## GEORGIA MEDICAID FEE-FOR-SERVICE

### MULTIPLE SCLEROSIS AGENTS PA SUMMARY

<table>
<thead>
<tr>
<th>Preferred</th>
<th>Non-Preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avonex (interferon beta-1a)</td>
<td>Aubagio (teriflunamide)</td>
</tr>
<tr>
<td>Copaxone (glatiramer acetate) 20 mg/ml</td>
<td>Bafiertam (monomethyl fumarate)</td>
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<tr>
<td>Dalfampridine generic*</td>
<td>Betaseron (interferon beta-1b)</td>
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<tr>
<td>Dimethyl fumarate generic</td>
<td>Copaxone (glatiramer acetate) 40 mg/ml</td>
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<td></td>
<td>Extavia (interferon beta-1b)</td>
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<td></td>
<td>Gilenya 0.5 mg ( fingolimod)</td>
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<td></td>
<td>Glatiramer acetate 20 mg/ml generic</td>
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<td></td>
<td>Kesimpta (ofatumumab)</td>
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<td></td>
<td>Mavenclad (cladribine)</td>
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<td></td>
<td>Mayzent (siponimod)</td>
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<td></td>
<td>Plegridy ( peginterferon beta-1a)</td>
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<td></td>
<td>Ponvory ( ponesimod)</td>
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<td></td>
<td>Rebif/Rebif Rebise ( interferon beta-1a)</td>
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<td></td>
<td>Vumerity ( diroximel fumarate)</td>
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<td>Zeposia ( ozanimod)</td>
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</tbody>
</table>

*Preferred that requires prior authorization.

### LENGTH OF AUTHORIZATION: Varies

### NOTES:
- Dalfampridine generic is preferred that requires prior authorization.
- Gilenya 0.25 mg is not covered under Pharmacy Services.
- **The criteria details below are for the outpatient pharmacy program.** If a medication is being administered in a physician’s office or clinic, then the medication must be billed through the DCH physician services program and not the outpatient pharmacy program. Information regarding the physician services program is located at [www.mmis.georgia.gov](http://www.mmis.georgia.gov).

### PA CRITERIA:

#### Dalfampridine Generic

- Approvable for members 18 years of age or older with a diagnosis of multiple sclerosis (MS) who can walk at least 25 feet in 8-45 seconds when prescribed by or in consultation with a neurologist or a MS-specialist  

  **AND**

- Member’s estimated creatinine clearance must be measured before treatment initiation and at least annually, and must be greater than 50 ml/min.

#### Aubagio, Bafiertam, Mayzent, Vumerity and Zeposia

- Approvable for members 18 years of age or older with a diagnosis of relapsing forms of MS, including clinically isolated syndrome (CIS), including relapsing remitting MS (RRMS) or secondary progressive MS (SPMS), when prescribed by or in consultation with a neurologist or a MS-specialist and member must have experienced an inadequate response, allergy.

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contraindication, drug-drug interaction or intolerable side effect to the preferred product, dimethyl fumarate (Tecfidera).

**Betaseron, Extavia, Plegridy and Rebif/Rebif Rebidose**

- Approvable for members 18 years of age or older with a diagnosis of relapsing forms of MS, including clinically isolated syndrome (CIS), including relapsing remitting MS (RRMS) or secondary progressive MS (SPMS), when prescribed by or in consultation with a neurologist or a MS-specialist and member must have experienced an inadequate response or intolerable side effect to the preferred product, interferon beta-1a (Avonex) and experienced an inadequate response, allergy, contraindication, drug-drug interaction or intolerable side effect to the preferred product, glatiramer (Copaxone).

**Copaxone 40 mg/ml, Glatiramer 20 mg/ml Generic**

- Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, Copaxone 20 mg/ml, is not appropriate for the member.

**Gilenya 0.5 mg**

- Approvable for members 10 to 17 years of age with a diagnosis of relapsing forms of MS, including clinically isolated syndrome (CIS), including relapsing remitting MS (RRMS) or secondary progressive MS (SPMS), when prescribed by or in consultation with a neurologist or a MS-specialist.
- Approvable for members 18 years of age or older with a diagnosis of relapsing forms of MS, including clinically isolated syndrome (CIS), including relapsing remitting MS (RRMS) or secondary progressive MS (SPMS), when prescribed by or in consultation with a neurologist or a MS-specialist and member must have experienced an inadequate response, allergy, contraindication, drug-drug interaction or intolerable side effect to the preferred product, dimethyl fumarate (Tecfidera).

**Kesimpta**

- Approvable for members 18 years of age or older with a diagnosis of relapsing forms of MS, including clinically isolated syndrome (CIS), including relapsing remitting MS (RRMS) or secondary progressive MS (SPMS), when prescribed by or in consultation with a neurologist or a MS-specialist and member must have experienced an inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects to the preferred products, Avonex or Copaxone and dimethyl fumarate (Tecfidera).

**Mavenclad**

- Approvable for members 18 years of age or older who weigh 40 kg or more with a diagnosis of relapsing forms of MS, including RRMS or SPMS, when prescribed by or in consultation with a neurologist or a MS-specialist and member must have experienced an inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects to dimethyl fumarate (Tecfidera), Aubagio, Bafiertam, Gilenya, Mayzent, Ponvory, Vumerity and Zeposia.

**Ponvory**

- Approvable for members 18 years of age or older with a diagnosis of relapsing forms of MS, including RRMS or SPMS, when prescribed by or in consultation with a neurologist or a
MS-specialist and member must have experienced an inadequate response, allergies, contraindications, drug-drug interactions, or intolerable side effects to dimethyl fumarate (Tecfidera), Bafiertam, Gilenya, Mayzent, Vumerity and Zeposia.

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling OptumRx at 1-866-525-5827.

PREFERRED DRUG LIST:

- For online access to the Preferred Drug List (PDL), please go to http://dch.georgia.gov/preferred-drug-lists.

PA AND APPEAL PROCESS:

- For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Pharmacy and click on Other Documents, then select the most recent quarters QLL list.