Field Name	Field Description
Prior Authorization Group Description	**Healthcare professional (HCP) administered Disease Modifying Therapies (DMTs) for Multiple Sclerosis (MS)**
Drugs	**Ocrevus (ocrelizumab), Riabni (rituximab), Ruxience (rituximab), Truxima (rituximab), Rituxan (rituximab), Rituxan Hycela (rituximab/hyaluronidase), Lemtrada (alemtuzumab), Tysabri (natalizumab), Briumvi (ublituximab)**
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, 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** CIS, Relapsing Remitting MS (RRMS), Secondary Progressive MS (SPMS) • 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 both (dimethyl fumarate and glatiramer) 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 dimethyl fumarate and glatiramer is not required. • 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), 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 Multiplate 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) or rituximab, documentation of the following has been submitted 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)

Revision/Review Date 4/2023	• If the request is for Rituxan Hycela (rituximab/hyaluronidase), all of the above AND documented medical reason why the patient cannot use Rituxan (rituximab).
	
	<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/Grandfathering Provision:</u>
	
	Members with history (within the past 90 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.