PREFERRED SPECIALTY MANAGEMENT POLICY

POLICY: Multiple Sclerosis – Dalfampridine Preferred Specialty Management Policy

- Ampyra® (dalfampridine extended-release tablets – Acorda, generic)

REVIEW DATE: 11/08/2023

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Dalfampridine is a potassium channel blocker that is indicated to improve walking in adults with multiple sclerosis.[1] This was demonstrated by an increase in walking speed.

POLICY STATEMENT

This Preferred Specialty Management program has been developed to encourage the use of the Preferred Product. For all medications (Preferred and Non-Preferred), the patient is required to meet the respective standard *Prior Authorization Policy* criteria. This program also directs the patient to try the Preferred Product prior to approval of a Non-Preferred Product. Requests for the Non-Preferred Product will also be reviewed using the exception criteria (below). All approvals are provided for 1 year in duration. If the patient meets the standard *Multiple Sclerosis – Dalfampridine Prior Authorization Policy* criteria but has not tried the Preferred Product, approval for a Preferred Product will be authorized.

Documentation: Documentation is required where noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to, chart notes, prescription claims records, and/or other information.

Preferred Product: generic dalfampridine
Non-Preferred Product: Ampyra

Multiple Sclerosis – Dalfampridine non-preferred product(s) is(are) covered as medically necessary when the following non-preferred product exception criteria is(are) met. Any other exception is considered not medically necessary.

NON-PREFERRED PRODUCT EXCEPTION CRITERIA

Non-Preferred Product	Exception Criteria
Ampyra	**1.** Approve for 1 year if the patient meets the following (A and B): **A)** Patient meets the standard *Multiple Sclerosis – Dalfampridine Prior Authorization Policy* criteria; AND **B)** Patient meets both of the following (i and ii): **i.** Patient has tried generic dalfampridine **[documentation required]**; AND **ii.** Patient cannot continue to use generic dalfampridine due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. **2.** If the patient has met criterion 1A (the standard *Multiple Sclerosis – Dalfampridine Prior Authorization Policy* criteria), but criterion 1B is not met and the requested product is not approved, approve the Preferred Product.

REFERENCES

1. Ampyra® extended-release tablets [prescribing information]. Pearl River, NY: Acorda; June 2022.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	10/26/2022
Annual Revision	No criteria changes.	11/08/2023