PART B DRUG MEDICAL/PHARMACY	ASPIRE HEALTH	**Effective Date** January 1, 2024	
		Policy # Ocrevus (ocrelizumab)	
	OCREVUS (OCRELIZUMAB)	**Review Date** 11/29/2023	**Applicable to:** ☑ Medicare Advantage ☐ Commercial ☐ Elevance Health HMO ☐ Blue Shield Trio
	Approver's Name & Title QI & UM Drug Subcommittee		

Aspire Health Plan (AHP) applies medical drug clinical criteria as a reference for medical policy information only. Federal and state laws or requirements, contract language, and Plan benefit may take precedence over the application of these clinical criteria. Please consult the applicable certificate or contract for benefit details. This policy is subject to revision at the discretion of the Plan and is therefore subject to change. Refer to the disclaimer section below for more information.

POLICY

This policy addresses the coverage of Ocrevus (ocrelizumab) in the treatment of primary progressive multiple sclerosis (MS) in adults and relapsing forms of MS, including clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease in adults.

APPLICABLE HCPCS

J2350: Injection, ocrelizumab, 1 mg; 1 mg = 1 billable unit

Available Dosage Form: 300 mg/10 mL (30 mg/mL) in a single-dose vial

CLINICAL CRITERIA

A. INITIAL CRITERIA

Ocrevus (ocrelizumab) may be authorized when **ALL** of the following criteria have been met with documentation (i.e., office chart notes, treatment response to previous therapy or drug regimens, lab results, treatment plan, other relevant clinical information).

1. Prescribed by, or in consultation with, a neurologist; **AND**

2. Documented diagnosis of **ONE** of the following clinical subtypes of multiple sclerosis (MS):
   a. Clinically isolated syndrome (CIS); **or**
   b. Relapsing-remitting multiple sclerosis (RRMS); **or**
   c. Active secondary progressive multiple sclerosis (SPMS) (e.g., SPMS with a documented relapse); **or**
   d. Primary progressive multiple sclerosis (PPMS).

AND

3. Member has been evaluated/screened for the presence of the following conditions and meets **ALL** of the following:

    a. No active hepatitis B infection (i.e., negative hepatitis B surface antigen and negative hepatitis B core antibody testing); **and**

    b. No concurrent use of live vaccine; **and**

    c. No severe or active infection (e.g., cellulitis, bronchitis, herpes virus infection, pneumonia).

AND

4. Ocrevus (ocrelizumab) is not prescribed for, or intended to be administered with, other MS disease-modifying agents (e.g., Aubagio, Avonex, Bafiertam, Betaseron, Copaxone/Glatiramer/Glatopa, Extavia, Gilenya, Kesimpta, Lemtrada, Mavenclad, Mayzent, Plegridy, Ponvory, Rebif, Tecfidera, Tysabri, Vumerity and Zeposia); (NOTE: Ampyra and Nuedexta are not disease-modifying); **AND**

5. Assessment of baseline serum immunoglobulins.

B. REAUTHORIZATION / CONTINUATION OF THERAPY CRITERIA

Ocrevus (ocrelizumab) may be authorized for continuation of therapy when initial criteria have been met AND there is documentation of beneficial response from previous course of treatment:

1. *Positive response to therapy: Stabilization or improvement in disease activity, signs and symptoms, or functional capacity as compared to baseline (or prior to treatment with Ocrevus [ocrelizumab]).

    *Positive clinical response of MS disease activity include, but are not limited to, an increase in annualized relapse rate (ARR), development of new/worsening T2 hyperintensities or enhancing lesions on brain/spinal MRI, and progression of sustained impairment as evidenced by expanded disability status scale (EDSS), timed 25-foot walk (T25-FW), 9-hole peg test (9-HPT)].

2. Absence of intolerance or adverse events from the previous course of treatment (e.g., severe infusion reactions, severe infections, progressive multifocal leukoencephalopathy, malignancy, hypogammaglobulinemia, immune-mediated colitis, etc.); **AND**

3. Ocrevus (ocrelizumab) is not administered concurrently with other disease-modifying therapies for MS; AND

4. Member has not received a dose of ocrelizumab within the past 5 months.

STEP THERAPY

Step therapy criteria do not apply for members who are currently being treated with the requested medications. Step therapy is only applied for members that are new to therapy (have not received the requested drug in the last 365 days.

A. **PREFERRED PRODUCT: No Step therapy required.**

DOSAGE AND AUTHORIZATION TIMEFRAMES

1. Recommended Dose
    a. Initial dose. 300 mg by intravenous infusion, followed 2 weeks later by a second 300 mg intravenous infusion.
    b. Subsequent doses: 600 mg by intravenous infusion once every 6 months (administer first subsequent dose 6 months after infusion of the initial dose).

2. Quantity (Ocrevus 300 mg single-dose vial)
    a. Initial dose: 2 vials in first 2 weeks; 300 billable units (300 mg) on day 1 and day 15
    b. Subsequent doses: 2 vials per 6 month; 600 billable units (300 mg) every 6 months

3. Authorization Period
    a. Initial authorization: May be authorized for up to 6 months.
    b. Continuation of treatment authorization: May be authorized for up to 12 months.

DRUG INFORMATION

PHARMACOLOGIC CATEGORY: Anti-CD20 Monoclonal Antibody

ROUTE OF ADMINISTRATION: Intravenous Infusion

FDA-APPROVED INDICATIONS
- Relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults
- Primary progressive MS, in adults

COMPENDIAL APPROVED OFF-LABELED USES: None
Off-Label / Investigational Uses: Requests for off-label uses with a paucity of clinical evidence, or uses that are not generally accepted by the medical community (such as professional guidelines or consensus), CMS-recognized compendia, or peer-reviewed literature is considered investigational and will not be authorized due to insufficient evidence of overall therapeutic value of safety and efficacy.

CONTRAINDICATIONS:
History of life-threatening infusion reaction to ocrelizumab or any component of the formulation; active hepatitis B virus (HBV) infection

OTHER CONSIDERATIONS

Monitoring:
- Hepatitis B surface antigen (HBsAg) and hepatitis B core antibody (anti-HBc) tests (prior to therapy initiation); do not administer to patients with active hepatitis B virus confirmed by positive results for HBsAg and anti-HB tests; for patients who are negative for surface antigen (HBsAg) and positive for HB core antibody (HBcAb+) or are carriers of HBV (HBsAg+), consult a liver disease specialist prior to initiating and during therapy.
- Perform latent infection screening (e.g., hepatitis, tuberculosis) in high-risk populations or in countries with high tuberculosis burden (baseline). Monitor quantitative serum immunoglobulins (baseline, throughout treatment as clinically necessary, especially in patients with opportunistic or recurrent infections, after discontinuation of therapy until B-cell repletion). Assess for active infection prior to treatment. Monitor for infusion reactions during infusion and for at least 1 hour following the end of the infusion. Monitor for signs/symptoms of immune-mediated colitis (evaluate promptly if colitis is suspected), infection, malignancy, and progressive multifocal leukoencephalopathy (PML). Perform brain MRI (at first signs/symptoms suggestive of PML and as clinically indicated to monitor for early signs of PML).

CLINICAL SUMMARY / APPENDIX

Multiple sclerosis (MS) is an autoimmune inflammatory demyelinating disease of the central nervous system. Common symptoms of the disease include fatigue, numbness, coordination and balance problems, bowel and bladder dysfunction, emotional and cognitive changes, spasticity, vision problems, dizziness, sexual dysfunction and pain. MS can be subdivided into four phenotypes: clinically isolated syndrome (CIS), relapsing remitting (RRMS), primary progressive (PPMS) and secondary progressive (SPMS). Relapsing multiple sclerosis (RMS) is a general term for all relapsing forms of multiple sclerosis including CIS, RRMS and active SPMS.

The American Academy of Neurology (AAN) published practice guidelines in 2018 regarding disease-modifying therapies for adults with MS. The guidelines recommend initiating disease-modifying therapy in patients with relapsing forms of MS who have recently experienced clinical relapses or MRI activity. The guidelines also recommend DMT for individuals who have experienced a single clinical demyelinating event and two or more brain lesions consistent with MS, if the individual wishes to initiate therapy after a discussion of risks and benefits. The guidelines do not specify a preferred DMT. In addition, the AAN guidelines state that Ocrevus is the only DMT demonstrated to alter disease progression in ambulatory patients with primary progressive MS, and they recommend Ocrevus for this population.

REFERENCES

Government Agency

1. Centers for Medicare and Medicaid Services (CMS). Medicare coverage database: National coverage determination (NCD) (search: Rituximab: Riabni, Rituxan, Ruxience, Truxima). Available from CMS. No NCD identified (LCD available but not applicable to MAC).
2. CMS IOM, Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 50.4.5
3. CMS Transmittal 96, Change Request (CR) 6191 .

Prescribing Information

1. Ocrevus (ocrelizumab) [prescribing information]. South San Francisco, CA: Genetech Inc; August 2022.
2. Olek MJ, Howard J. Clinical presentation, course, and prognosis of multiple sclerosis in adults. González-Scarano, F. (ed). UpToDate. Waltham, MA: UpToDate Inc. www.uptodate.com. Accessed September 2023.
3. 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: 777-788. Available from: AAN. Accessed September 2023.

Peer Reviewed Literature, Guidelines

Milliman Care Guidelines (MCG). Ambulatory Care 27th Edition ACG: A-0977 (AC). 2023.

IMPORTANT REMINDER

This Medicare Part B Step Therapy Medical Necessity Guideline is provided for informational purposes only and neither constitutes nor replaces professional medical advice. Physicians, hospitals, and other providers are expected to administer or use drugs/biologicals in the most effective and clinically appropriate manner. Treating physicians and other health care providers are solely responsible for all medical care decisions. In accordance with the member's Evidence of Coverage (EOC), every benefit plan has its own coverage provisions, limitations, and exclusions. In the event of a conflict between this policy and the member's EOC, the member's EOC provisions will take precedence.

Aspire Health Plan (AHP) adheres to Medicare guidelines, including National Coverage Determination (NCD), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs), and other relevant Medicare manuals established by CMS. Compliance with these guidelines is required when applicable. Refer to the CMS website at http://www.cms.hhs.gov. For the most up-to-date Medicare policies and coverage, please search the Medicare Coverage Database. All LCDS are the same for each state within a Jurisdiction.

Medicare Part B Administrative Contractor (MAC) for CA [Jurisdiction E (1)]: Active LCDs - JE Part B – Noridian (noridianmedicare.com). In the event of a discrepancy between this policy and the Medicare NCD or LCD, the Medicare NCD/LCD will govern.

This policy is utilized by AHP to determine coverage in the absence of applicable CMS Medicare guidelines. Please refer to the links provided in the References section below to access the Medicare source materials that were used for developing this resource document. This document does not serve as a substitute for the official Medicare source materials that provide detailed information on Medicare coverage requirements. In the event of a conflict between this document and Medicare source materials, the Medicare source materials will take precedence.

The inclusion of a code in this policy does not imply that the health service it describes is covered or not covered. Benefit coverage for health services is determined by the member-specific plan document and applicable laws that may mandate coverage for a particular service. Inclusion of a code does not imply or guarantee reimbursement or payment of a claim. Other Policies and Standards may also apply. Providers are expected to retain or have access to the necessary documentation when requested in order to support coverage.

POLICY HISTORY

Version	Date	Revision Author/Title	Summary of Changes
1	11/29/2023		New Policy