescriber) also counts. **iii.** Patient meets both of the following (a and b): **a)** Patient has tried generic glatiramer injection; AND **b)** Patient has experienced inadequate efficacy or significant intolerance, according to the prescriber. Note: Prior use of Copaxone or Glatopa with inadequate efficacy or significant intolerance (according to the prescriber) also counts.

Non-Preferred Product	Exception Criteria
Gilenya	**1.** Approve if the patient meets the following criteria (A and B): **A)** Patient meets the standard *Multiple Sclerosis – Gilenya Prior Authorization Policy* criteria; AND **B)** Patient meets one of the following (i, ii, iii, iv, or v): **i.** Patient has been established on Gilenya for ≥ 120 days; OR **ii.** Patient is ≥ 10 to < 18 years of age; OR **iii.** According to the prescriber, the patient has highly active or aggressive multiple sclerosis meeting one of the following (a, b, c, or d): **a)** Patient has demonstrated rapidly advancing deterioration(s) in physical functioning **[documentation required]**; OR Note: Examples include loss of mobility/or lower levels of ambulation, or severe changes in strength or coordination. **b)** Disabling relapse(s) with suboptimal response to systemic corticosteroids **[documentation required]**; OR **c)** Magnetic resonance imaging (MRI) findings suggest highly active or aggressive multiple sclerosis **[documentation required]**; OR Note: Examples include new, enlarging, or a high burden of T2 lesions or gadolinium-enhancing lesions. **d)** Manifestations of multiple sclerosis-related cognitive impairment **[documentation required]**; OR **iv.** Patient meets both of the following (a and b): **a)** Patient has tried generic dimethyl fumarate delayed-release capsules; AND **b)** Patient has experienced inadequate efficacy or significant intolerance according to the prescriber; OR Note: Prior use of Tecfidera with inadequate efficacy or significant intolerance (according to the prescriber) also counts. **v.** Patient meets both of the following (a and b): **a)** Patient has tried generic glatiramer injection; AND **b)** Patient has experienced inadequate efficacy or significant intolerance, according to the prescriber. Note: Prior use of Copaxone or Glatopa with inadequate efficacy or significant intolerance (according to the prescriber) also counts.

Non-Preferred Product	Exception Criteria
Glatopa 20 mg/mL and 40 mg/mL	**1.** Approve if the patient meets the following criteria (A and B): **A)** Patient meets the standard *Multiple Sclerosis – Glatiramer Products Prior Authorization Policy* criteria; AND **B)** Patient meets one of the following (i or ii): **i.** Patient meets both of the following criteria (a and b): **a)** Patient has tried generic dimethyl fumarate delayed-release capsules; AND **b)** Patient has experienced inadequate efficacy or significant intolerance, according to the prescriber; OR Note: Prior use of Tecfidera with inadequate efficacy or significant intolerance (according to the prescriber) also counts. **ii.** Patient meets both of the following (a and b): **a)** Patient has tried generic glatiramer injection; AND **b)** Glatopa is being requested due to a formulation difference in the inactive ingredient(s) [e.g., preservatives] between the brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction.
Kesimpta	**1.** Approve if the patient meets the following criteria (A and B): **A)** Patient meets the standard *Multiple Sclerosis – Kesimpta Prior Authorization Policy* criteria; AND **B)** Patient meets one of the following (i ii, or iii): **i.** Patient has been established on Kesimpta for ≥ 120 days; OR **ii.** Patient meets both of the following (a and b): **a)** Patient has tried generic dimethyl fumarate delayed-release capsules; AND **b)** Patient has experienced inadequate efficacy or significant intolerance, according to the prescriber; OR Note: Prior use of Tecfidera with inadequate efficacy or significant intolerance (according to the prescriber) also counts. **iii.** Patient meets both of the following (a and b): **a)** Patient has tried generic glatiramer injection; AND **b)** Patient has experienced inadequate efficacy or significant intolerance, according to the prescriber. Note: Prior use of Copaxone or Glatopa with inadequate efficacy or significant intolerance (according to the prescriber) also counts.

Non-Preferred Product	Exception Criteria
Mavenclad	**1.** Approve if the patient meets the following criteria (A and B): **A)** Patient meets the standard *Multiple Sclerosis – Mavenclad Prior Authorization Policy* criteria; AND **B)** Patient meets one of the following (i, ii, or iii): **i.** Patient has been established on Mavenclad for ≥ 120 days; OR **ii.** Patient meets both of the following (a and b): **a)** Patient has tried generic dimethyl fumarate delayed-release capsules; AND **b)** Patient has experienced inadequate efficacy or significant intolerance, according to the prescriber; OR Note: Prior use of Tecfidera with inadequate efficacy or significant intolerance (according to the prescriber) also counts. **iii.** Patient meets both of the following (a and b): **a)** Patient has tried generic glatiramer injection; AND **b)** Patient has experienced inadequate efficacy or significant intolerance, according to the prescriber. Note: Prior use of Copaxone or Glatopa with inadequate efficacy or significant intolerance (according to the prescriber) also counts.
Mayzent	**1.** Approve if the patient meets the following criteria (A and B): **A)** Patient meets the standard *Multiple Sclerosis – Mayzent Prior Authorization Policy* criteria; AND **B)** Patient meets one of the following (i, ii, iii, or iv): **i.** Patient has been established on Mayzent for ≥ 120 days; OR **ii.** Patient has active secondary progressive multiple sclerosis; OR **iii.** Patient meets both of the following (a and b): **a)** Patient has tried generic dimethyl fumarate delayed-release capsules; AND **b)** Patient has experienced inadequate efficacy or significant intolerance, according to the prescriber; OR Note: Prior use of Tecfidera with inadequate efficacy or significant intolerance (according to the prescriber) also counts. **iv.** Patient meets both of the following (a and b): **a)** Patient has tried generic glatiramer injection; AND **b)** Patient has experienced inadequate efficacy or significant intolerance, according to the prescriber. Note: Prior use of Copaxone or Glatopa with inadequate efficacy or significant intolerance (according to the prescriber) also counts.

Non-Preferred Product	Exception Criteria
Plegridy	**1.** Approve if the patient meets the following criteria (A and B): **A)** Patient meets the standard *Multiple Sclerosis – Plegridy Prior Authorization Policy* criteria; AND **B)** Patient meets one of the following (i, ii, or ii): **i.** Patient has been established on Plegridy for ≥ 120 days; OR **ii.** Patient meets both of the following (a and b): **a)** Patient has tried generic dimethyl fumarate delayed-release capsules; AND **b)** Patient has experienced inadequate efficacy or significant intolerance, according to the prescriber; OR Note: Prior use of Tecfidera with inadequate efficacy or significant intolerance (according to the prescriber) also counts. **iii.** Patient meets both of the following (a and b): **a)** Patient has tried generic glatiramer injection; AND **b)** Patient has experienced inadequate efficacy or significant intolerance, according to the prescriber. Note: Prior use of Copaxone or Glatopa with inadequate efficacy or significant intolerance (according to the prescriber) also counts.
Ponvory	**1.** Approve if the patient meets the following criteria (A and B): **A)** Patient meets the standard Multiple Sclerosis – *Ponvory Prior Authorization Policy* criteria; AND **B)** Patient meets one of the following (i, ii, or iii): **i.** Patient has been established on Ponvory for ≥ 120 days; OR **ii.** Patient meets both of the following (a and b): **a)** Patient has tried generic dimethyl fumarate delayed-release capsules; AND **b)** Patient has experienced inadequate efficacy or significant intolerance, according to the prescriber; OR Note: Prior use of Tecfidera with inadequate efficacy or significant intolerance (according to the prescriber) also counts. **iii.** Patient meets both of the following (a and b): **a)** Patient has tried generic glatiramer injection; AND **b)** Patient has experienced inadequate efficacy or significant intolerance, according to the prescriber. Note: Prior use of Copaxone or Glatopa with inadequate efficacy or significant intolerance (according to the prescriber) also counts.

Non-Preferred Product	Exception Criteria
Rebif	**1.** Approve if the patient meets the following criteria (A and B): **A)** Patient meets the standard *Multiple Sclerosis – Rebif Prior Authorization Policy* criteria; AND **B)** Patient meets one of the following (i, ii, or iii): **i.** Patient has been established on Rebif for ≥ 120 days; OR **ii.** Patient meets both of the following (a and b): **a)** Patient has tried generic dimethyl fumarate delayed-release capsules; AND **b)** Patient has experienced inadequate efficacy or significant intolerance, according to the prescriber; OR Note: Prior use of Tecfidera with inadequate efficacy or significant intolerance (according to the prescriber) also counts. **iii.** Patient meets both of the following (a and b): **a)** Patient has tried generic glatiramer injection; AND **b)** Patient has experienced inadequate efficacy or significant intolerance, according to the prescriber. Note: Prior use of Copaxone or Glatopa with inadequate efficacy or significant intolerance (according to the prescriber) also counts.
Vumerity	**1.** Approve if the patient meets the following criteria (A and B): **A)** Patient meets the standard *Multiple Sclerosis – Vumerity Prior Authorization Policy* criteria; AND **B)** Patient meets one of the following (i, ii, or iii): **i.** Patient has been established on Vumerity for ≥ 120 days; OR **ii.** Patient meets both of the following (a and b): **a)** Patient has tried generic dimethyl fumarate delayed-release capsules; AND **b)** Patient has experienced inadequate efficacy or significant intolerance according to the prescriber; OR Note: Prior use of Tecfidera with inadequate efficacy or significant intolerance (according to the prescriber) also counts. **iii.** Patient meets both of the following (a and b): **a)** Patient has tried generic glatiramer injection; AND **b)** Patient has experienced inadequate efficacy or significant intolerance, according to the prescriber. Note: Prior use of Copaxone or Glatopa with inadequate efficacy or significant intolerance (according to the prescriber) also counts.
Zeposia	Refer to the *Multiple Sclerosis and Ulcerative Colitis – Zeposia Care Value Policy* criteria.

II. Tecfidera (Brand) Care Value Program

Non-Preferred Product	Exception Criteria
Tecfidera (brand)	**1.** Approve if the patient meets the following criteria (A and B): **A)** Patient meets the standard *Multiple Sclerosis – Dimethyl Fumarate (Tecfidera) Prior Authorization Policy* criteria; AND **B)** Patient meets one of the following (i or ii): **i.** Patient established on Tecfidera (brand) for ≥ 120 days must meet the following (a and b): **a)** Patient has tried generic dimethyl fumarate delayed-release capsules; AND **b)** Brand Tecfidera is being requested due to a formulation difference in the inactive ingredient(s) [e.g., differences in dyes, fillers, preservatives] between the brand and the bioequivalent generic which, per the prescriber, would result in a significant allergy or serious adverse reaction; OR **ii.** Patient has not received Tecfidera (brand) or has received Tecfidera (brand) for < 120 days must meet both of the following (a and b): **a)** Patient meets both of the following [(1) and (2)]: **(1)** Patient has tried generic dimethyl fumarate delayed-release capsules; AND **(2)** Brand Tecfidera is being requested due to a formulation difference in the inactive ingredient(s) [e.g., differences in dyes, fillers, preservatives] between the brand and the bioequivalent generic which, per the prescriber, would result in a significant allergy or serious adverse reaction; AND **b)** Patient meets both of the following [(1) and (2)]: **(1)** Patient has tried generic glatiramer injection; AND **(2)** Patient has experienced inadequate efficacy or significant intolerance according to the prescriber. Note: Prior use of Copaxone or Glatopa with inadequate efficacy or significant intolerance (according to the prescriber) also counts.

REFERENCES

1. Avonex® intramuscular injection [prescribing information]. Cambridge, MA: Biogen, Inc.; March 2020.
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3. Copaxone® injection for subcutaneous use [prescribing information]. Overland Park, KS and North Wales, PA Teva Neuroscience/Pharmaceuticals, Inc.; July 2020.
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7. Glatopa™ injection for subcutaneous use [prescribing information]. Princeton, NJ: Sandoz; February 2020.
8. Rebif® subcutaneous injection [prescribing information]. Rockland, MA: EMD Serono, Inc; June 2020.
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13. Mayzent™ tablets [prescribing information]. East Hanover, NJ: Novartis; March 2019.
14. Tecfidera® delayed-release capsules [prescribing information]. Cambridge, MA: Biogen Idec, Inc; February 2020.

15. Vumerity® delayed-release capsules [prescribing information]. Cambridge, MA and Waltham, MA: Biogen and Alkermes; March 2020.
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