

RX.PA.025.MPC Ocrevus® (Ocrelizumab)

The purpose of this policy is to define the prior authorization process for Ocrevus® (ocrelizumab).

Ocrevus® (ocrelizumab) is indicated for relapsing or primary progressive forms of multiple sclerosis (MS).

The drug, Ocrevus® (ocrelizumab), is subject to the prior authorization process.

PROCEDURE

Initial Authorization Criteria:

Must meet all of the criteria listed below:

- Must be prescribed by a neurologist
- Must have a diagnosis of relapsing form of MS or primary progressive MS
- Must be age 18 years or older
- Must have chart documentation showing negative result for hepatitis B virus
- Must have previously had an inadequate response or intolerance to at least ONE of the following multiple sclerosis therapies: Avonex (interferon beta-1a), Copaxone (glatiramer acetate), Plegridy (peginterferon beta- 1a), or Tecfidera (dimethyl fumarate)
 - Previous trial of another multiple sclerosis therapy is not required in the following patients:
 - Patients with rapidly evolving severe relapsing remitting MS defined as 2 or more disabling relapses in 1 year AND with 1 or more Gadolinium enhancing lesions on brain MRI or a significant increase in T2 lesion load as compared to a previous recent MRI7 OR
 - Patients who have 3 or more predictive factors of poor prognosis:
 - Age of onset 40 years or older
 - Motor system involvement at onset including weakness of the extremities or ataxia
 - 4 or more T2-weighted lesions suggestive of MS seen on MRI
 - 2.5 years or less between the first 2 relapses
 - 2 or more relapses in the first year of disease
 - Poor recovery from the initial 2 relapses defined as an EDSS of 1.5 or higher sustained for at least 1 year
- Must not have an active infection

- Must not be receiving chronic immunosuppressant or immunomodulatory therapy (including interferon beta-1a, interferon beta-1b, glatiramer acetate, or fingolimod) or have systemic medical conditions resulting in significant compromised immune system function

Reauthorization Criteria:

All prior authorization renewals are reviewed on an annual basis to determine the Medical Necessity for continuation of therapy. Authorization may be extended at 1-year intervals based upon:

- Chart documentation from the prescriber that the member's condition has improved based or stabilized upon the prescriber's assessment while on therapy

Limitations:

| Length of Authorization (if above criteria met) | |
|---|--------------------|
| Initial Authorization | 1 year |
| Reauthorization | Same as initial |
| Quantity Level Limit | |
| 300 mg/10ml | 20 ml per 6 months |

If the established criteria are not met, the request is referred to a Medical Director for review, if required for the plan and level of request.

HCPCS Code(s):

| Code | Description |
|-------|------------------------------|
| J2350 | Injection, ocrelizumab, 1 mg |

REFERENCES

1. Ocrevus (ocrelizumab) [prescribing information]. San Francisco, CA: Genentech, Inc.; March 2017.