This policy applies to the following:

✓	Standard Opt-in	✓	ACSF	VF	Marketplace
	Standard Opt-in NTMB	\	PDPD	ммт	Medical Benefit
					Medical Benefit:
	Standard Opt-out		Generics First		Managed Medicaid

	Reference #
Ī	3051-D

EXCEPTIONS CRITERIA

MULTIPLE SCLEROSIS

PREFERRED PRODUCT FOR EXTAVIA: Betaseron

PREFERRED PRODUCTS FOR MAVENCLAD: Aubagio, Betaseron, Copaxone, Gilenya, glatiramer, Rebif, Tecfidera, Tysabri

PREFERRED PRODUCTS FOR MAYZENT: Aubagio, Betaseron, Copaxone, Gilenya, glatiramer, Rebif, Tecfidera, Tysabri

POLICY

This policy informs prescribers of preferred products and provides an exception process for targeted products through prior authorization.

I. PLAN DESIGN SUMMARY

This program applies to the multiple sclerosis products specified in this policy. Coverage for targeted products is provided based on clinical circumstances that would exclude the use of the preferred product and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to all members requesting treatment with Betaseron. This program applies to members requesting treatment with Mayzent and Mavenclad for the first time.

Each referral is reviewed based on all utilization management (UM) programs implemented for the client.

Table 1. Extavia

	Products					
Preferred	Betaseron (interferon beta-1b)					
Targeted	Extavia (interferon beta-1b)					

Table 2. Mavenclad

	Products				
Preferred	Aubagio (teriflunomide)				
	Betaseron (interferon beta-1b)				
	Copaxone (glatiramer)				
	Gilenya (fingolimod)				
	glatiramer				
	Rebif (interferon beta-1a)				
	Tecfidera (dimethyl fumarate)				
	Tysabri (natalizumab)				
Targeted	Mavenclad (cladribine)				

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	Standard Opt-in NTMB	✓	PDPD	ммт	Medical Benefit
	•				Medical Benefit:
	Standard Opt-out		Generics First		Managed Medicaid

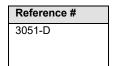


Table 3. Mayzent

	Products
Preferred	Aubagio (teriflunomide)
	Betaseron (interferon beta-1b)
	Copaxone (glatiramer)
	Gilenya (fingolimod)
	glatiramer
	Rebif (interferon beta-1a)
	Tecfidera (dimethyl fumarate)
	Tysabri (natalizumab)
Targeted	Mayzent (siponimod)

II. EXCEPTION CRITERIA

This program applies to members requesting treatment for an indication that is FDA-approved for the preferred product.

A. Extavia

Coverage for Extavia is provided when the member meets the following criteria:

There is a documented clinical reason that the member must use Extavia over Betaseron. (*Please note that Extavia and Betaseron are the exact same products with different labels and brand names, which are made in the same manufacturing facility.*)

B. Mavenclad

Coverage for Mavenclad is provided when the member meets any of the following criteria:

- 1. Member has had a documented inadequate response or intolerable adverse effect to treatment with at least three of the preferred products.
- 2. Member has a documented contraindication to therapy with all of the preferred products.
- 3. Member is currently receiving therapy with Mavenclad, excluding when Mavenclad is obtained as samples or via manufacturer's patient assistance programs.

C. Mayzent

Coverage for Mayzent is provided when the member meets any of the following criteria:

- 1. Member has had a documented inadequate response or intolerable adverse effect to treatment with Gilenya and two other preferred products.
- 2. Member has a documented contraindication to therapy with all of the preferred products.
- 3. Member is currently receiving therapy with Mayzent, excluding when Mayzent is obtained as samples or via manufacturer's patient assistance programs.
- 4. Member is being treated for clinically isolated syndrome.

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	Standard Opt-in NTMB	✓	PDPD	ммт	Medical Benefit
	-				Medical Benefit:
	Standard Opt-out		Generics First		Managed Medicaid

Reference #
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