RX.PA.025.CCH 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).

POLICY

It is the policy of the Health Plan to maintain a prior authorization process that promotes appropriate utilization of specific drugs with potential for misuse or limited indications. This process involves a review using Food and Drug Administration (FDA) criteria to make a determination of Medical Necessity, and approval by the Medical Policy Committee.

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

PROCEDURE

Initial Authorization Criteria:

Must meet all 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: Betaseron (interferon beta-1b), Rebif (interferon beta-1a), Copaxone (glatiramer acetate), 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	Brand	Description
J2350	OCREVUS	INJECTION, OCRELIZUMAB, 1 MG

REFERENCES

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

RECORD RETENTION

Records Retention for Evolent Health documents, regardless of medium, are provided within the Evolent Health records retention policy and as indicated in CORP.028.E Records Retention Policy and Procedure.

REVIEW HISTORY

DESCRIPTION OF REVIEW / REVISION	DATE APPROVED
Initial Review	3/22