



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

Preferred	Non-Preferred
Ampyra (dalfampridine)* Aubagio (teriflunamide) Avonex (interferon beta-1a) Betaseron (interferon beta-1b) Copaxone (glatiramer acetate) 20 mg/ml Gilenya (fingolimod) Rebif/Rebif Rebidose (interferon beta-1a) Tecfidera (dimethyl fumarate)	Copaxone (glatiramer acetate) 40 mg/ml Extavia (interferon beta-1b) Glatiramer acetate 20 mg/ml generic Plegridy (peginterferon beta-1a) Zinbryta (daclizumab)

*Preferred agent that requires prior authorization.

LENGTH OF AUTHORIZATION: Varies

PA CRITERIA:

Ampyra

- ❖ Approvable for members 18 years of age or older with 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 50ml/min.

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.

Extavia

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, Betaseron, is not appropriate for the member.

Plegridy

- ❖ Approvable for members 18 years of age or older with relapsing forms of MS when prescribed by or in consultation with a neurologist or a MS-specialist

AND

- ❖ Member must have experienced ineffectiveness or intolerable side effect to the preferred product, interferon beta-1a (Avonex, Rebif), AND ineffectiveness, allergy, contraindication, drug-drug interaction or intolerable side effect to the preferred product, glatiramer (Copaxone).

Zinbryta

- ❖ Approvable for members 18 years of age or older with relapsing forms of MS when prescribed by or in consultation with a neurologist or a MS-specialist

AND

- ❖ Prescriber, member and pharmacy must be enrolled in the Zinbryta Risk Evaluation and Mitigation Strategy (REMS) Program

AND



- ❖ Member's baseline serum transaminases (alanine aminotransferase [ALT] and aspartate aminotransferase [AST]) and total bilirubin levels must be evaluated within the past 4 weeks prior to initiating therapy and levels must be monitored monthly prior to each dose as well as monthly for 6 months after the last dose

AND

- ❖ Member must have experienced ineffectiveness with interferon beta 1a or 1b product (Avonex, Betaseron, Extavia, Plegridy, Rebif), glatiramer (Copaxone, Glatopa) and one other preferred product (Aubagio, Gilenya, Tecfidera).

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 Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.