Clinical Policy: Ocrelizumab (Ocrevus)

Reference Number: CP.PHAR.335
Effective Date: 04/17
Last Review Date: 04/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
The intent of the criteria is to ensure that patients follow selection elements established by Centene® clinical policy for ocrelizumab (Ocrevus™).

Policy/Criteria
It is the policy of health plans affiliated with Centene Corporation® that ocrelizumab (Ocrevus) is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Multiple Sclerosis (must meet all):

1. Diagnosis of relapsing-remitting or primary-progressive multiple sclerosis (MS);
2. Prescribed by or in consultation with a neurologist;
3. MRI (magnetic resonance imaging) features are consistent with MS;
4. If member has relapsing-remitting MS, failure of one of the following (a or b), at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects were experienced:
   a. Tecfidera or Gilenya and any of the following: an interferon-beta agent *(Avonex and Plegridy are preferred agents)*, or Glatiramer *(Glatopa 20mg and Copaxone 40mg are preferred agents);*
   b. Tecfidera and Gilenya;
5. Member will not use other disease modifying therapies for MS concurrently;
6. Dose does not exceed the following:
   a. Initial dose: 300 mg, followed by a second 300 mg dose 2 weeks later;
   b. Maintenance dose: 600 mg every 6 months;
7. At the time of request, member does not have active hepatitis B infection (positive results for hepatitis B surface antigen and anti-hepatitis B virus tests).

Approval duration: 12 months

B. Other diagnoses/indications: Refer to CP.PHAR.57 – Global Biopharm Policy.

II. Continued Approval

A. Multiple Sclerosis (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
2. Documentation of positive response to therapy (e.g.: improved or maintained disease control evidenced by decreased or stabilized expanded disability status scale (EDSS) score, or reduction in relapses or MRI lesions shows disease improvement);
3. Member is not using other disease modifying therapies for MS concurrently;

4. If request is for a dose increase, new dose does not exceed 600 mg every 6 months.

Approval duration: 12 months

B. Other diagnoses/indications (1 or 2)**:**
1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy;
   Approval duration: per request or 6 months (whichever is less); or

2. Refer to CP.PHAR.57 - Global Biopharm Policy

Background
Description/Mechanism of Action:
The precise mechanism by which ocrelizumab exerts its therapeutic effects in multiple sclerosis is unknown, but is presumed to involve binding to CD20, a cell surface antigen present on pre-B and mature B lymphocytes. Following cell surface binding to B lymphocytes, ocrelizumab results in antibody-dependent cellular cytolysis and complement-mediated lysis.

Formulations:
Single-dose vial: 300 mg/10 mL

FDA Approved Indications:
Ocrevus is a CD20-directed cytolytic antibody/intravenous infusion indicated for the treatment of patients with relapsing or primary progressive forms of multiple sclerosis (MS).

Appendices
Appendix A: Abbreviation Key

EDSS: Expanded Disability Status Scale	MS: multiple sclerosis
FDA: Food and Drug Administration	MRI: magnetic resonance imaging

Appendix B: General Information
- There are 4 types of MS: clinically isolated syndrome, relapsing-remitting, secondary-progressive, and primary-progressive. Unlike relapsing-remitting MS, primary progressive MS is not characterized by acute relapses and is instead characterized by steady functional decline (continuous progression).
- One way to assess disease progression is with the EDSS, a standardized measure of global neurological impairment which utilizes the following functional systems: pyramidal, cerebellar, brain stem, sensory, bowel and bladder, visual (or optic), cerebral (or mental), and other. In the OPERA I, OPERA II, and ORATORIO phase 3 trials, disability progression was defined as an increase in EDSS score of $\geq$ 1 point from baseline that was sustained for at least 12 weeks if the baseline EDSS score was $\leq$ 5.5 (increase of $\geq$ 0.5 points if the baseline EDSS score was > 5.5). At baseline, patients with relapsing MS in these trials had EDSS scores between 0 and 5.5 while those with primary progressive MS had EDSS scores between 3 and 6.5.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
N/A	

Reviews, Revisions, and Approvals	Date	Approval Date
New policy.	04/17	04/17
Changed requirement of failure of glatiramer acetate, Tecfidera, or Gilenya, to the following: Tecfidera or Gilenya and either an interferon-beta agent or glatiramer; or Tecfidera and Gilenya.	05/17	

References

1. Ocrevus Prescribing Information. South San Francisco, CA: Genentech, Inc; March 2017. Available at www.ocrevus.com. Accessed March 30, 2017.
2. Costello K, Halper J, Kalb R, Skutnik L, Rapp R. The use of disease-modifying therapies in multiple sclerosis, principles and current evidence – a consensus paper by the Multiple Sclerosis Coalition. July 2016. Accessed January 9, 2017.
3. Goodin DS, Frohman EM, Garmany GP, et al. Disease modifying therapies in multiple sclerosis: Subcommittee of the American Academy of Neurology and the MS Council for Clinical Practice Guidelines. Neurology. 2002; 58(2): 169-178.
4. Polman CH, Reingold SC, Banwell B, et al. Diagnostic criteria for multiple sclerosis: 2010 revisions to the McDonald criteria. Ann Neurol. 2011; 69(2): 292-302.
5. Kurtzke JF. Rating neurologic impairment in multiple sclerosis: an expanded disability status scale (EDSS). Neurology. 1983; 33(11): 1444-1452.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence

of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.