GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA MEDICAID FEE-FOR-SERVICE
MULTIPLE SCLEROSIS AGENTS PA SUMMARY

Preferred	Non-Preferred
Avonex (interferon beta-1a) Copaxone (glatiramer acetate) 20 mg/ml Dalfampridine generic* Dimethyl fumarate generic Fingolimod generic Kesimpta (ofatumumab) Teriflunamide generic	Bafiertam (monomethyl fumarate) Betaseron (interferon beta-1b) Copaxone (glatiramer acetate) 40 mg/ml Extavia (interferon beta-1b) Glatiramer acetate 20 mg/ml generic Mavenclad (cladribine) Mayzent (siponimod) Plegridy (peginterferon beta-1a) Ponvory (ponesimod) Rebif/Rebif Rebidose (interferon beta-1a) Tascenso ODT (fingolimod 0.25 mg orally disintegrating tablets) Vumerity (diroximel fumarate) Zeposia (ozanimod)

*Preferred that requires PA

LENGTH OF AUTHORIZATION: Varies

NOTES:

- Dalfampridine generic is preferred that requires prior authorization.
- **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.

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.

Bafiertam, Mayzent, Ponvory, 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), who have experienced an inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects to the preferred products, dimethyl fumarate (Tecfidera), fingolimod (Gilenya) and teriflunomide (Aubagio).

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), who 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.

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), teriflunamide (Aubagio), Bafiertam, fingolimod (Gilenya), Mayzent, Ponvory, Vumerity and Zeposia.

Tascenso ODT

- 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).
- 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), who have experienced an inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects to the preferred products, dimethyl fumarate (Tecfidera), fingolimod (Gilenya) and teriflunomide (Aubagio).

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.