DR.003.A OCREVUS® (Ocrelizumab)

Health Partners Plans

Title: Ocrevus ®(Ocrelizumab)
Policy #: DR.003.A
Type: Drug | **Sub-Type:** Drug (DR)

Original Implementation Date: 6/1/2019
Version Date [A]: 6/1/2019
Last Review Date: 4/17/2019

DRUG POLICY BULLETIN

***** NOTIFICATION OF PENDING IMPLEMENTATION *****

Please note that this Drug Policy Bulletin will be implemented on 6/1/2019.
This document provides a 30-day notification of this change.

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FDA APPROVED INDICATIONS

Ocrelizumab® is a CD20-directed cytolytic antibody used to treat patients with relapsing or primary progressive forms of multiple sclerosis.

OFF-LABELED USE

Authorization for off-labeled use of medication will be evaluated on an individual basis. Review of an off-labeled request by the Medical Staff will be predicated on the appropriateness of treatment and full consideration of medical necessity.

For off-label use, Medical Directors will review scientific literature and local practice patterns.

PRIOR AUTHORIZATION CRITERIA

INITIAL CRITERIA

*AUTHORIZATION DURATION: IF **ALL CRITERIA MET**, APPROVE FOR 6 MONTHS*

1) Adults 18 years of age and older; AND
2) Medication is being prescribed by or in consultation with a specialist (who specializes in treatment of multiple sclerosis (MS) or a neurologist); AND

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3) Patient has a documented diagnosis of a relapsing form of multiple sclerosis or primary progressive multiple sclerosis (according to revised McDonald criteria), with one year of disease progression (retrospectively or prospectively determined) and two of the following
   I. One or more T2 lesions in at least one area characteristic for multiple sclerosis(periventricular, juxtacortial, or infratentorial);
   II. Two or more T2 lesions in the spinal cord;
   III. Presence of cerebrospinal fluid-specific oligoclonal bands.
4) If patient is female and of childbearing potential, has documentation of recent negative pregnancy test; AND
5) For relapsing multiple sclerosis, medical records (including dates, dosage, directions and treatment response) are attached showing the patient has contraindications or intolerance or previously tried and failed at least three MS therapies including but not limted to (Aubagio, Avonex, Rebif, Betaseron, Copaxone, glatiramer, Glatopa, Gilenya, Tecfidera), Failure of an adequate trial of therapy for multiple sclerosis is defined as follows:
   I. Having increasing relapses (defined as two or more relapses in a year, or one severe relapse associated with either poor recovery or MRI lesion progression); or
   II. Having lesion progression by MRI (increased number or volume of gadolinium-enhancing lesions, T2 hyperintense lesions or T1 hypointense lesions); or
   III. The patient has worsening disability (sustained worsening of Expanded Disability Status Scale (EDSS) score or neurological examination findings); AND
6) Documentation showing Ocrelizumab will not be administered with other disease modifying therapies for MS; AND
7) Documentation, showing absence of active infections and documentation, showing screening for hepatitis B(HBsAG and anti-HBc measurements); AND
8) Documentation that live-attenuated or live vaccines will not be administered during treatment or after discontinuation of Ocrelizumab until B-cell repletion. (Current recommendations- all necessary immunizations per guidelines should be administered at least 6 weeks prior to treatment initiation).
9) Please note: For members who are new to the plan and are already treated and stable with Ocrevus (records must be attached), the medication will be approved for continuation of treatment.

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RENEWAL CRITERIA

*AUTHORIZATION DURATION**: IF ALL RENEWAL CRITERIA MET**, APPROVE FOR 6 MONTHS*

1) Patient continues to meet criteria identified for initial approval; AND
2) Patient has not received dose of Ocrelizumab within the past 5 months; AND
3) Medical records are attached showing treatment response (including absence of unacceptable toxicity such as severe infusion reactions or infections, malignancy, etc.); AND
4) The patient has had an improvement of symptoms or stabilization of MS disease course from baseline. (Must attach documentation); AND
5) If patient is female of childbearing potential, documentation of use of adequate contraception to prevent pregnancy during treatment and for 6 months following last infusion.

DOSAGE AND ADMINISTRATION

DOSING RECOMMENDATIONS:

- Recommendation is to pre-medicate with 100 mg methylprednisolone (or an equivalent corticosteroid) and an antihistamine(e.g., diphenhydramine) given intravenously ~30 minutes prior to each infusion with Ocrelizumab.
- Initial dose: 300 mg intravenous (IV) infusion, followed two weeks later by a second 300 mg IV infusion.
- Following doses: single 600 mg IV infusion beginning 6 months after the first 300 mg dose.
- Patient should be observed for at least one hour after infusion completion.

This information is not meant to replace clinical decision making when initiating or modifying medication therapy and should only be used as a guide. Patient-specific variables should be taken into account.

RISK FACTORS/SIDE EFFECTS

Infusion Reactions:
Ocrelizumab can cause infusion reactions with the highest incidence with the first infusion. No fatal infusion reactions occurred but some required hospitalization. Observe patients treated with Ocrelizumab for at least one hour after completion of the infusion. Patients should be informed that infusion reactions can occur up to 24 hours after the infusion. Pre-medication should be administered to reduce frequency and severity of infusion reactions.

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Infections:
A higher proportion of patients treated with Ocrelizumab experienced infections compared to those taking REBIF or placebo in clinical trials. Delay Ocrelizumab administration in patients until active infection resolves.

- **Progressive Multifocal Leukoencephalopathy (PML):**
  No cases of PML were seen in OCRELIZUMAB clinical trials, however JC virus infection resulting in PML has been observed during treatment with other anti-CD20 antibodies and other MS therapies. At first sign/symptom of PML, Ocrelizumab should be discontinued and patient should be appropriately evaluated.
- **Hepatitis B Virus (HBV) Reactivation:**
  Perform HBV screening in all patients before starting treatment with Ocrelizumab. No reports of reactivation in MS patients treated with Ocrelizumab occurred. For patients who are negative for surface antigen (HBsAg) and positive for HB core antibody (HBcAb+) or are carriers of HBV (HBsAg+), a liver disease expert should be consulted before starting or during treatment.

Malignancies:
An increased risk of malignancy may exist in treatment with Ocrelizumab. In clinical trials, malignancies, (including breast cancer), occurred more frequently in patients treated with Ocrelizumab. Patients should follow standard screening guiltiness.

MONITORING

- During therapy: Infusion reactions.
- Prior to therapy and during: Infections, Hepatitis B Virus screening.

CODING

HCPCS Code	Description
J2350	Injection, ocrelizumab, 1 mg
ICD-10 Code	**Description**
G35	G35

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POLICY HISTORY

This section provides a high-level summary of changes to the policy since the previous version.

Summary	Version	Version Effective Date
New Policy.	A	2/1/2019

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