

PHARMACY COVERAGE GUIDELINE

[AMPYRA](#) (dalfampridine ER)
[AUBAGIO](#) (teriflunomide)
[BAFIERTAM](#) (monomethyl fumarate)
[Dalfampridine ER](#), generic
[Dimethyl fumarate](#), generic
[GILENYA](#) (fingolimod)
[MAVENCLAD](#) (cladribine)
[MAYZENT](#) (siponimod)
[PONVORY](#) (ponesimod)
[TASCENSO ODT](#) (fingolimod lauryl sulfate)
[TECFIDERA](#) (dimethyl fumarate)
[VUMERITY](#) (diroximel fumarate)
[ZEPOSIA](#) (ozanimod)

This Pharmacy Coverage Guideline (PCG):

- Provides information about the reasons, basis, and information sources we use for coverage decisions
- Is not an opinion that a drug (collectively “Service”) is clinically appropriate or inappropriate for a patient
- Is not a substitute for a provider’s judgment (Provider and patient are responsible for all decisions about appropriateness of care)
- Is subject to all provisions e.g. (benefit coverage, limits, and exclusions) in the member’s benefit plan; and
- Is subject to change as new information becomes available.

Scope

- This PCG applies to Commercial and Marketplace plans
- This PCG does not apply to the Federal Employee Program, Medicare Advantage, Medicaid or members of out-of-state Blue Cross and/or Blue Shield Plans

Instructions & Guidance

- To determine whether a member is eligible for the Service, read the entire PCG.
 - This PCG is used for FDA approved indications including, but not limited to, a diagnosis and/or treatment with dosing, frequency, and duration.
 - Use of a drug outside the FDA approved guidelines, refer to the appropriate Off-Label Use policy.
 - The “[Criteria](#)” section outlines the factors and information we use to decide if the Service is medically necessary as defined in the Member’s benefit plan.
 - The “[Description](#)” section describes the Service.
 - The “[Definition](#)” section defines certain words, terms or items within the policy and may include tables and charts.
 - The “[Resources](#)” section lists the information and materials we considered in developing this PCG
 - **We do not accept patient use of samples as evidence of an initial course of treatment, justification for continuation of therapy, or evidence of adequate trial and failure.**
 - Information about medications that require precertification is available at www.azblue.com/pharmacy. You must fully complete the [request form](#) and provide chart notes, lab workup and any other supporting documentation. The prescribing provider must sign the form. Fax the form to BCBSAZ Pharmacy Management at (602) 864-3126 or email it to Pharmacyprecert@azblue.com.
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Criteria:

MAVENCLAD (cladribine)

- **Criteria for initial therapy:** Mavenclad (cladribine) is considered *medically necessary* and will be approved when **ALL** of the following criteria are met:
1. Prescriber is a physician specializing in the patient's diagnosis or is in consultation with a Neurologist
 2. Individual is 18 years of age or older
 3. A confirmed diagnosis of relapsing forms of multiple sclerosis (MS), including relapsing-remitting disease and active secondary progressive disease, in patients who have had an inadequate response to, or are unable to tolerate, an alternate drug indicated for the treatment of MS
 4. Documented failure after a trial of at least four (4) weeks, contraindication per FDA label, intolerance to at least **TWO** alternate drugs indicated for the treatment of MS
 5. Individual does not have clinically isolated syndrome (CIS)
 6. **ALL** of the following tests have been completed before initiation of **EACH Treatment Course** with continued monitoring as clinically appropriate:
 - a. Cancer screening that follows standard screening guidelines for breast, cervical, colorectal, endometrial, lung, prostate, or other type
 - b. Negative pregnancy test in a woman of childbearing age
 - c. Complete blood count with differential
 - d. Lymphocytes must be within normal limits before 1st treatment course
 - e. A baseline (within 3 months) magnetic resonance imaging prior to the first treatment course
 - f. Serum aminotransferase, alkaline phosphatase, and total bilirubin
 - g. Individual does not have HIV infection
 - h. TB screening, and if positive, delay Mavenclad (cladribine) until infection has been treated
 - i. Hepatitis B & C screening, and if positive, delay Mavenclad (cladribine) until infection has been treated

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- j. Evaluate for acute infections, and delay Mavenclad (cladribine) until any active infection is fully controlled
 - k. Varicella zoster virus antibody negative individuals must be vaccinated
 - l. Any needed immunizations that are recommended by immunization guidelines must be given prior to starting Mavenclad (cladribine) with live-attenuated or live vaccines given at least 4-6 weeks prior to starting Mavenclad (cladribine)
7. Anti-herpes prophylaxis is used in an individual with lymphocyte count < 200 cell per microliter
 8. There are **NO** FDA-label contraindications, such as:
 - a. Individual with current malignancy
 - b. Woman who is pregnant
 - c. Woman of reproductive potential who does not plan to use effective contraception
 - d. Male of reproductive potential who does not plan to use effective contraception
 - e. Individual with HIV infection
 - f. Use in an individual with chronic active infections (e.g., hepatitis or tuberculosis)
 - g. Woman who is breast feeding an infant or child
 9. Individual does not have moderate to severe renal impairment (CrCl < 60 mL/min)
 10. Individual does not have moderate to severe hepatic impairment (Child-Pugh score > 6)
 11. Will **not be used** concurrently **with** other **oral multiple sclerosis medications** except for dalfampridine (brand Ampyra or generic which is intended to improve walking speed rather than disease progression), **or injectable therapies for multiple sclerosis** (e.g., interferon beta-1a or 1b, glatiramer, Lemtrada, Ocrevus, Tysabri, or mitoxantrone) **or other immunomodulatory, immunosuppressive or myelosuppressive therapy**
 12. There are no significant interacting drugs

Initial approval duration:

- a. Cumulative dose is 3.5 mg/kg divided into 2 yearly treatment courses (1.75 mg/kg per treatment course) with each course divided into 2 treatment cycles
- b. Initial approval is One Treatment Course with two treatment cycles

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c. **First Treatment Course with two treatment cycles**

- i. First cycle dosage is weight based and is started at anytime
- ii. Second cycle is administered 23-27 days of the last dose of a first cycle

➤ **Criteria for continuation of coverage (renewal request):** Mavenclad (cladribine) is considered *medically necessary* and will be approved when **ALL** of the following criteria are met (**samples are not considered for continuation of therapy**):

1. Individual continues to be seen by a physician specializing in the patient's diagnosis or is in consultation with a Neurologist
2. Individual successfully completed First Treatment Course
3. Individual has been adherent with the medication
4. Second Treatment Course to begin at least 43 weeks after the last dose of the First Treatment Course/Second Cycle
5. **ALL** of the following tests have been completed before initiation of **EACH Treatment Course** with continued monitoring as clinically appropriate:
 - a. Cancer screening that follows standard screening guidelines for breast, cervical, colorectal, endometrial, lung, prostate, or other type
 - b. Negative pregnancy test in a woman of childbearing age
 - c. Complete blood count with differential
 - d. Lymphocytes must be at least 800 cells per microliter before 2nd treatment course
 - e. Serum aminotransferase, alkaline phosphatase, and total bilirubin
 - f. Individual does not have HIV infection
 - g. TB screening, and if positive, delay Mavenclad (cladribine) until infection has been treated
 - h. Hepatitis B & C screening, and if positive, delay Mavenclad (cladribine) until infection has been treated
 - i. Evaluate for acute infections, and delay Mavenclad (cladribine) until any active infection is fully controlled

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- j. Varicella zoster virus antibody negative individuals must be vaccinated, unless has received vaccination
 - k. Any needed immunizations that are recommended by immunization guidelines must be given prior to starting Mavenclad (cladribine) with live-attenuated or live vaccines given at least 4-6 weeks prior to starting Mavenclad (cladribine)
6. Anti-herpes prophylaxis is used in an individual with lymphocyte count < 200 cell per microliter
 7. There are **NO** FDA-label contraindications as listed in the **Criteria for initial therapy** section
 8. Individual has not developed any significant adverse drug effects that may exclude continued use
 - a. Malignancy
 - b. Infection
 - c. Lymphopenia
 - d. Hematologic toxicity
 - e. Graft-versus-host-disease with blood transfusion
 - f. Liver injury
 9. Individual does not have moderate to severe renal impairment (CrCl < 60 mL/min)
 10. Individual does not have moderate to severe hepatic impairment (Child-Pugh score > 6)
 11. Will **not be used** concurrently **with** other **oral multiple sclerosis medications** except for dalfampridine (brand Ampyra or generic which is intended to improve walking speed rather than disease progression), **or injectable therapies for multiple sclerosis** (e.g., interferon beta-1a or 1b, glatiramer, Lemtrada, Ocrevus, Tysabri, or mitoxantrone) **or other immunomodulatory, immunosuppressive or myelosuppressive therapy**
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Renewal duration:

- One Treatment Course with two treatment cycles
- **Second Treatment Course with two treatment cycles**

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- i. First cycle is given at least 43 weeks after the last dose of the First Treatment Course/Second Cycle
- ii. Second cycle is administered 23-27 days of the last dose of a first cycle
- The safety and efficacy of reinitiating Mavenclad (cladrabine) more than 2 years after completing 2 Treatment Courses has not been studied
- More than 2 Treatment Courses per lifetime **will not** be approved

➤ Criteria for a request for non-FDA use or indication, treatment with dosing, frequency, or duration outside the FDA-approved dosing, frequency, and duration, refer to one of the following Pharmacy Coverage Guideline:

1. **Off-Label Use of Non-Cancer Medications**
2. **Off-Label Use of Cancer Medications**

BAFIERTAM (monomethyl fumarate)
Dimethyl fumarate
TECFIDERA (dimethyl fumarate)
VUMERITY (diroximel fumarate)

- **Criteria for initial therapy:** Bafiertam (monomethyl fumarate) capsules, Tecfidera (dimethyl fumarate) delayed-release capsules, generic dimethyl fumarate or Vumerity (diroximel fumarate) delayed-release capsules is considered **medically necessary** and will be approved when **ALL** of the following criteria are met:
1. Prescriber is a physician specializing in the patient's diagnosis or is in consultation with a Neurologist
 2. Individual is 18 years of age or older
 3. A confirmed diagnosis of relapsing forms of multiple sclerosis, including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease

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[ZEPOSIA \(ozanimod\)](#)

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4. **Additional criteria for Tecfidera (dimethyl fumarate) ONLY:** Documented failure, contraindication per FDA label, intolerance to dimethyl fumarate generic
 5. **ALL** of the following baseline tests have been completed before initiation of treatment with continued monitoring as clinically appropriate:
 - a. Complete blood count (CBC) including lymphocyte count
 - b. Alanine aminotransferase (ALT), aspartate aminotransferase (AST), alkaline phosphatase (ALP) and total bilirubin
 6. There are **NO** FDA-label contraindications:
 - a. Contraindications for **Bafiertam** (monomethyl fumarate) include:
 - i. Known hypersensitivity (e.g., anaphylaxis, angioedema) to monomethyl fumarate, dimethyl fumarate, diroximel fumarate, or to any component of the formulation
 - ii. Concomitant use with dimethyl fumarate or diroximel fumarate
 - b. Contraindications for **Tecfidera** (dimethyl fumarate) include:
 - i. Known hypersensitivity (e.g., anaphylaxis, angioedema) to dimethyl fumarate or any of the excipients of Tecfidera
 - c. Contraindications for **Vumerity** (diroximel fumarate) include:
 - i. Hypersensitivity (e.g., anaphylaxis, angioedema) to diroximel fumarate, Tecfidera (dimethyl fumarate), or to any component of the formulation
 - ii. Concomitant use of Tecfidera (dimethyl fumarate)
 7. **Additional criteria for Vumerity only:** Individual does not have moderate or severe renal impairment
 8. Will not be used concurrently with other oral multiple sclerosis medications except for dalfampridine (brand Ampyra or generic), which is intended to improve walking speed rather than disease progression, or injectable therapies for multiple sclerosis (e.g., interferon beta-1a or 1b, glatiramer, Lemtrada, Ocrevus, Tysabri, or mitoxantrone) or other immunomodulatory, immunosuppressive or myelosuppressive therapy

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9. There are no significant interacting drugs

Initial approval duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Bafiertam (monomethyl fumarate) capsules, Tecfidera (dimethyl fumarate) delayed-release capsules or Vumerity (diroximel fumarate) delayed-release capsules is considered **medically necessary** and will be approved when **ALL** of the following criteria are met (**samples are not considered for continuation of therapy**):
1. Individual continues to be seen by a physician specializing in the patient's diagnosis or is in consultation with a Neurologist
 2. Individual's condition responded while on therapy with response defined as **THREE** of the following:
 - a. Mild/minimal to no functional neurologic (pyramidal, cerebellar, brainstem, sensory) disabilities
 - b. Ambulatory without need for assistance
 - c. Reduction in number of exacerbations or relapses of MS
 - d. Prolonged time to exacerbation or relapses of MS
 - e. Reduction in hospitalizations for MS
 3. Individual has been adherent with the medication and is tolerating the product labeled maintenance dose:
[Note: Temporary dose reductions due to side effects are allowed but after 4-weeks at a lower dose, individuals should be returned to the maintenance dose]
 - a. For **Bafiertam** (monomethyl fumarate) dose is 190 mg twice daily
 - b. For **Tecfidera** (dimethyl fumarate) dose is 240 mg twice daily
 - c. For **Vumerity** (diroximel fumarate) dose is 462 mg twice daily
 4. Individual has not developed any contraindications or other significant adverse drug effects that may exclude continued use
 - a. Contraindications as listed in the criteria for initial therapy section
 - b. Significant adverse effect such as:
 - i. Liver toxicity
 - ii. Progressive Multifocal Leukoencephalopathy
 - iii. Anaphylaxis, angioedema

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5. **Additional criteria for Vumerity only:** Individual does not have moderate or severe renal impairment
6. Request for continuation of **brand Tecfidera only:** Individual has failure, contraindication or intolerance to **generic dimethyl fumarate**
7. Will not be used concurrently with other oral multiple sclerosis medications except for dalfampridine (brand Ampyra or generic), which is intended to improve walking speed rather than disease progression, or injectable therapies for multiple sclerosis (e.g., interferon beta-1a or 1b, glatiramer, Lemtrada, Ocrevus, Tysabri, or mitoxantrone) or other immunomodulatory, immunosuppressive or myelosuppressive therapy
8. There are no significant interacting drugs

Renewal duration: 12 months

- Criteria for a request for non-FDA use or indication, treatment with dosing, frequency, or duration outside the FDA-approved dosing, frequency, and duration, refer to one of the following Pharmacy Coverage Guideline:
 1. **Off-Label Use of Non-Cancer Medications**
 2. **Off-Label Use of Cancer Medications**

GILENYA (fingolimod)
PONVORY (ponesimod)
MAYZENT (siponimod)
TASCENSO ODT (fingolimod lauryl sulfate)

- **Criteria for initial therapy:** Gilenya (fingolimod), Tascenso ODT (fingolimod lauryl sulfate), Ponvory (ponesimod), or Mayzent (siponimod) is considered **medically necessary** and will be approved when **ALL** of the following criteria are met:

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Dalfampridine ER, generic

Dimethyl fumarate, generic

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MAVENCLAD (cladribine)

MAYZENT (siponimod)

PONVORY (ponesimod)

TASCENSO ODT (fingolimod lauryl sulfate)

TECFIDERA (dimethyl fumarate)

VUMERITY (diroximel fumarate)

ZEPOSIA (ozanimod)

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1. Prescriber is a physician specializing in the patient's diagnosis or is in consultation with a Neurologist
 2. **ONE** of the following:
 - a. For **Gilenya**: individual is 10 years of age or older
 - b. For **Ponvory** or **Mayzent**: individual is 18 years of age or older
 - c. For **Tascenso ODT**: individual is 10 years to 17 years of age **AND** weighs less than or equal to 40 kg (88 pounds)
 3. A confirmed diagnosis of relapsing forms of multiple sclerosis, including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
 4. **Additional criteria for Ponvory and Mayzent ONLY**: Documented failure after a trial of at least four (4) weeks, contraindication per FDA label, intolerance to use **at least two (2)** of the following: [**Note**: each of the following requires precertification]
 - a. Aubagio (teriflunomide)
 - b. Avonex (interferon beta-1a) injection
 - c. Bafiertam (monomethyl fumarate)
 - d. Betaseron (interferon beta-1a) injection
 - e. Copaxone (glatiramer acetate injection)
 - f. Dimethyl fumarate (generic or brand Tecfidera)
 - g. Kesimpta (ofatumumab) injection
 - h. Gilenya (fingolimod)
 - i. Plegridy (peginterferon beta-1a injection)
 - j. Rebif (interferon beta-1a injection)
 - k. Vumerity (diroximel fumarate)
 5. **ALL** of the following baseline tests have been completed before initiation of treatment with continued monitoring as clinically appropriate:
 - a. Complete blood count (CBC) within the last 6 months
 - b. Alanine aminotransferase (ALT), aspartate aminotransferase (AST), and total bilirubin within the last 6 months
 - c. Electrocardiogram (ECG)
 - d. Where clinically indicated, spirometric evaluation of respiratory function
 - e. Ophthalmologic examination

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- f. Evidence of varicella zoster virus (VZV) immunity by **either** of the following:
- A healthcare provider-confirmed history of chickenpox **OR**
 - Documented full course of VZV vaccination **OR**
 - Positive antibodies to VZV; any needed vaccination of antibody negative patients to be completed 1 month before initiation
- g. **Additional criteria for Mayzent ONLY:** Tested for CYP2C9 variants to determine genotype
6. There are **NO** FDA-label contraindications:
- Contraindications for **each agent** include:
 - Myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III/IV heart failure within the last 6 months
 - History or presence of Mobitz Type II second-degree or third-degree atrioventricular (AV) block, sick sinus syndrome or sino-atrial block, unless individual has a functioning pacemaker
 - Contraindications specific for **Gilenya**, and **Tascenso ODT** include:
 - Baseline QTc interval \geq 500 msec
 - Cardiac arrhythmia requiring treatment with Class IA or Class III anti-arrhythmic drugs
 - History of a hypersensitivity reaction to fingolimod or any of the excipients in Gilenya
 - Contraindications specific for **Mayzent** include:
 - Patients with a CYP2C9*3/*3 genotype
7. Will **not be used in** the following:
- Individual with an active infection
 - Additional criteria for Ponvory ONLY:**
 - Individual with moderate or severe hepatic impairment (Child-Pugh Class B and C)
 - Individual with a resting heart rate of less than 50 bpm at baseline
 - Presence of any severe cardiac disease
 - Cardiac conduction or rhythm disorders (including symptomatic bradycardia, atrial flutter or atrial fibrillation, ventricular arrhythmia, cardiac arrest) either in history or observed at screening

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- v. QTcF interval greater than 470 ms (females) and greater than 450 ms (males) observed at screening
 - vi. History of syncope associated with cardiac disorders
 - vii. Uncontrolled systemic arterial hypertension

c. **Additional criteria for Mayzent ONLY:**

- i. Individual with significant QT prolongation (QTc > 500 msec), individual on Class Ia or Class III anti-arrhythmic drugs, or New York Heart Association Class II heart failure, unless has been cleared by a Cardiologist
 - ii. Individual with complete left bundle branch block, sinus arrest or symptomatic bradycardia unless patient has a functioning pacemaker, unless has been cleared by a Cardiologist
8. Will not be used concurrently with other oral multiple sclerosis medications except for dalfampridine (brand Ampyra or generic, which is intended to improve walking speed rather than disease progression), or injectable therapies for multiple sclerosis (e.g., interferon beta-1a or 1b, glatiramer, Lemtrada, Ocrevus, Tysabri, or mitoxantrone) or other immunomodulatory, immunosuppressive or myelosuppressive therapy
9. There are no significant interacting drugs

Initial approval duration: 6 months

➤ **Criteria for continuation of coverage (renewal request):** Gilenya (fingolimod), Ponvory (ponesimod), Mayzent (siponimod) or Tascenso ODT (fingolimod lauryl sulfate) is considered **medically necessary** and will be approved when **ALL** of the following criteria are met (**samples are not considered for continuation of therapy**):

- 1. Individual continues to be seen by a physician specializing in the patient's diagnosis or is in consultation with a Neurologist
- 2. For **Tascenso ODT**: individual is 10 years to 17 years of age **AND** weighs less than or equal to 40 kg (88 pounds)

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[TASCENSO ODT](#) (fingolimod lauryl sulfate)

[TECFIDERA](#) (dimethyl fumarate)

[VUMERITY](#) (diroximel fumarate)

[ZEPOSIA](#) (ozanimod)

-
3. Individual's condition responded while on therapy with response defined as **THREE** of the following:
 - a. Mild/minimal to no functional neurologic (pyramidal, cerebellar, brainstem, sensory) disabilities
 - b. Ambulatory without need for assistance
 - c. Reduction in number of exacerbations or relapses of MS
 - d. Prolonged time to exacerbation or relapses of MS
 - e. Reduction in hospitalizations for MS
 4. Individual has been adherent with the medication
 5. **For continuation of a branded product:** Individual has failure, contraindication per FDA label, or intolerance to their equivalent **generic** product
 6. Individual has not developed any contraindications or other significant adverse drug effects that may exclude continued use
 - a. Contraindications as listed in the criteria for initial therapy section
 - b. Significant adverse effect such as:
 - i. Severe, uncontrolled infection
 - ii. Macular edema or uveitis
 - iii. Serious arrhythmia such as symptomatic bradycardia, AV block, QT prolongation, etc.
 - iv. Liver toxicity/injury
 - v. Posterior Reversible Encephalopathy Syndrome
 - vi. Progressive Multifocal Leukoencephalopathy
 7. Will not be used in the following:
 - a. Patients with an active infection
 - b. With live vaccines during therapy
 - c. **Additional criteria for Ponvory ONLY:**
 - i. Patients with moderate or severe hepatic impairment (Child-Pugh Class B and C)
 - ii. A patient with a resting heart rate of less than 50 bpm at baseline
 - iii. Presence of any severe cardiac disease

PHARMACY COVERAGE GUIDELINE

[AMPYRA](#) (dalfampridine ER)

[AUBAGIO](#) (teriflunomide)

[BAFIERTAM](#) (monomethyl fumarate)

[Dalfampridine ER](#), generic

[Dimethyl fumarate](#), generic

[GILENYA](#) (fingolimod)

[MAVENCLAD](#) (cladribine)

[MAYZENT](#) (siponimod)

[PONVORY](#) (ponesimod)

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- iv. Cardiac conduction or rhythm disorders (including symptomatic bradycardia, atrial flutter or atrial fibrillation, ventricular arrhythmia, cardiac arrest) either in history or observed at screening
- v. QTcF interval greater than 470 ms (females) and greater than 450 ms (males) observed at screening
- vi. History of syncope associated with cardiac disorders
- vii. Uncontrolled systemic arterial hypertension

d. Additional criteria for Mayzent ONLY:

- i. Individual with significant QT prolongation (QTc > 500 msec), individual on Class Ia or Class III anti-arrhythmic drugs, or New York Heart Association Class II heart failure, unless has been cleared by a Cardiologist
- ii. Individual with complete left bundle branch block, sinus arrest or symptomatic bradycardia unless patient has a functioning pacemaker, unless has been cleared by a Cardiologist

8. Will not be used concurrently with other oral multiple sclerosis medications except for dalfampridine (brand Ampyra or generic), which is intended to improve walking speed rather than disease progression, or injectable therapies for multiple sclerosis (e.g., interferon beta-1a or 1b, glatiramer, Lemtrada, Ocrevus, Tysabri, or mitoxantrone) or other immunomodulatory, immunosuppressive or myelosuppressive therapy

9. There are no significant interacting drugs

Renewal duration: 12 months

➤ Criteria for a request for non-FDA use or indication, treatment with dosing, frequency, or duration outside the FDA-approved dosing, frequency, and duration, refer to one of the following Pharmacy Coverage Guideline:

1. **Off-Label Use of Non-Cancer Medications**

2. **Off-Label Use of Cancer Medications**

PHARMACY COVERAGE GUIDELINE

[AMPYRA](#) (dalfampridine ER)

[AUBAGIO](#) (teriflunomide)

[BAFIERTAM](#) (monomethyl fumarate)

[Dalfampridine ER](#), generic

[Dimethyl fumarate](#), generic

[GILENYA](#) (fingolimod)

[MAVENCLAD](#) (cladribine)

[MAYZENT](#) (siponimod)

[PONVORY](#) (ponesimod)

[TASCENSO ODT](#) (fingolimod lauryl sulfate)

[TECFIDERA](#) (dimethyl fumarate)

[VUMERITY](#) (diroximel fumarate)

[ZEPOSIA](#) (ozanimod)

ZEPOSIA (ozanimod)

- **Criteria for initial therapy:** Zeposia (ozanimod) is considered *medically necessary* and will be approved when **ALL** of the following criteria are met:
1. Prescriber is a physician specializing in the patient's diagnosis or is in consultation with a Neurologist or Gastroenterologist
 2. Individual is 18 years of age or older
 3. A confirmed diagnosis of **ONE** of the following:
 - a. Relapsing forms of multiple sclerosis, including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
 - b. Moderately to severely active ulcerative colitis as defined by the American College of Gastroenterology Ulcerative Colitis activity index rating of disease **AND** has at least five signs and symptoms ([see Definitions section](#))
 4. **ONE of the following:**
 - a. For multiple sclerosis: Documented failure after a trial of at least four (4) weeks, contraindication per FDA label, intolerance to use **at least two (2)** of the following: [**Note**: each of the following requires precertification]
 - i. Aubagio (teriflunomide)
 - ii. Avonex (interferon beta-1a) injection
 - iii. Bafiertam (monomethyl fumarate)
 - iv. Betaseron (interferon beta-1a) injection
 - v. Copaxone (glatiramer acetate injection)
 - vi. Dimethyl fumarate (generic or brand Tecfidera)
 - vii. Gilenya (fingolimod)
 - viii. Kesimpta (ofatumumab) injection
 - ix. Plegridy (peginterferon beta-1a injection)
 - x. Rebif (interferon beta-1a injection)
 - xi. Vumerity (diroximel fumarate)

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PHARMACY COVERAGE GUIDELINE

[AMPYRA \(dalfampridine ER\)](#)

[AUBAGIO \(teriflunomide\)](#)

[BAFIERTAM \(monomethyl fumarate\)](#)

[Dalfampridine ER, generic](#)

[Dimethyl fumarate, generic](#)

[GILENYA \(fingolimod\)](#)

[MAVENCLAD \(cladribine\)](#)

[MAYZENT \(siponimod\)](#)

[PONVORY \(ponesimod\)](#)

[TASCENSO ODT \(fingolimod lauryl sulfate\)](#)

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[VUMERITY \(diroximel fumarate\)](#)

[ZEPOSIA \(ozanimod\)](#)

-
- b. For ulcerative colitis:
- i. Documented failure (used for > 3 consecutive months), contraindication per FDA label, or intolerance to **ONE** or more of the following: [**Note**: this criterion is waived if the individual already has tried an FDA approved Ulcerative Colitis biologic]
 1. 6-mercaptopurine
 2. Azathioprine
 3. Oral corticosteroids
 4. Salicylates (such as mesalamine, sulfasalazine, balsalazide, olsalazine)
 - ii. Documented failure (used for \geq 3 consecutive months), contraindication per FDA label, intolerance to **TWO** or more of the following:
 1. Humira (adalimumab)
 2. Rinvoq (upadacitinib)
 3. Simponi (golimumab)
 4. Stelara (ustekinumab)
5. **ALL** of the following baseline tests have been completed before initiation of treatment with continued monitoring as clinically appropriate:
- a. Complete blood count (CBC) within the last 6 months
 - b. Electrocardiogram (ECG)
 - c. Alanine aminotransferase (ALT), aspartate aminotransferase (AST), and total bilirubin within the last 6 months
 - d. Ophthalmologic examination
 - e. Where clinically indicated, spirometric evaluation of respiratory function
 - f. Evidence of varicella zoster virus (VZV) immunity by **either** of the following:
 - i. Healthcare provider-confirmed history of chickenpox **OR**
 - ii. Documented full course of VZV vaccination **OR**
 - iii. Positive test for antibodies to VZV; any needed vaccination of antibody negative patients to be completed 1 month before initiation
6. There are **NO** FDA-label contraindications, such as:
- a. Myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III/IV heart failure within the last 6 months

PHARMACY COVERAGE GUIDELINE

[AMPYRA](#) (dalfampridine ER)

[AUBAGIO](#) (teriflunomide)

[BAFIERTAM](#) (monomethyl fumarate)

[Dalfampridine ER](#), generic

[Dimethyl fumarate](#), generic

[GILENYA](#) (fingolimod)

[MAVENCLAD](#) (cladribine)

[MAYZENT](#) (siponimod)

[PONVORY](#) (ponesimod)

[TASCENSO ODT](#) (fingolimod lauryl sulfate)

[TECFIDERA](#) (dimethyl fumarate)

[VUMERITY](#) (diroximel fumarate)

[ZEPOSIA](#) (ozanimod)

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- b. History or presence of Mobitz Type II second-degree or third-degree atrioventricular (AV) block, sick sinus syndrome or sino-atrial block, unless individual has a functioning pacemaker
 - c. Severe untreated sleep apnea
 - d. Concomitant use a monoamine oxidase inhibitor
7. Individual does not have an active infection
 8. Individual does not have hepatic impairment
 9. Individual does not have cardiac conduction or rhythm disorders, including significant QT prolongation (QTcF > 450 msec in males, > 470 msec in females), risk factors for QT prolongation, or other conduction abnormalities or cardiac condition that could jeopardize the patient's health, unless has been cleared by a Cardiologist
 10. Individual does not have a resting heart rate of less than 55 bpm at baseline
 11. Will not be used concurrently with other biologics (e.g., Humira, Rinvoq, Simponi, Stelara), other oral multiple sclerosis medications except for dalfampridine, or injectable therapies for multiple sclerosis (e.g., interferon beta-1a or 1b, glatiramer, Lemtrada, Ocrevus, Tysabri, or mitoxantrone), or other immunomodulatory, immuosuppressive or myelosuppressive therapy
 12. There are no significant interacting drugs

Initial approval duration: 6 months

➤ **Criteria for continuation of coverage (renewal request):** Zeposia (ozanimod) is considered **medically necessary** and will be approved when **ALL** of the following criteria are met (**samples are not considered for continuation of therapy**):

1. Individual continues to be seen by a physician specializing in the patient's diagnosis or is in consultation with a Neurologist or Gastroenterologist

PHARMACY COVERAGE GUIDELINE

[AMPYRA](#) (dalfampridine ER)

[AUBAGIO](#) (teriflunomide)

[BAFIERTAM](#) (monomethyl fumarate)

[Dalfampridine ER](#), generic

[Dimethyl fumarate](#), generic

[GILENYA](#) (fingolimod)

[MAVENCLAD](#) (cladribine)

[MAYZENT](#) (siponimod)

[PONVORY](#) (ponesimod)

[TASCENSO ODT](#) (fingolimod lauryl sulfate)

[TECFIDERA](#) (dimethyl fumarate)

[VUMERITY](#) (diroximel fumarate)

[ZEPOSIA](#) (ozanimod)

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2. Individual's condition responded while on therapy is **ONE** of the following:
 - a. Response for multiple sclerosis is defined as **THREE** of the following:
 - i. Mild/minimal to no functional neurologic (pyramidal, cerebellar, brainstem, sensory) disabilities
 - ii. Ambulatory without need for assistance
 - iii. Reduction in number of exacerbations or relapses of MS
 - iv. Prolonged time to exacerbation or relapses of MS
 - v. Reduction in hospitalizations for MS
 - b. Response for ulcerative colitis is defined as **TWO** of the following:
 - i. Achieved and maintains clinical remission or clinical response
 - ii. Achieved and maintains endoscopic improvement or endoscopic histologic mucosal improvement
 - iii. Achieved and maintains corticosteroid free clinical remission
 3. Individual has been adherent with the medication
 4. Individual has not developed any contraindications or other significant adverse drug effects that may exclude continued use
 - a. Contraindications as listed in the criteria for initial therapy section
 - b. Significant adverse effect such as:
 - i. Severe, uncontrolled infection
 - ii. Macular edema or uveitis
 - iii. Serious arrhythmia such as symptomatic bradycardia, AV block, QT prolongation, etc.
 - iv. Liver toxicity/injury
 - v. Posterior Reversible Encephalopathy Syndrome
 - vi. Progressive Multifocal Leukoencephalopathy
 5. Individual does not have an active infection
 6. Individual does not have hepatic impairment
 7. Individual does not have cardiac conduction or rhythm disorders, including significant QT prolongation (QTcF > 450 msec in males, > 470 msec in females), risk factors for QT prolongation, or other conduction

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[BAFIERTAM](#) (monomethyl fumarate)
[Dalfampridine ER](#), generic
[Dimethyl fumarate](#), generic
[GILENYA](#) (fingolimod)
[MAVENCLAD](#) (cladribine)
[MAYZENT](#) (siponimod)
[PONVORY](#) (ponesimod)
[TASCENSO ODT](#) (fingolimod lauryl sulfate)
[TECFIDERA](#) (dimethyl fumarate)
[VUMERITY](#) (diroximel fumarate)
[ZEPOSIA](#) (ozanimod)

abnormalities or cardiac condition that could jeopardize the patient's health, unless has been cleared by a Cardiologist

8. Individual does not have a resting heart rate of less than 55 bpm at baseline
9. Will not be used concurrently with other biologics (e.g., Humira, Rinvoq, Simponi, Stelara), other oral multiple sclerosis medications except for dalfampridine, or injectable therapies for multiple sclerosis (e.g., interferon beta-1a or 1b, glatiramer, Lemtrada, Ocrevus, Tysabri, or mitoxantrone), or other immunomodulatory, immunosuppressive or myelosuppressive therapy
10. There are no significant interacting drugs

Renewal duration: 12 months

- Criteria for a request for non-FDA use or indication, treatment with dosing, frequency, or duration outside the FDA-approved dosing, frequency, and duration, refer to one of the following Pharmacy Coverage Guideline:
 1. **Off-Label Use of Non-Cancer Medications**
 2. **Off-Label Use of Cancer Medications**

AUBAGIO (teriflunomide)

- **Criteria for initial therapy:** Aubagio (teriflunomide) is considered **medically necessary** and will be approved when **ALL** of the following criteria are met:
 1. Prescriber is a physician specializing in the patient's diagnosis or is in consultation with a Neurologist
 2. Individual is 18 years of age or older
 3. A confirmed diagnosis of relapsing forms of multiple sclerosis, including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease

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PHARMACY COVERAGE GUIDELINE

[AMPYRA](#) (dalfampridine ER)

[AUBAGIO](#) (teriflunomide)

[BAFIERTAM](#) (monomethyl fumarate)

[Dalfampridine ER](#), generic

[Dimethyl fumarate](#), generic

[GILENYA](#) (fingolimod)

[MAVENCLAD](#) (cladribine)

[MAYZENT](#) (siponimod)

[PONVORY](#) (ponesimod)

[TASCENSO ODT](#) (fingolimod lauryl sulfate)

[TECFIDERA](#) (dimethyl fumarate)

[VUMERITY](#) (diroximel fumarate)

[ZEPOSIA](#) (ozanimod)

-
4. **ALL** of the following baseline tests have been completed before initiation of treatment with continued monitoring as clinically appropriate:
 - a. Alanine aminotransferase (ALT), aspartate aminotransferase (AST), and total bilirubin within the last 6 months
 - b. Complete blood count (CBC) within the last 6 months
 - c. Screening for latent tuberculosis infection with a tuberculin skin test or blood test; if positive, treat tuberculosis with standard medical therapy before use of Aubagio (teriflunomide)
 - d. Blood pressure measurement: with elevated blood pressure managed during treatment
 - e. Negative pregnancy test in a woman of childbearing potential
 5. There are **NO** FDA-label contraindications, such as:
 - a. Severe hepatic impairment (Child-Pugh Class C)
 - b. Concurrent use with Arava (leflunomide)
 - c. History of a hypersensitivity reaction to Aubagio (teriflunomide), Arava (leflunomide), or to any of the inactive ingredients in Aubagio (teriflunomide)
 - d. Woman of childbearing potential who is pregnant or not currently using effective contraception
 6. Will not be used in patients with an active acute or chronic infection
 7. Will not be used with live vaccines during therapy
 8. Will not be used concurrently with other oral multiple sclerosis medications except for dalfampridine (brand Ampyra or generic), which is intended to improve walking speed rather than disease progression, or injectable therapies for multiple sclerosis (e.g., interferon beta-1a or 1b, glatiramer, Lemtrada, Ocrevus, Tysabri, or mitoxantrone) or other immunomodulatory, immunosuppressive or myelosuppressive therapy
 9. There are no significant interacting drugs

Initial approval duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Aubagio (teriflunomide) is considered **medically necessary** and will be approved when **ALL** of the following of the following criteria are met (**samples are not considered for continuation of therapy**):

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PHARMACY COVERAGE GUIDELINE

[AMPYRA](#) (dalfampridine ER)

[AUBAGIO](#) (teriflunomide)

[BAFIERTAM](#) (monomethyl fumarate)

[Dalfampridine ER](#), generic

[Dimethyl fumarate](#), generic

[GILENYA](#) (fingolimod)

[MAVENCLAD](#) (cladribine)

[MAYZENT](#) (siponimod)

[PONVORY](#) (ponesimod)

[TASCENSO ODT](#) (fingolimod lauryl sulfate)

[TECFIDERA](#) (dimethyl fumarate)

[VUMERITY](#) (diroximel fumarate)

[ZEPOSIA](#) (ozanimod)

-
1. Individual continues to be seen by a physician specializing in the patient's diagnosis or is in consultation with a Neurologist
 2. Individual's condition responded while on therapy with response defined as **THREE** of the following:
 - i. Mild/minimal to no functional neurologic (pyramidal, cerebellar, brainstem, sensory) disabilities
 - ii. Ambulatory without need for assistance
 - iii. Reduction in number of exacerbations or relapses of MS
 - iv. Prolonged time to exacerbation or relapses of MS
 - v. Reduction in hospitalizations for MS
 3. Individual has been adherent with the medication
 4. Individual has not developed any contraindications or other significant adverse drug effects that may exclude continued use
 - a. Contraindications as listed in the criteria for initial therapy section
 - b. Significant adverse effect such as:
 - i. Severe liver injury
 - ii. Severe immunodeficiency
 - iii. Bone marrow depression
 - iv. Severe peripheral neuropathy
 - v. Interstitial lung disease, including acute interstitial pneumonitis
 - vi. Anaphylaxis, angioedema
 - vii. Stevens-Johnson syndrome
 - viii. Toxic epidermal necrolysis
 - ix. Drug reaction with eosinophilia and systemic symptoms (DRESS)
 5. Will not be used in patients with an active acute or chronic infection
 6. Will not be used with live vaccines during therapy
 7. Will not be used concurrently with other oral multiple sclerosis medications except for dalfampridine (brand Ampyra or generic), which is intended to improve walking speed rather than disease progression,

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PHARMACY COVERAGE GUIDELINE

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[Dalfampridine ER, generic](#)
[Dimethyl fumarate, generic](#)
[GILENYA \(fingolimod\)](#)
[MAVENCLAD \(cladribine\)](#)
[MAYZENT \(siponimod\)](#)
[PONVORY \(ponesimod\)](#)
[TASCENSO ODT \(fingolimod lauryl sulfate\)](#)
[TECFIDERA \(dimethyl fumarate\)](#)
[VUMERITY \(diroximel fumarate\)](#)
[ZEPOSIA \(ozanimod\)](#)

or injectable therapies for multiple sclerosis (e.g., interferon beta-1a or 1b, glatiramer, Lemtrada, Ocrevus, Tysabri, or mitoxantrone) or other immunomodulatory, immunosuppressive or myelosuppressive therapy

8. There are no significant interacting drugs

Renewal duration: 12 months

- Criteria for a request for non-FDA use or indication, treatment with dosing, frequency, or duration outside the FDA-approved dosing, frequency, and duration, refer to one of the following Pharmacy Coverage Guideline:

1. **Off-Label Use of Non-Cancer Medications**
2. **Off-Label Use of Cancer Medications**

AMPYRA (dalfampridine ER)

Dalfampridine ER

- **Criteria for initial therapy:** Ampyra (dalfampridine ER) or generic dalfampridine ER is considered **medically necessary** and will be approved with medical record documentation of **ALL** of the following:
1. Prescriber is a physician specializing in neurologic disorders or is in consultation with a Neurologist
 2. Individual is 18 years of age or older
 3. A confirmed diagnosis of Multiple Sclerosis (MS) in a patient who is still ambulatory and has a baseline timed 25-foot walking speed of between 8-45 seconds **or** has significant limitations of instrumental activities of daily living attributable to slow ambulation
 4. Continues concurrent MS therapy agents that may include: Aubagio, Avonex, Betaseron, Copaxone, Extavia, Gilenya, Glatopa, Lemtrada, Novantrone, Ocrevus, Plegridy, Rebif, Tysabri, or Zinbryta as indicated

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PHARMACY COVERAGE GUIDELINE

[AMPYRA \(dalfampridine ER\)](#)

[AUBAGIO \(teriflunomide\)](#)

[BAFIERTAM \(monomethyl fumarate\)](#)

[Dalfampridine ER, generic](#)

[Dimethyl fumarate, generic](#)

[GILENYA \(fingolimod\)](#)

[MAVENCLAD \(cladribine\)](#)

[MAYZENT \(siponimod\)](#)

[PONVORY \(ponesimod\)](#)

[TASCENSO ODT \(fingolimod lauryl sulfate\)](#)

[TECFIDERA \(dimethyl fumarate\)](#)

[VUMERITY \(diroximel fumarate\)](#)

[ZEPOSIA \(ozanimod\)](#)

-
5. Prescribed dosage will not be greater than 10mg twice daily
 6. The baseline Creatinine clearance (CrCl) is greater than 50 mL/min
 7. Will not be used with Firdapse (amifampridine phosphate) or Ruzurgi (amifampridine)
 8. There are **NO** FDA-label contraindications, such as:
 - a. History of seizures or is at high risk for seizures
 - b. Moderate to severe renal impairment (CrCl \leq to 50 mL/min)
 - c. Hypersensitivity to Ampyra, dalfampridine, or 4-aminopyridine (4-AP, fampridine)

Initial approval duration: 6 months

➤ **Criteria for continuation of coverage (renewal request):** Ampyra (dalfampridine ER) or dalfampridine ER is considered **medically necessary** and will be approved when **ALL** of the following criteria are met (**samples are not considered for continuation of therapy**):

1. Individual continues to be seen by a physician specializing in neurologic disorders or is in consultation with a Neurologist
2. Individual's condition responded while on therapy with response defined as:
 - a. Improvement in walking speed of at least 20% over baseline
 - b. Remains ambulatory
3. Individual has been adherent with the medication **and** the dose does not exceed 10 mg every 12 hours
4. The baseline Creatinine clearance (CrCl) is greater than 50 mL/min
5. Individual has not developed any contraindications or other significant adverse drug effects that may exclude continued use
 - a. Contraindications as listed in the criteria for initial therapy section
 - b. Significant adverse effect such as
 - i. Seizure

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PHARMACY COVERAGE GUIDELINE

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[Dimethyl fumarate](#), generic
[GILENYA](#) (fingolimod)
[MAVENCLAD](#) (cladribine)
[MAYZENT](#) (siponimod)
[PONVORY](#) (ponesimod)
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[ZEPOSIA](#) (ozanimod)

ii. Anaphylaxis

6. Will not be used with Firdapse (amifampridine phosphate) or Ruzurgi (amifampridine)
7. There are no significant interacting drugs

Renewal duration: 12 months

- Criteria for a request for non-FDA use or indication, treatment with dosing, frequency, or duration outside the FDA-approved dosing, frequency, and duration, refer to one of the following Pharmacy Coverage Guideline:

1. **Off-Label Use of Non-Cancer Medications**
 2. **Off-Label Use of Cancer Medications**
-

Description:

MS is a chronic autoimmune disorder of the central nervous system (CNS) in which white blood cells (WBCs) attack and damage the myelin sheath of nerve cells in the CNS. This damage disrupts transmission of nerve impulses. Damage occurs in areas of the brain, spinal cord, and optic nerves.

The damage ultimately leads to progressive physical and cognitive disabilities. The clinical course of MS is highly variable. There are four recognized clinical forms: relapsing remitting (RRMS), secondary progressive (SPMS), primary progressive (PPMS), and progressive relapsing (PRMS). RRMS is the most common form of the disease. Because MS can affect any area of the brain, optic nerve, or spinal cord, MS can cause almost any neurologic symptom. Patients often present as young adults with 2 or more clinically distinct episodes of CNS dysfunction with at least partial resolution. Episodes involve numbness, weakness, or incoordination affecting an arm, a leg, or both. Additional symptoms include pain, vertigo, cognitive deficits (such as impaired memory, attention, or judgment), fatigue, speech deficits (such as dysarthria or less commonly aphasia), and bowel, bladder, and sexual dysfunction.

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PHARMACY COVERAGE GUIDELINE

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[AUBAGIO \(teriflunomide\)](#)

[BAFIERTAM \(monomethyl fumarate\)](#)

[Dalfampridine ER, generic](#)

[Dimethyl fumarate, generic](#)

[GILENYA \(fingolimod\)](#)

[MAVENCLAD \(cladribine\)](#)

[MAYZENT \(siponimod\)](#)

[PONVORY \(ponesimod\)](#)

[TASCENSO ODT \(fingolimod lauryl sulfate\)](#)

[TECFIDERA \(dimethyl fumarate\)](#)

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[ZEPOSIA \(ozanimod\)](#)

The pathological hallmark of MS is the cerebral or spinal plaque on magnetic resonance imaging (MRI). Plaques are discrete regions of demyelination with relative preservation of axons. The neurologic history and physical examination help establish the diagnosis of MS. Diagnostic criteria are symptoms and signs disseminated in time and space (i.e., more than one episode involving more than one area of the CNS). These criteria have been largely replaced by the McDonald criteria, developed in 2001 by the International Panel on the Diagnosis of Multiple Sclerosis. The McDonald criteria retain many features of the original criteria and are intended for use in both clinical practice and clinical trial settings. Diagnoses of “definite MS,” “possible MS,” or, if there is a better explanation for the clinical presentation, “not MS” are determined by findings on clinical exam, MRI, cerebrospinal fluid, and visual evoked potentials. The term “clinically isolated syndrome” (CIS) describes patients who have suffered a first clinical attack but do not meet diagnostic criteria for definite MS. The most recent update in 2010 allows the diagnosis of MS in some patients with CIS.

Multiple observational trials confirm that people with a single clinical demyelinating event with two or more brain or spinal cord lesions remain at increased risk of a future MS diagnosis and are at highest risk within 5 years of the initial event. Evidence from multiple trials confirm that treatment is associated with a significant delay in second clinical relapse or new brain MRI-detected lesions in people with a first demyelinating event who are considered to be at high risk for MS on the basis of brain MRI-detected lesions.

Mavenclad (cladribine) is indicated for the treatment of relapsing forms of MS, including relapsing-remitting disease and active secondary progressive disease, in adults. Because of its safety profile, use of Mavenclad (cladribine) is recommended for patients who have had an inadequate response to, or are unable to tolerate, an alternate drug indicated for the treatment of MS. Mavenclad (cladribine) is not recommended for use in patients with CIS because of its safety profile.

Mavenclad (cladribine) is a nucleoside metabolic inhibitor. The mechanism by which cladribine exerts its therapeutic effects in patients with MS has not been fully elucidated but is thought to involve cytotoxic effects on B and T lymphocytes through impairment of DNA synthesis, resulting in depletion of lymphocytes. Cladribine is a prodrug that becomes active upon phosphorylation to its 2-chlorodeoxyadenosine triphosphate (Cd-ATP) metabolite.

It is given as two treatment courses, with two treatment cycles per course. The second treatment course is given at least 43 weeks after the last dose of the first course/second cycle. Each cycle is separated by 23-27 days after the last dose of a cycle. Following the administration of 2 treatment courses, do not administer additional Mavenclad (cladribine) treatment during the next 2 years. Treatment during these 2 years may further increase

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the risk of malignancy. The safety and efficacy of reinitiating Mavenclad (cladribine) more than 2 years after completing 2 treatment courses has not been studied.

Tecfidera (dimethyl fumarate, DMF) is indicated for the treatment of patients with relapsing forms of MS, including CIS, relapsing-remitting disease, and active secondary progressive disease, in adults. The mechanism by which DMF exerts its therapeutic effect in MS is unknown. DMF and its active metabolite, monomethyl fumarate (MMF), have been shown to activate the Nuclear factor (erythroid-derived 2)-like 2 (Nrf2) pathway *in vitro* and *in vivo* in animals and humans. The Nrf2 pathway is involved in the cellular response to oxidative stress. MMF has been identified as a nicotinic acid receptor agonist *in vitro*. DMF and MMF are postulated to decrease oxidative stress and protect axons from inflammatory mediators. Tecfidera (dimethyl fumarate) is available generically.

Vumerity (diroximel fumarate) is indicated for the treatment of relapsing forms of MS, including CIS, relapsing-remitting disease, and active secondary progressive disease, in adults. The mechanism by which diroximel fumarate exerts its therapeutic effect in MS is unknown. Diroximel fumarate undergoes rapid pre-systemic hydrolysis by esterases and is converted to its active metabolite, monomethyl fumarate (MMF). MMF has been shown to activate the nuclear factor (erythroid-derived 2)-like 2 (Nrf2) pathway *in vitro* and *in vivo* in animals and humans.

Bafiertam (monomethyl fumarate) is indicated for the treatment of relapsing forms of MS, including CIS, relapsing-remitting disease, and active secondary progressive disease, in adults. The mechanism by which monomethylfumarate (MMF) fumarate exerts its therapeutic effect in MS is unknown. MMF has been shown to activate the nuclear factor (erythroid-derived 2)-like 2 (Nrf2) pathway *in vitro* and *in vivo* in animals and humans. The Nrf2 pathway is involved in the cellular response to oxidative stress. MMF has been identified as a nicotinic acid receptor agonist *in vitro*. DMF and MMF are postulated to decrease oxidative stress and protect axons from inflammatory mediators.

Fingolimod (brand Gilenya and generic) is a sphingosine 1-phosphate (S1P) receptor modulator indicated for the treatment of patients with relapsing forms of MS, including CIS, relapsing-remitting disease, and active secondary progressive disease in patients 10 years of age or older for the brand (18 years of age or older for the generic), to reduce the frequency of clinical exacerbations and to delay the accumulation of physical disability. Fingolimod is metabolized by sphingosine kinase to the active metabolite, fingolimod-phosphate. Fingolimod-phosphate is a sphingosine 1-phosphate receptor modulator, and binds with high affinity to S1P receptors 1, 3, 4, and 5. Fingolimod-phosphate blocks the capacity of lymphocytes to egress from lymph nodes, reducing the

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number of lymphocytes in peripheral blood. The mechanism by which fingolimod exerts therapeutic effects in MS is unknown but may involve reduction of lymphocyte migration into the central nervous system.

Zeposia (ozanimod), Ponvory (ponesimod) and Mayzent (siponimod) are a S1P receptor modulator indicated for the treatment of relapsing forms of MS, including CIS, relapsing-remitting disease, and active secondary progressive disease, in adults. Ozanimod and siponimod bind with high affinity to S1P receptors 1 and 5. Ponesimod binds with high affinity to S1P receptor 1. Ozanimod, ponesimod, and siponimod block the capacity of lymphocytes to egress from lymph nodes, reducing the number of lymphocytes in peripheral blood.

The mechanism by which ozanimod, ponesimod, and siponimod exert therapeutic effects in MS is unknown but may involve the reduction of lymphocyte migration into the central nervous system.

Zeposia (ozanimod) is also indicated for the treatment of moderately to severely active ulcerative colitis.

Aubagio (teriflunomide) is a pyrimidine synthesis inhibitor indicated for the treatment of individuals with relapsing forms of MS, including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults. It is the principle active metabolite of Arava (leflunomide) which is indicated for the treatment of rheumatoid arthritis. Teriflunomide is an immunomodulatory agent with anti-inflammatory properties. It inhibits the mitochondrial enzyme involved in pyrimidine synthesis, dihydro-orotate dehydrogenase. The exact mechanism by which teriflunomide exerts its therapeutic effect in MS is unknown. It is thought that teriflunomide helps reduce the number of active T and B lymphocytes, two types of WBCs, thought to be particularly damaging in MS.

Ampyra (dalfampridine) and generic dalfampridine are indicated as a treatment to improve walking in adult patients with MS. The mechanism by which dalfampridine exerts its therapeutic effect in MS has not been fully elucidated. Dalfampridine is a broad spectrum potassium channel blocker that blocks the exposed potassium channels and restores the action potential and improves neuronal conduction. It does not alter the disease course of MS relapse has been reported while on dalfampridine.

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Definitions:

Oral Disease-Modifying Agents Used in the Treatment of Multiple Sclerosis (MS):

Oral Agents:
Mavenclad (cladribine)
Dimethyl fumarate (brand Tecfidera and generic)
Vumerity (diroximel fumarate)
Bafiertam (monomethyl fumarate)
Gilenya (fingolimod)
Ponvory (ponesimod)
Zeposia (ozanimod)
Mayzent (siponimod)
Aubagio (teriflunomide)
Adjunct to improve walking speed
Dalfampridine (brand Ampyra and generic)

Forms of multiple sclerosis:

Relapsing-remitting multiple sclerosis (RRMS)

This form of MS is characterized by acute relapses that are followed by some degree of recovery; patients do not develop worsening of disability between relapses.

Secondary progressive multiple sclerosis (SPMS)

This form of MS is defined as sustained progression of physical disability occurring separately from relapses, in patients who previously had RRMS. There may, or may not be intermittent relapses, remissions, or periods of temporary minor improvements. As long as the person continues to have relapses, the SPMS course is considered to be both progressive and relapsing.

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Progressive-relapsing multiple sclerosis (PRMS)

This form of MS is characterized by steadily worsening disease from the beginning, but with occasional relapses along the way. PRMS is considered to be both a progressive and a relapsing form of the disease because people experience steady disease progression and relapses.

Primary-progressive multiple sclerosis (PPMS)

This form of MS is defined as progression of disability from onset without superimposed relapses. This type of MS is characterized by a steady decline in function from the beginning without acute attacks. There are no distinct relapses or remissions. This is not a relapsing form of MS.

Clinically isolated syndrome (CIS):

A clinical syndrome, that describes patients who demonstrate a first clinical attack but do not meet the diagnostic criteria for definite MS. The McDonald criteria is a set of criteria used in clinical practice and in clinical trials. It has been updated in 2010 such that it allows the diagnosis of MS in some patients with CIS.

McDonald criteria:

Clinical Presentation	Additional Data Needed
* 2 or more attacks (relapses) * 2 or more objective clinical lesions	None; clinical evidence will suffice (additional evidence desirable but must be consistent with MS)
* 2 or more attacks * 1 objective clinical lesion	Dissemination in space, demonstrated by: * MRI * or a positive CSF and 2 or more MRI lesions consistent with MS * or further clinical attack involving different site
* 1 attack * 2 or more objective clinical lesions	Dissemination in time, demonstrated by: * MRI * or second clinical attack
* 1 attack * 1 objective clinical lesion (monosymptomatic presentation)	Dissemination in space demonstrated by: * MRI * or positive CSF and 2 or more MRI lesions consistent with MS and Dissemination in time demonstrated by: * MRI * or second clinical attack

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Insidious neurological progression suggestive of MS (primary progressive MS)	One year of disease progression (retrospectively or prospectively determined) and Two of the following: a. Positive brain MRI (nine T2 lesions or four or more T2 lesions with positive VEP) b. Positive spinal cord MRI (two focal T2 lesions) c. Positive CSF
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The Child-Pugh classification system:

The Child-Pugh classification is a scoring system used to determine the prognosis of individuals with cirrhosis. Scoring is based upon several factors: albumin, ascites, total bilirubin, prothrombin time, and encephalopathy, as follows:

	Score: 1 point	Score: 2 points	Score: 3 points
Serum Albumin (g/dL)	>3.5	3.0 - 3.5	<3.0
Serum Bilirubin (mg/dL)	<2.0	2.0 - 3.0	>3.0
Prothrombin time (seconds)	1 - 4	4 - 6	>6
Ascites	none	moderate	severe
Encephalopathy	none	mild	severe

The three classes and their scores are:

- **Class A** is score 5 – 6: Well compensated
- **Class B** is score 7 – 9: Significant functional compromise
- **Class C** is score >9: Decompensated disease

Activities of daily living (ADL):

Instrumental ADL:

Prepare meals, shop for groceries or clothes, use the telephone, manage money, etc.

Self-care ADL:

Bathe, dress and undress, feed self, use the toilet, take medications, not bedridden

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Kurtzke Expanded Disability Status Scale (EDSS):

A method of quantifying disability in MS. The EDSS quantifies disability in eight Functional Systems (FS) and allows neurologists to assign a Functional System Score (FSS) in each of these. The Functional Systems are:

- Pyramidal
- Cerebellar
- Brainstem
- Sensory
- Bowel and bladder
- Visual
- Cerebral
- Other

EDSS steps of 1.0-4.5 refer to people with MS who are fully ambulatory. EDSS steps of 5.0-9.5 are defined by the impairment to ambulation.

Kurtzke Expanded Disability Status Scale	
0.0	Normal neurological examination
1.0	No disability, minimal signs in one FS
1.5	No disability, minimal signs in more than one FS
2.0	Minimal disability in one FS
2.5	Mild disability in one FS or minimal disability in two FS
3.0	Moderate disability in one FS, or mild disability in three or four FS. Fully ambulatory
3.5	Fully ambulatory but with moderate disability in one FS and more than minimal disability in several others
4.0	Fully ambulatory without aid, self-sufficient, up and about some 12 hours a day despite relatively severe disability; able to walk without aid or rest some 500 meters
4.5	Fully ambulatory without aid, up and about much of the day, able to work a full day, may otherwise have some limitation of full activity or require minimal assistance; characterized by relatively severe disability; able to walk without aid or rest some 300 meters.
5.0	Ambulatory without aid or rest for about 200 meters; disability severe enough to impair full daily activities (work a full day without special provisions)

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5.5	Ambulatory without aid or rest for about 100 meters; disability severe enough to preclude full daily activities
6.0	Intermittent or unilateral constant assistance (cane, crutch, brace) required to walk about 100 meters with or without resting
6.5	Constant bilateral assistance (canes, crutches, braces) required to walk about 20 meters without resting
7.0	Unable to walk beyond approximately five meters even with aid, essentially restricted to wheelchair; wheels self in standard wheelchair and transfers alone; up and about in wheelchair some 12 hours a day
7.5	Unable to take more than a few steps; restricted to wheelchair; may need aid in transfer; wheels self but cannot carry on in standard wheelchair a full day; May require motorized wheelchair
8.0	Essentially restricted to bed or chair or perambulated in wheelchair, but may be out of bed itself much of the day; retains many self-care functions; generally has effective use of arms
8.5	Essentially restricted to bed much of day; has some effective use of arms retains some self-care functions
9.0	Confined to bed; can still communicate and eat.
9.5	Totally helpless bed patient; unable to communicate effectively or eat/swallow
10.0	Death due to MS

Signs and symptoms of Ulcerative Colitis:

- i. Anemia
- ii. Bloody diarrhea or visible blood in stool
- iii. Bowel movements 4-6 or more times per day
- iv. Colicky abdominal pain
- v. Elevated fecal calprotectin
- vi. Elevated serum C-reactive protein or erythrocyte sedimentation rate
- vii. Fatigue
- viii. Fever
- ix. Tenesmus
- x. Urgency

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Ulcerative Colitis Activity:

American College of Gastroenterology Ulcerative Colitis Activity Index				
	Remission	Mild	Moderate-severe	Fulminant
Stools (no./d)	Formed	< 4	> 6	> 10
Blood in stools	None	Intermittent	Frequent	Continuous
Urgency	None	Mild, occasional	Often	Continuous
Hemoglobin	Normal	Normal	< 75% of normal	Transfusion needed
ESR	< 30	< 30	> 30	> 30
CRP (mg/L)	Normal	Elevated	Elevated	Elevated
Fecal calprotectin (mg/g)	< 150-200	> 150-200	> 150-200	> 150-200
Endoscopy (Mayo score)	0-1	1	2-3	3
UCEIS	0-1	2-4	5-8	7-8
<p>The above factors are general guides for disease activity. With the exception of remission, a patient does not need to have all the factors to be considered in a specific category. CRP, C-reactive protein; ESR, erythrocyte sedimentation rate; UCEIS, Ulcerative Colitis Endoscopic Index of Severity.</p>				
Endoscopic Assessment of Disease Activity				
Endoscopic Features	UCEIS Score	Mayo Score		
Normal	0	0		
Erythema, decreased vascular pattern, mild friability	1-3	1		
Marked erythema, absent vascular pattern, friability, erosions	4-6	2		
Spontaneous bleeding, ulceration	7-8	3		

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Resources:

Ampyra (dalfampridine) product information, revised by manufacturer Acorda Therapeutics, Inc 11-2021, at DailyMed <http://dailymed.nlm.nih.gov>. Accessed March 28, 2022.

Aubagio (teriflunomide) product information, revised by manufacturer Genzyme Corporation 04-2021, at DailyMed <http://dailymed.nlm.nih.gov>. Accessed March 28, 2022.

Bafiertam (monomethyl fumarate) product information, revised by manufacturer Banner Life Sciences LLC. 04-2020. Available at DailyMed <http://dailymed.nlm.nih.gov>. Accessed March 28, 2022.

Dalfampridine product information, revised by manufacturer Sun Pharmaceutical Industries, Inc 12-2021, at DailyMed <http://dailymed.nlm.nih.gov>. Accessed May 11, 2022.

Dimethyl fumarate product information, revised by manufacturer Mylan Pharmaceuticals Inc 02-2022, at DailyMed <http://dailymed.nlm.nih.gov>. Accessed March 28, 2022.

Gilenya (fingolimod) product information, revised by manufacturer Novartis Pharmaceuticals Corporation 12-2019, at DailyMed <http://dailymed.nlm.nih.gov>. Accessed March 28, 2022.

Tascenso ODT (fingolimod) product information, revised by manufacturer Handa Neuroscience, LLC. 12-2021, at FDA <http://fda.gov>. Accessed August 09, 2022.

Mavenclad (cladribine) product information, revised by manufacturer EMD Serono, Inc 04-2019. Available at DailyMed <http://dailymed.nlm.nih.gov>. Accessed March 28, 2022.

Mayzent (siponimod) product information, revised by manufacturer Novartis Pharmaceuticals Corporation 03-2022, at DailyMed <http://dailymed.nlm.nih.gov>. Accessed March 28, 2022.

Ponvory (ponesimod) product information, revised by manufacturer Janssen Pharmaceutical, Inc. 04-2021, at DailyMed <http://dailymed.nlm.nih.gov>. Accessed March 28, 2022.

Tecfidera (dimethyl fumarate) product information, revised by manufacturer Biogen Inc 02-2022. Available at DailyMed <http://dailymed.nlm.nih.gov>. Accessed March 28, 2022.

Vumerity (diroximel fumarate) product information, revised by manufacturer Biogen Inc 02-2022, at DailyMed <http://dailymed.nlm.nih.gov>. Accessed March 28, 2022.

Zeposia (ozanimod) product information, revised by manufacturer Celgene Corporation 12-2021, at DailyMed <http://dailymed.nlm.nih.gov>. Accessed March 28, 2022.

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Olek MJ, Mowry E. Initial disease-modifying therapy for relapsing-remitting multiple sclerosis. In: UpToDate, Gonzalez-Scarano F, Dashe JF. (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at <http://uptodate.com>. Topic last updated February 01, 2022. Accessed April 08, 2022.