Ocrelizumab (Ocrevus®)	Place of Service Home infusion Administration Infusion Center Administration Office Administration Outpatient Facility Infusion Administration HCPCS: J2350 per 1 mg

Condition listed in policy *(see criteria for details)*

- Multiple sclerosis - primary progressive (PPMS)
- Multiple sclerosis - relapsing forms that includes clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease

AHFS therapeutic class: Immunomodulatory agent

Mechanism of action: Humanized IgG1 anti-CD20 monoclonal antibody

(1) Special Instructions and Pertinent Information

Covered under the Medical Benefit, please submit clinical information for prior authorization review.

(2) Prior Authorization/Medical Review is required for the following condition(s)

All requests for Ocrevus® (ocrelizumab) must be sent for clinical review and receive authorization prior to drug administration or claim payment.

Multiple sclerosis - primary progressive (PPMS)

1. Not used in combination with other immunomodulators for multiple sclerosis

Covered Dose
Up to 600 mg IV every 6 months [*for first infusion: 2 infusions of 300mg, given 2 weeks apart*]

Coverage Period
Initial: Yearly
Subsequent:

- Yearly if administered at a hospital outpatient facility
- Indefinite if administered in a preferred site of service

ICD-10:
G35

Multiple sclerosis - relapsing forms that includes clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease

1. Not used in combination with other immunomodulators for multiple sclerosis

Covered Dose
Up to 600 mg IV every 6 months [*for first infusion: 2 infusions of 300mg, given 2 weeks apart*]

Coverage Period
Initial: Yearly
Subsequent:

- Yearly if administered at a hospital outpatient facility
- Indefinite if administered in a preferred site of service

ICD-10:
G35

(3) The following condition(s) DO NOT require Prior Authorization/Preservice

All requests for Ocrevus® (ocrelizumab) must be sent for clinical review and receive authorization prior to drug administration or claim payment.

(4) This Medication is NOT medically necessary for the following condition(s)

Coverage for a Non-FDA approved indication, requires that criteria outlined in Health and Safety Code § 1367.21, including objective evidence of efficacy and safety are met for the proposed indication.

Please refer to the Provider Manual and User Guide for more information.

(5) Additional Information

How Supplied:
300 mg (single-dose vial)

(6) References

- AHFS®. Available by subscription at http://www.lexi.com
- DrugDex®. Available by subscription at http://www.micromedexsolutions.com/home/dispatch
- Ocrevus® (ocrelizumab) [Prescribing information]. South San Francisco, CA: Genentech, Inc.; 8/2023.
- 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(17):777-788.

(7) Policy Update

Date of last review: 4Q2023
Date of next review: 4Q2024
Changes from previous policy version:

- No clinical change to policy following routine annual review.

BSC Drug Coverage Criteria to Determine Medical Necessity
Reviewed by P&T Committee