AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Ocrevus	Page:	1 of 2
Effective Date:	10/25/2023	Last Review Date:	10/2023

Applies to:	☒Illinois	☐Florida	☐Florida Kids
	☐New Jersey	☐Maryland	☐Michigan
	☐Pennsylvania Kids	☐Virginia	☐Kentucky PRMD

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Ocrevus under the patient's prescription drug benefit.

Description:

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

A. Ocrevus is indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.
B. Ocrevus is indicated for the treatment of primary progressive MS, in adults.

All other indications are considered experimental/investigational and not medically necessary.

Applicable Drug List:

Ocrevus

Policy/Guideline:

Prescriber Specialty:
This medication must be prescribed by or in consultation with a neurologist.

Criteria for Initial Approval:

A. Relapsing Forms of Multiple Sclerosis
Authorization of 12 months may be granted to members who have been diagnosed with a relapsing form of multiple sclerosis (including relapsing-remitting and secondary progressive disease for those who continue to experience relapse) and patient is unable to take the required number of formulary alternatives (3) for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication.

B. Clinically Isolated Syndrome
Authorization of 12 months may be granted to members for the treatment of clinically isolated syndrome of multiple sclerosis and patient is unable to take the required

number of formulary alternatives (3) for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication.

C. Primary Progressive Multiple Sclerosis
Authorization of 12 months may be granted to members for the treatment of primary progressive multiple sclerosis and patient is unable to take the required number of formulary alternatives (3) for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication.

Continuation of Therapy:
For all indications: Authorization of 12 months may be granted for members who are experiencing disease stability or improvement while receiving Ocrevus.

Other Criteria:
A. Members will not use Ocrevus concomitantly with other disease modifying multiple sclerosis agents (Note: Ampyra and Nuedexta are not disease modifying).
B. Authorization may be granted for pediatric members less than 18 years of age when benefits outweigh risks.

Approval Duration and Quantity Restrictions:
Approval: 12 months

Quantity Level Limits:
- Ocrevus (ocrelizumab) vial 300mg/10mL: 2 vials per 168 days with loading dose of up to 2 vials for the first 15 days (Daily Limit: 1.429)

References:
1. Ocrevus [package insert]. South San Francisco, CA: Genentech, Inc.; March 2023.
2. Clinical Consult: CVS Caremark Clinical Program Review. Focus on Multiple Sclerosis Clinical Programs. June 22, 2017.