Montana Healthcare Programs
Physician Administered Drug Coverage Criteria

OCREVUS® (ocrelizumab)

I. Medication Description

Ocrevus® is a CD-20 directed cytolytic antibody indicated for treatment of:

- 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.

II. Position Statement

Coverage is determined through a prior authorization process **that must include** supporting clinical documentation for each request.

III. Initial Coverage Criteria

Relapsing forms of MS

Member must meet all the following criteria:

- Member has a relapsing form of multiple sclerosis:
  - Clinically isolated syndrome (CIS)
  - Relapsing-remitting MS (RRMS)
  - Secondary progressive MS (SPMS)
- Member has had an adequate trial with a Montana Health Care Programs preferred drug or provider has clinical rationale as to why the preferred molecules are not appropriate.
  - Montana Health Care Programs preferred drugs currently are:
    - Interferon beta-1a (Avonex®, Rebif®),
    - Interferon beta-1b (Betaseron®),
    - Glatiramer acetate (Copaxone®) and
    - Fingolimod (Gilenya®).
- Member is being treated by a neurologist or has a current neurology consult on file.
- Member has been screened for Hepatitis B and shown not to have active disease prior to initial dose.

Primary Progressive MS

Member must meet all the following criteria:

- Member is 18 years of age or older.
- Member has a diagnosis of primary progressive multiple sclerosis (PPMS).
- Member is ambulatory when therapy is instituted (not required for renewals).
- Member is being treated by a neurologist or has a current neurology consult on file.
- Member has been screened for Hepatitis B and shown not to have active disease prior to initial dose.

IV. Renewal Coverage Criteria

Member must meet all the following criteria:

- Member has been adherent to Ocrevus®.

V. Quantity Limitations

Max of 300mg IV at weeks 0 and 2 and 600mg IV every 6 months thereafter

VI. Coverage Duration

Initial approval duration: 1 year
Renewal approval duration: 1 year