PREFERRED SPECIALTY MANAGEMENT POLICY

POLICY: Multiple Sclerosis and Ulcerative Colitis – Zeposia Preferred Specialty Management Policy for National Preferred Formularies
- Zeposia® (ozanimod capsules – Celgene/Bristol Myers Squibb)

REVIEW DATE: 11/08/2023; selected revision 11/22/2023, 01/24/2024, 02/28/2024

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. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. 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

Zeposia, a sphingosine 1-phosphate receptor modulator, is indicated for the following uses:[1]

- **Relapsing forms of multiple sclerosis**, to include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease in adults.
- **Ulcerative colitis**, in adults with moderately to severely active disease.

For more information on criteria within a Prior Authorization program by specific condition refer to the standard *Multiple Sclerosis and Ulcerative Colitis – Zeposia Prior Authorization Policy.*

Preferred and Non-Preferred Products.¥

	Multiple Sclerosis	Ulcerative Colitis
Step 1 **Preferred**	• generic glatiramer SC injection • generic dimethyl fumarate delayed-release capsules • generic fingolimod capsules • generic teriflunomide tablets	• Adalimumab Products^ – Humira (NDCs starting with 00074), Cyltezo/adalimumab-adbm, Hyrimoz (NDCs starting with 61314)/adalimumab-adaz

		• Stelara SC
Step 2 **Non-Preferred** (directed to **ONE** Step 1 Product)	• Zeposia	--
Step 2 **Non-Preferred** (directed to **TWO** Step 1 Products)	--	• Zeposia

¥ For Non-Preferred Adalimumab Products, refer to the *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies* or the Choice version of that policy. Note that adalimumab-adaz and adalimumab-adbm are Non-Preferred for some plans; ^ A trial of more than one adalimumab product counts as ONE Preferred Product; SC – Subcutaneous.

POLICY STATEMENT

The Multiple Sclerosis Preferred Specialty Management Program has been developed to encourage the use of the Preferred Products. For all medications (Preferred and Non-Preferred) the patient is required to meet the respective standard *Prior Authorization Policy* criteria. The Program also directs the patient to try one Preferred Product prior to the approval of a Non-Preferred Product. Requests for Non-Preferred Products will also be reviewed using the exception criteria (below). All approvals are provided for 1 year. If a patient requesting a Non-Preferred Product meets the respective standard *Prior Authorization Policy* criteria but has not tried one Preferred Product, an offer to review for the Preferred Product(s) will be made.

The Inflammatory Conditions Preferred Specialty Management Program has been developed to encourage the use of the Preferred Products. For all medications, this program requires the patient to meet the respective standard *Prior Authorization Policy* criteria. Additionally, this program requires trial(s) of the Preferred Product(s) according to the table above, when clinically appropriate, prior to the approval of the Non-Preferred Products. There are also situations when trials of Non-Preferred Products will be considered; see criteria below. Other details of the program are as follows:

- **Continuation of Therapy:** Approval for a patient continuing therapy with a **Non-Preferred** (subcutaneous or oral) Product must be supported with verification, noted in the criteria as either **[verification in prescription claims history required]** or, if not available, as **[verification by prescriber required]**.
  - If the patient has at least 130 days of prescription claims history on file, claims history must support that the patient has received the Non-Preferred Product for the specified period of time (90 or 120 days) within a 130-day look-back period; OR
  - When 130 days of the patient's prescription claim history file is unavailable for verification, the prescriber must verify that the patient has been receiving the Non-Preferred Product for a specified period of time (90 or 120 days), AND that the patient has been receiving the Non-Preferred Product via paid claims (e.g., patient has not been receiving samples or coupons or other types of waivers in order to obtain access to the Non-Preferred Product).

- For a patient continuing therapy, other conditions may also apply. Refer to criteria below.
- **Approval Duration:** All approvals for continuation of therapy for Preferred and Non-Preferred Products are provided for 1 year unless noted otherwise below. In cases where the initial approval is authorized in months, 1 month is equal to 30 days.

Multiple Sclerosis and Ulcerative Colitis – Zeposia 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
Zeposia	**1. <u>Multiple Sclerosis</u>.** Approve for 1 year if the patient meets the following (A <u>and</u> B): **A)** Patient meets the standard *Multiple Sclerosis and Ulcerative Colitis – Zeposia Prior Authorization Policy* criteria; AND **B)** Patient meets ONE of the following (i, ii, iii, iv, <u>or</u> v): **i.** Patient has been established on Zeposia for ≥ 120 days; OR **ii.** Patient meets BOTH of the following (a <u>and</u> b): **a)** Patient has tried generic dimethyl fumarate delayed-release capsules; AND **b)** Patient has experienced inadequate efficacy or significant intolerance, according to the prescriber; OR <u>Note</u>: Prior use of Tecfidera, Bafiertam, or Vumerity with inadequate efficacy or significant intolerance (according to the prescriber) also counts. **iii.** Patient meets BOTH of the following (a <u>and</u> b): **a)** Patient has tried generic glatiramer injection; AND **b)** Patient has experienced inadequate efficacy or significant intolerance, according to the prescriber; OR <u>Note</u>: Prior use of Copaxone or Glatopa with inadequate efficacy or significant intolerance (according to the prescriber) also counts. **iv.** Patient meets BOTH of the following (a <u>and</u> b): **a)** Patient has tried generic fingolimod capsules; AND **b)** Patient has experienced inadequate efficacy or significant intolerance, according to the prescriber; OR <u>Note</u>: Prior use of Gilenya or Tascensco ODT with inadequate efficacy or significant intolerance (according to the prescriber) also counts. **v.** Patient meets BOTH of the following (a <u>and</u> b):

a) Patient has tried generic teriflunomide tablets; AND
b) Patient has experienced inadequate efficacy or significant intolerance, according to the prescriber.
Note: Prior use of Aubagio with inadequate efficacy or significant intolerance (according to the prescriber) also counts.

C) If the patient meets the standard *Multiple Sclerosis and Ulcerative Colitis – Zeposia Prior Authorization Policy* criteria, but does not meet criterion 1B, offer to review for a Preferred Product (dimethyl fumarate, glatiramer, fingolimod, or teriflunomide).

2. Ulcerative Colitis – Initial Therapy.

A) Approve for 6 months if the patient meets the following (i and ii):
i. Patient meets the standard *Multiple Sclerosis and Ulcerative Colitis – Zeposia Prior Authorization Policy* criteria; AND
ii. Patient has tried BOTH an adalimumab product and Stelara subcutaneous.
Note: Examples of adalimumab products include Humira, Abrilada, adalimumab-aacf, adalimumab-adaz, adalimumab-adbm, adalimumab-fkjp, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Yuflyma, and Yusimry. A trial of an infliximab product (e.g., Remicade, biosimilars; Zymfentra), Simponi subcutaneous, Entyvio intravenous or subcutaneous, Omvoh intravenous or subcutaneous, or Stelara intravenous also counts.

B) If the patient has met criterion 2Ai (the standard *Multiple Sclerosis and Ulcerative Colitis – Zeposia Prior Authorization Policy* criteria), but criterion 2Aii is not met, offer to review for a Preferred Product (Humira [NDCs starting with 00074], adalimumab-adaz, adalimumab-adbm, Cyltezo, Hyrimoz [NDCs starting with 61314, or Stelara subcutaneous) using the respective standard *Inflammatory Conditions Prior Authorization Policy* criteria.
Note: Adalimumab-adaz and adalimumab-adbm are Non-Preferred for some plans. Refer to respective *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies Policies.*

3. Ulcerative Colitis – Patient is Currently Receiving Zeposia.

A) Approve for 1 year if the patient meets the following (i and ii):
i. Patient meets the standard *Multiple Sclerosis and Ulcerative Colitis – Zeposia Prior Authorization Policy* criteria; AND
ii. Patient meets ONE of the following conditions (a or b):

	a) Patient has tried BOTH an adalimumab product and Stelara subcutaneous; OR Note: Examples of adalimumab products include Humira, Abrilada, adalimumab-aacf, adalimumab-adaz, adalimumab-adbm, adalimumab-fkjp, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Yuflyma, and Yusimry. A trial of an infliximab product (e.g., Remicade, biosimilars; Zymfentra), Simponi subcutaneous, Entyvio intravenous or subcutaneous, Omvoh intravenous or subcutaneous, or Stelara intravenous also counts. **b)** Patient has been established on Zeposia for at least 90 days and prescription claims history indicates at least a 90-day supply of Zeposia was dispensed within the past 130 days **[verification in prescription claims history required]** if claims history is not available, according to the prescriber **[verification by prescriber required]**. Note: In cases where 130 days of the patient's prescription claim history file is unavailable to be verified, an exception to this requirement is allowed if the prescriber has verified that the patient has been receiving Zeposia for at least 90 days AND the patient has been receiving Zeposia via paid claims (e.g., patient has not been receiving samples or coupons or other types of waivers in order to obtain access to Zeposia). **B)** If the patient has met criterion 3Ai (the standard *Multiple Sclerosis and Ulcerative Colitis – Zeposia Prior Authorization Policy* criteria), but criterion 3Aii is not met, offer to review for a Preferred Product (Humira [NDCs starting with 00074], adalimumab-adaz, adalimumab-adbm, Cyltezo, Hyrimoz [NDCs starting with 61314], or Stelara subcutaneous) using the respective standard *Inflammatory Conditions Prior Authorization Policy* criteria. Note: Adalimumab-adaz and adalimumab-adbm are Non-Preferred for some plans. Refer to respective *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies Policy* or the Choice version of that policy.

REFERENCES

1. Zeposia® capsules [prescribing information]. Princeton, NJ: Celgene/Bristol Myers Squibb; August 2023.

HISTORY

Type of Revision	Summary of Changes	Review Date
Early Annual Revision	**Multiple Sclerosis Preferred Specialty Management Program:** Generic fingolimod capsules were added as a Preferred Product. **Zeposia:** For **Multiple Sclerosis**, generic fingolimod capsules were added to the list of products that may have been tried with inadequate efficacy or significant intolerance (according to the prescriber) prior to Zeposia. Also a Note was added that prior use of Gilenya (brand) with inadequate efficacy or significant intolerance (according to the prescriber) also counts.	10/26/2022
Selected Revision	**Effective 02/01/2023** **Zeposia:** For **Ulcerative Colitis**, the requirement to try two Preferred Products was changed to require a trial of one Preferred Product. Documentation of trial(s) of the Preferred Product(s) was removed.	12/21/2022
Selected Revision	**Zeposia:** For Ulcerative Colitis, Amjevita was added as a Preferred adalimumab product that may have been tried prior to Zeposia.	01/11/2023
Selected Revision	**Zeposia:** For **Multiple Sclerosis**, Tascensco ODT was added to the Note related to the requirement of a trial of generic fingolimod capsules that prior use of Tascensco ODT, with inadequate efficacy or significant intolerance (according to the prescriber), also counts.	03/01/2023
Selected Revision	**Zeposia: For Ulcerative Colitis**, the requirement to try one Preferred Product was changed to require a trial of both Preferred Products (effective 06/15/2023).	05/24/2023
Selected Revision	Policy was changed to apply only to National Preferred, High Performance, and Basic Formularies, which is now specified in the title. **Ulcerative Colitis:** Examples of adalimumab products were moved to a note. Adalimumab-adaz, Cyltezo, and Hyrimoz were added as Preferred adalimumab products.	07/12/2023
Selected Revision	**Multiple Sclerosis:** Generic teriflunomide was added as a Preferred Product. If a patient has tried generic teriflunomide tablets and has experienced inadequate efficacy or significant intolerance, according to the prescriber, this would count toward the requirement to receive Zeposia. A Note was added that prior use of Aubagio with inadequate efficacy or significant intolerance (according to the prescriber) also counts.	07/26/2023
Annual Revision	No criteria changes.	11/08/2023
Selected Revision	**Effective 01/01/2024** Amjevita was removed and adalimumab-adbm was added to the Preferred Adalimumab Products. It was clarified that the Preferred Hyrimoz Product is specific for NDCs starting with 61314. A Note was added stating that Adalimumab-adaz and Adalimumab-adbm are Non-Preferred for some plans. Refer to respective *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for National Preferred, High Performance, and Basic Formularies Policies* for more information.	11/22/2023
Selected Revision	**Effective 03/01/2024** **Ulcerative Colitis:** Zymfentra, Entyvio subcutaneous, and Omvoh intravenous and subcutaneous were added to the list of biologics that would generally count towards a trial of a Preferred Product.	01/24/2024
Selected Revision	**Effective 04/01/2024** **Ulcerative Colitis:** It was clarified that the Preferred Humira formulation includes NDCs starting with 00074.	02/28/2024