

Multiple Sclerosis Agents

Applies To:

Avonex (interferon beta-1a)
Betaseron (interferon beta-1b)
Kesimpta (ofatumumab)
Plegridy (peginterferon beta-1a)
Rebif (interferon beta-1a)

Diagnosis Considered for Coverage:

- Multiple sclerosis (MS)

Coverage Criteria for Commercial Plus:

For diagnosis listed above:

- Dose does not exceed FDA label maximum, **and**
- Not being used in combination with another multiple sclerosis disease modifying therapy, **and**
- Inadequate response or intolerable side effects with TWO preferred MS disease-modifying agents including: Extavia, fingolimod (Gilenya), dimethyl fumarate (Tecfidera), Tecfidera, and a glatiramer containing products (Glatopa 20 mg, Glatopa 40 mg, glatiramer 20 mg, glatiramer 40 mg), or contraindication to all preferred MS agents.

Coverage Duration: one year

Effective Date: 1/31/2024