PREFERRED SPECIALTY MANAGEMENT POLICY

POLICY: Multiple Sclerosis Preferred Specialty Management Policy

Beta Interferon Products (Self-Injectable)
• Extavia® (interferon beta-1b subcutaneous injection – Novartis)
Fumarate Products (Oral)
• Tecfidera® (dimethyl fumarate delayed-release capsules – Biogen, generic)
Glatiramer Products (Self-Injectable)
• Copaxone® (glatiramer subcutaneous injection – Teva, generic)
Pyrimidine Synthesis Inhibitor (Oral)
• Aubagio® (teriflunomide tablets – Genzyme/Sanofi, generic)
Sphingosine 1-Phosphate Receptor Modulator
• Gilenya® (fingolimod capsules – Novartis, generic) • Ponvory® (ponesimod tablets – Vanda) • Tascenso ODT® (fingolimod orally disintegrating tablets – Handa/Cycle)

REVIEW DATE: 10/09/2024; selected revision 01/08/2025 and 01/22/2025

INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment and have discretion in making individual coverage determinations. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Cigna National Formulary Coverage:

OVERVIEW

This Preferred Specialty Management policy involves the use of selected self-administered injectable products and selected oral disease-modifying agents used for **multiple sclerosis**.[1-7] All products are indicated for use in adults. Of note, fingolimod and Tascenso ODT are the only agents specifically indicated for children ≥ 10 years of age for the treatment of relapsing forms of multiple sclerosis.[3,6] A practice guideline recommendation regarding disease-modifying agents for adults with multiple sclerosis from the American Academy of Neurology (2018) includes

fingolimod as one of the agents to consider for patients with multiple sclerosis who have highly active disease.[8]

POLICY STATEMENT

The Multiple Sclerosis Preferred Specialty Management Program has been developed to encourage the use of the Preferred Products. For all medications (Preferred and Non-Preferred), the patient is required to meet the respective standard *Prior Authorization Policy* criteria. The Program also directs the patient to try both Preferred Products 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. If a patient requesting a Non-Preferred Product meets the standard *Prior Authorization Policy* criteria but has not tried both Preferred Products (generic glatiramer injection and generic dimethyl fumarate delayed-release capsules), an offer to review for the Preferred Products will be made.

The Tecfidera (Brand) Preferred Specialty Management Program has been developed to encourage the use of generic dimethyl fumarate delayed-release capsules. For all medications (Preferred and Non-Preferred) the patient is required to meet the respective 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. If a patient requesting the Non-Preferred Product (Tecfidera [brand]) meets the standard *Prior Authorization Policy* criteria but has not tried the Preferred Product, an offer to review for the Preferred Product will be made.

The S1P Preferred Specialty Management Program has been developed to encourage the use of the Preferred Products (generic dimethyl fumarate delayed-release capsules and generic fingolimod capsules). For all medications (Preferred and Non-Preferred) the patient is required to meet the respective 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. If a patient requesting a Non-Preferred Product meets the standard *Prior Authorization Policy* criteria but has not tried the Preferred Products, an offer to review for the Preferred Products will be made.

The Aubagio Preferred Specialty Management Program has been developed to encourage the use of the Preferred Products (generic glatiramer injection, generic dimethyl fumarate delayed-release capsules, generic fingolimod capsules, and generic teriflunomide tablets). For all medications (Preferred and Non-Preferred), the patient is required to meet the respective 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. If a patient requesting a Non-Preferred Product meets the standard *Prior Authorization Policy* criteria but has not tried the Preferred Products, an offer to review for the Preferred Products will be made.

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

Multiple Sclerosis Preferred Specialty Management Program

Preferred Products:	generic glatiramer injection and generic dimethyl fumarate delayed-release capsules
Non-Preferred Products:	Copaxone, Extavia

Tecfidera (Brand) Preferred Specialty Management Program

Preferred Product:	generic dimethyl fumarate delayed-release capsules
Non-Preferred Product:	Tecfidera (brand)

S1P Preferred Specialty Management Program

Preferred Products:	generic fingolimod capsules and generic dimethyl fumarate delayed-release capsules
Non-Preferred Products:	Gilenya (brand), Tascenso ODT, Ponvory

Aubagio Preferred Specialty Management Program

Preferred Products:	generic teriflunomide tablets and generic glatiramer injection and generic dimethyl fumarate delayed-release capsules and generic fingolimod capsules
Non-Preferred Product:	Aubagio (brand)

Multiple Sclerosis Preferred Specialty Management Policy non-preferred product(s) is(are) covered as medically necessary when the following non-preferred product exception criteria is(are) met. Any other exception is considered not medically necessary.

NON-PREFERRED PRODUCT EXCEPTION CRITERIA

I. Multiple Sclerosis Preferred Specialty Management Program

Non-Preferred Product	Exception Criteria
Copaxone 20 mg/mL and 40 mg/mL	**1.** Approve for 1 year if the patient meets BOTH of the following (A and B): **A)** Patient meets the standard *Multiple Sclerosis – Glatiramer Products Prior Authorization Policy* criteria; AND **B)** Patient meets BOTH of the following (i and ii): **i.** Patient meets ONE of the following (a or b): **a)** Patient has been established on a glatiramer product for ≥ 120 days; OR **b)** Patient meets BOTH of the following [(1) and (2)]: **(1)** Patients has tried generic dimethyl fumarate delayed-release capsules **[documentation required]**; AND **(2)** Patient has experienced inadequate efficacy or significant intolerance, according to the prescriber **[documentation required]**; AND Note: Prior use of Tecfidera, Bafiertam, or Vumerity 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 **[documentation required]**; AND **b)** Patient cannot continue to use generic glatiramer injection 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 **[documentation required]**. **2.** If the patient meets the standard *Multiple Sclerosis – Glatiramer Prior Authorization Policy* criteria, but does not meet criterion 1B, offer to review for the Preferred Product(s).

Non-Preferred Product	Exception Criteria
Extavia	**1.** Approve for 1 year if the patient meets BOTH of the following (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 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 meets BOTH of the following [(1) and (2)]: **(1)** Patient has tried generic dimethyl fumarate delayed-release capsules **[documentation required]**; AND **(2)** Patient has experienced inadequate efficacy or significant intolerance, according to the prescriber **[documentation required]**; AND Note: Prior use of Tecfidera, Bafiertam, or Vumerity with inadequate efficacy or significant intolerance (according to the prescriber) also counts. **b)** Patient meets BOTH of the following [(1) and (2)]: **(1)** Patient has tried generic glatiramer injection **[documentation required]**; AND **(2)** Patient has experienced inadequate efficacy or significant intolerance according to the prescriber **[documentation required]**. Note: Prior use of Copaxone or Glatopa with inadequate efficacy or significant intolerance (according to the prescriber) also counts. **2.** If the patient meets the standard *Multiple Sclerosis – Betaseron/Extavia Prior Authorization Policy* criteria, but does not meet criterion 1B, offer to review for the Preferred Product(s).

II. Tecfidera (Brand) Preferred Specialty Management Program

Non-Preferred Product	Exception Criteria
Tecfidera (brand)	**1.** Approve for 1 year if the patient meets BOTH of the following (A and B): **A)** Patient meets the standard *Multiple Sclerosis – Dimethyl Fumarate Prior Authorization Policy* criteria; AND **B)** Patient meets BOTH of the following (i and ii): **i.** Patient has tried generic dimethyl fumarate delayed-release capsules **[documentation required]**; AND **ii.** Patient cannot continue to use generic dimethyl fumarate delayed-release capsules 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 **[documentation required]**. **2.** If the patient meets the standard *Multiple Sclerosis – Dimethyl Fumarate Prior Authorization Policy* criteria, but does not meet criterion 1B, offer to review for the Preferred Product.

III. S1P Preferred Specialty Management Program

Non-Preferred Product	Exception Criteria
Ponvory	**1.** Approve for 1 year if the patient meets BOTH of the following (A and B): **A)** Patient meets the standard *Multiple Sclerosis – Ponvory Prior Authorization Policy* criteria; AND **B)** Patient meets ONE of the following (i or ii): **i.** Patient has been established on Ponvory for ≥ 120 days; OR **ii.** Patient meets 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 **[documentation required]**; AND **(2)** Patient has experienced inadequate efficacy or significant intolerance according to the prescriber **[documentation required]**; AND Note: Prior use of Tecfidera, Bafiertam, or Vumerity with inadequate efficacy or significant intolerance (according to the prescriber) also counts **[documentation required]**. **b)** Patient meets BOTH of the following [(1) and (2)]: **(1)** Patient has tried generic fingolimod capsules **[documentation required]**; AND **(2)** Patient has experienced inadequate efficacy or significant intolerance according to the prescriber **[documentation required]**. Note: Prior use of Gilenya (brand) or Tascenso ODT with inadequate efficacy or significant intolerance (according to the prescriber) also counts **[documentation required]**. **2.** If the patient meets the standard *Multiple Sclerosis – Ponvory Prior Authorization Policy* criteria, but does not meet criterion 1B, offer to review for the Preferred Product(s).
Gilenya (brand)	**1.** Approve for 1 year if the patient meets BOTH of the following (A and B): **A)** Patient meets the standard *Multiple Sclerosis – Fingolimod Prior Authorization Policy* criteria; AND **B)** Patient meets BOTH of the following (i and ii): **i.** Patient meets ONE of the following (a, b, c, or d): **a)** Patient has been established on Gilenya (brand or generic) for ≥ 120 days; OR **b)** According to the prescriber, the patient has highly active or aggressive multiple sclerosis by meeting ONE of the following [(1), (2), (3), or (4)]:

Non-Preferred Product	Exception Criteria
	(1) Patient has demonstrated rapidly advancing deterioration(s) in physical functioning **[documentation required]**; OR Note: Examples include loss of mobility, lower levels of ambulation, and/or severe changes in strength or coordination. **(2)** Disabling relapse(s) with suboptimal response to systemic corticosteroids **[documentation required]**; OR **(3)** Magnetic resonance imaging (MRI) suggests 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. **(4)** Manifestations of multiple sclerosis-related cognitive impairment **[documentation required]**; OR **c)** Patient is ≥ 10 to < 18 years of age; OR **d)** Patient meets BOTH of the following [(1) and (2)]: **(1)** Patient has tried generic dimethyl fumarate delayed-release capsules **[documentation required]**; AND **(2)** Patient has experienced inadequate efficacy or significant intolerance according to the prescriber **[documentation required]**; AND Note: Prior use of Tecfidera, Bafiertam, or Vumerity with inadequate efficacy or significant intolerance (according to the prescriber) also counts **[documentation required]**. **ii.** Patient meets BOTH of the following (a and b): **a)** Patient has tried generic fingolimod capsules **[documentation required]**; AND **b)** Patient cannot continue to use generic fingolimod capsules 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 **[documentation required]**. **2.** If the patient meets the standard *Multiple Sclerosis – Fingolimod Prior Authorization Policy* criteria, but does not meet criterion 1B, offer to review for the Preferred Product(s).

Non-Preferred Product	Exception Criteria
Tascenso ODT	**1.** Approve for 1 year if the patient meets BOTH of the following (A and B): **A)** Patient meets the standard *Multiple Sclerosis – Tascenso ODT Prior Authorization Policy* criteria; AND **B)** Patient meets BOTH of the following (i and ii): **i.** Patient meets ONE of the following (a, b, c, d, or e): **a)** Patient cannot swallow or has difficulty swallowing tablets or capsules; OR **b)** Patient has been established on Tascenso ODT for ≥ 120 days; OR **c)** According to the prescriber, the patient has highly active or aggressive multiple sclerosis by meeting ONE of the following [(1), (2), (3), or (4)]: **(1)** Patient has demonstrated rapidly advancing deterioration(s) in physical functioning **[documentation required]**; OR Note: Examples include loss of mobility, lower levels of ambulation, and/or severe changes in strength or coordination. **(2)** Disabling relapse(s) with suboptimal response to systemic corticosteroids **[documentation required]**; OR **(3)** Magnetic resonance imaging (MRI) suggests 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. **(4)** Manifestations of multiple sclerosis-related cognitive impairment **[documentation required]**; OR **d)** Patient is ≥ 10 to < 18 years of age; OR **e)** Patient meets BOTH of the following [(1) and (2)]: **(1)** Patient has tried generic dimethyl fumarate delayed-release capsules **[documentation required]**; AND **(2)** Patient has experienced inadequate efficacy or significant intolerance according to the prescriber **[documentation required]**; AND Note: Prior use of Tecfidera, Bafiertam, or Vumerity with inadequate efficacy or significant intolerance (according to the prescriber) also counts **[documentation required]**. **ii.** Patient meets ONE of the following (a or b): **a)** Patient meets BOTH of the following (i and ii):

Non-Preferred Product	Exception Criteria
	i. Patient has tried generic fingolimod capsules **[documentation required]**; AND **ii.** Patient cannot continue to use generic fingolimod capsules 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 **[documentation required]**. **b)** Patient cannot swallow or has difficulty swallowing tablets or capsules. **2.** If the patient meets the standard *Multiple Sclerosis – Fingolimod Prior Authorization Policy* criteria, but does not meet criterion 1B, offer to review for the Preferred Product(s).

IV. Aubagio Preferred Specialty Management Program

Non-Preferred Product	Exception Criteria
Aubagio (brand)	**1.** Approve for 1 year if the patient meets BOTH of the following (A and B): **A)** Patient meets the standard *Multiple Sclerosis – Teriflunomide Prior Authorization Policy* criteria; AND **B)** Patient meets ONE the following (i or ii): **i.** Patient meets BOTH of the following (a and b): **a)** Patient has been established on Aubagio (brand or generic) for ≥ 120 days; AND **b)** Patient meets BOTH of the following [(1) and (2)]: **(1)** Patient has tried generic teriflunomide tablets **[documentation required]**; AND **(2)** Patient cannot continue to use generic teriflunomide tablets 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 **[documentation required]**; OR **ii.** Patient meets ALL of the following (a, b, c, and d): **a)** Patient meets BOTH of the following [(1) and (2)]: **(1)** Patient has tried generic dimethyl fumarate delayed-release capsules **[documentation required]**; AND **(2)** Patient has experienced inadequate efficacy or significant intolerance, according to the prescriber **[documentation required]**; AND Note: Prior use of Tecfidera, Bafiertam, or Vumerity with inadequate efficacy or significant intolerance (according to the prescriber) also counts. **b)** Patient meets BOTH of the following [(1) and (2)]: **(1)** Patient has tried generic glatiramer injection **[documentation required]**; AND **(2)** Patient has experienced inadequate efficacy or significant intolerance, according to the prescriber **[documentation required]**; AND Note: Prior use of Copaxone or Glatopa with inadequate efficacy or significant intolerance (according to the prescriber) also counts. **c)** Patient meets BOTH of the following [(1) and (2)]: **(1)** Patient has tried generic fingolimod capsules **[documentation required]**; AND

Non-Preferred Product	Exception Criteria
	(2) Patient has experienced inadequate efficacy or significant intolerance, according to the prescriber; AND **d)** Patient meets BOTH of the following [(1) and (2)] **(1)** Patient has tried generic teriflunomide tablets **[documentation required]**; AND **(2)** Patient cannot continue to use generic teriflunomide tablets 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 **[documentation required]**. **2.** If the patient meets the standard *Multiple Sclerosis – Teriflunomide Prior Authorization Policy* criteria, but does not meet criterion 1B, offer to review for the Preferred Product(s).

REFERENCES

1. Copaxone® subcutaneous injection [prescribing information]. Parsippany, NJ: Teva; November 2023.
2. Extavia® subcutaneous injection [prescribing information]. East Hanover, NJ: Novartis; July 2023.
3. Gilenya® capsules [prescribing information]. East Hanover, NJ: Novartis; June 2024.
4. Aubagio® tablets [prescribing information]. Cambridge, MA: Genzyme/Sanofi; June 2024.
5. Tecfidera® delayed-release capsules [prescribing information]. Cambridge, MA: Biogen; March 2024.
6. Tascenso ODT™ [prescribing information]. Cambridge, UK and San Jose, CA: Cycle/Handa; June 2024.
7. Ponvory® tablets [prescribing information]. Washington, DC: Vanda; October 2024.
8. Rae-Grant A, Day GS, Marrie RA, et al. Practice guideline recommendations summary: disease-modifying therapies for adults with multiple sclerosis. Report of the guideline development, dissemination, and implementation subcommittee of the American Academy of Neurology. *Neurology*. 2018;90:777-788.

HISTORY

Type of Revision	Summary of Changes	Review Date
Selected Revision	**Avonex, Bafiertam, Betaseron, Glatopa, Kesimpta, Mavenclad, Mayzent, Plegridy, Ponvory, Rebif, Vumerity**, and **Zeposia:** These agents were removed from the Multiple Sclerosis Preferred Specialty Management Program as Non-Preferred Products and related exception criteria were deleted. **Copaxone:** The exception criteria were revised due to changes in the Preferred Products. For the Multiple Sclerosis Preferred Specialty Management Program, previously, a patient was required to try one of the following: generic glatiramer injection, generic	03/27/2024 (effective 05/01/2024)

	dimethyl fumarate delayed-release capsules, generic fingolimod capsules, or generic teriflunomide tablets. Generic fingolimod capsules and generic teriflunomide tablets were removed as Preferred Products. Now, a patient is required to try both Preferred Products (generic glatiramer injection AND generic dimethyl fumarate delayed-release capsules); documentation was added for both of these trials. For the generic dimethyl fumarate delayed-release capsules, documentation has to be provided that the patient has experienced inadequate efficacy or significant intolerance, according to the prescriber. Also, for the trial of generic glatiramer injection, documentation has to be provided that the patient cannot continue to use generic glatiramer injection 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. Exceptions were added for a patient who has been established on a glatiramer product for ≥ 120 days that a trial of generic dimethyl fumarate delayed-release capsules are not required. Exception criteria regarding generic fingolimod and generic teriflunomide were deleted. **Extavia:** The exception criteria were revised due to changes in the Preferred Products. For the Multiple Sclerosis Preferred Specialty Management Program, previously, a patient was required to try one of the following: generic glatiramer injection, generic dimethyl fumarate delayed-release capsules, generic fingolimod capsules, or generic teriflunomide tablets. Generic fingolimod capsules and generic teriflunomide tablets were removed as Preferred Products. Now, a patient is required to try both Preferred Products (generic glatiramer injection AND generic dimethyl fumarate delayed-release capsules); documentation was added for both of these trials. Also, for both Preferred Products, documentation has to be provided that the patient has experienced inadequate efficacy or significant intolerance, according to the prescriber. Exception criteria regarding generic fingolimod and generic teriflunomide were deleted.	
Annual Revision	No criteria changes.	10/09/2024
Selected Revision	The name of the Fingolimod Preferred Specialty Management Program was changed to the S1P Preferred Specialty Management Program. In addition, the following changes were made: **Ponvory:** Ponvory was added as a Non-Preferred Product to the S1P Preferred Specialty Management Program. Exception criteria were added. **Gilenya (brand):** Regarding the trial of dimethyl fumarate delayed-release tablets, the exception was removed that prior use of glatiramer injection (brand or generic) with inadequate efficacy or significant intolerance (according to the prescriber) also counts [documentation required]. **Tascenso ODT:** Regarding the trial of dimethyl fumarate delayed-release tablets, the exception was removed that prior use of glatiramer injection (brand or generic) with inadequate efficacy or significant intolerance (according to the prescriber) also counts [documentation required].	01/08/2025
Selected Revision	In the S1P Preferred Specialty Management Program, criteria for Ponvory were clarified that a trial of generic dimethyl fumarate delayed-release capsules AND generic fingolimod capsules are required (along with inadequate efficacy or significant intolerance, according to the prescriber). Patients established on Ponvory for ≥ 120 days do not have to meet this requirement.	01/22/2025