Clinical Policy: Dimethyl Fumarate (Tecfidera), Diroximel Fumarate (Vumerity)
Reference Number: CP.PHAR.249
Effective Date: 09.01.16
Last Review Date: 08.20
Line of Business: Medicaid

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

Description
The following are nuclear factor-like 2 activators requiring prior authorization: dimethyl fumarate (Tecfidera®) and diroximel fumarate (Vumerity™).

FDA Approved Indication(s)
Tecfidera and Vumerity are indicated for the treatment of patients with relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Tecfidera and Vumerity are medically necessary when the following criteria are met:

I. Initial Approval Criteria
A. Multiple Sclerosis (must meet all):
   1. Diagnosis of one of the following (a, b, or c):
      a. Clinically isolated syndrome, and:
         i. If request is for Vumerity: Member is contraindicated to both or has experienced clinically significant adverse effects to one of the following at up to maximally indicated doses: an interferon-beta agent (Avonex®, Betaseron®, Rebif®, or Plegridy®), glatiramer (Copaxone®, Glatopa®);
      b. Relapsing-remitting MS, and:
         i. If request is for Vumerity: Failure of all of the following at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated (1, 2, 3, and 4):*
            1. Dimethyl fumarate (generic Tecfidera®);
            2. Aubagio®;
            3. Gilenya™;
            4. An interferon-beta agent (Avonex, Betaseron, Rebif, or Plegridy) or glatiramer (Copaxone, Glatopa);
         *Prior authorization is required for all disease modifying therapies for MS
      c. Secondary progressive MS;
   2. Prescribed by or in consultation with a neurologist;
3. Age ≥ 18 years;
4. For brand Tecfidera and brand Vumerity requests, medical justification supports inability to use generic dimethyl fumarate (e.g., contraindications to the excipients of generic product);
5. The requested agent is not prescribed concurrently with other disease modifying therapies for MS (see Appendix D);
6. Documentation of baseline number of relapses per year and expanded disability status scale (EDSS) score;
7. Dose does not exceed:
   a. Starting dose: Tecfidera 240 mg (2 capsules) or Vumerity 462 mg (2 capsules) per day for 7 days;
   b. Maintenance dose: Tecfidera 480 mg (2 capsules) or Vumerity 924 mg (4 capsules) per day.

Approval duration: 6 months

B. Other diagnoses/indications
1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid.

II. Continued Therapy
A. Multiple Sclerosis (must meet all):
   1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   2. Member meets one of the following (a or b):
      a. If member has received < 1 year of total treatment: Member is responding positively to therapy;
      b. If member has received ≥ 1 year of total treatment: Member meets one of the following (i, ii, iii, or iv):
         i. Member has not had an increase in the number of relapses per year compared to baseline;
         ii. Member has not had ≥ 2 new MRI-detected lesions;
         iii. Member has not had an increase in EDSS score from baseline;
         iv. Medical justification supports that member is responding positively to therapy;
   3. The requested agent is not prescribed concurrently with other disease modifying therapies for MS (see Appendix D);
   4. If request is for a dose increase, new dose does not exceed Tecfidera 480 mg (2 capsules) or Vumerity 924 mg (4 capsules) per day.

Approval duration: first re-authorization: 6 months; second and subsequent re-authorizations: 12 months

B. Other diagnoses/indications (must meet 1 or 2):
1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:
   A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.PMN.53 for Medicaid or evidence of coverage documents;
   B. Primary progressive MS.

IV. Appendices/General Information
   Appendix A: Abbreviation/Acronym Key
   EDSS: expanded disability status scale
   FDA: Food and Drug Administration
   MS: multiple sclerosis

   Appendix B: Therapeutic Alternatives
   This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aubagio® (teriflunomide)</td>
<td>7 mg or 14 mg PO QD</td>
<td>14 mg/day</td>
</tr>
<tr>
<td>Avonex®, Rebif® (interferon beta-1a)</td>
<td>Avonex: 30 mcg IM Q week Rebif: 22 mcg or 44 mcg SC TIW</td>
<td>Avonex: 30 mcg/week Rebif: 44 mcg TIW</td>
</tr>
<tr>
<td>Betaseron® (interferon beta-1b)</td>
<td>250 mcg SC QOD</td>
<td>250 mg QOD</td>
</tr>
<tr>
<td>Plegridy® (peginterferon beta-1a)</td>
<td>125 mcg SC Q2 weeks</td>
<td>125 mcg/2 weeks</td>
</tr>
<tr>
<td>glatiramer acetate (Copaxone®, Glatopa®)</td>
<td>20 mg SC QD or 40 mg SC TIW</td>
<td>20 mg/day or 40 mg TIW</td>
</tr>
<tr>
<td>Gilenya™ (fingolimod)</td>
<td>0.5 mg PO QD</td>
<td>0.5 mg/day</td>
</tr>
<tr>
<td>dimethyl fumarate (Tecfidera®)</td>
<td>120 mg PO BID for 7 days, followed by 240 mg PO BID</td>
<td>480 mg/day</td>
</tr>
</tbody>
</table>

   Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

   Appendix C: Contraindications/Boxed Warnings
   • Contraindication(s): known hypersensitivity to dimethyl fumarate, diroximel fumarate, or any of the excipients of Tecfidera or Vumerity; coadministration of Tecfidera and Vumerity
   • Boxed warning(s): none reported

   Appendix D: General Information
   • Disease-modifying therapies for MS are: glatiramer acetate (Copaxone®, Glatopa®), interferon beta-1a (Avonex®, Rebif®), interferon beta-1b (Betaseron®, Extavia®),
peginterferon beta-1a (Plegridy®), dimethyl fumarate (Tecfidera®), diroximel fumarate (Vumerity™), monomethyl fumarate (Bafiertam™), fingolimod (Gilenya™), teriflunomide (Aubagio®), alemtuzumab (Lemtrada®), mitoxantrone (Novantrone®), natalizumab (Tysabri®), ocrelizumab (Ocrevus™), cladribine (Mavenclad®), siponimod (Mayzent®), and ozanimod (Zeposia®).

- Of the disease-modifying therapies for MS that are FDA-labeled for CIS, only the interferon products, glatiramer, and Aubagio have demonstrated any efficacy in decreasing the risk of conversion to MS compared to placebo. This is supported by the AAN 2018 MS guidelines.

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dimethyl fumarate (Tecfidera)</td>
<td>Relapsing MS</td>
<td>Starting: 120 mg PO BID for 7 days Maintenance: 240 mg PO BID</td>
<td>480 mg/day</td>
</tr>
<tr>
<td>Diroximel fumarate (Vumerity)</td>
<td>Relapsing MS</td>
<td>Starting: 231 mg PO BID for 7 days Maintenance: 462 mg PO BID</td>
<td>924 mg/day</td>
</tr>
</tbody>
</table>

VI. Product Availability

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dimethyl fumarate (Tecfidera)</td>
<td>Delayed-release capsules: 120 mg, 240 mg</td>
</tr>
<tr>
<td>Diroximel fumarate (Vumerity)</td>
<td>Delayed-release capsules: 231 mg</td>
</tr>
</tbody>
</table>

VII. References

CLINICAL POLICY
Dimethyl Fumarate, Diroximel Fumarate

Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Date</th>
<th>P&amp;T Approval Date</th>
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<tbody>
<tr>
<td>07.17</td>
<td>08.17</td>
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Changed renewal approval duration to 12 months.

Added age requirement. Removed MRI requirement. Removed contraindication as it constitutes a hypersensitivity reaction. Removed reasons to discontinue.

01.05.18   05.18  

2Q 2018 annual review: no significant changes from previously approved corporate policy; policies combined for Medicaid, HIM and Commercial lines of business; age added; HIM: removed MRI requirement; Commercial: removed COC statement for reauth; added requirement for no concurrent use with other MS therapies; references reviewed and updated.

02.04.19   05.19  

2Q 2019 annual review: no significant changes; references reviewed and updated.

08.02.19

RT4: added coverage for CIS and SPMS per updated FDA labeling; references reviewed and updated.

12.03.19

RT4: added newly approved agent Vumerity.

01.27.20   05.20  

2Q 2020 annual review: modified CIS re-direction for Vumerity to include glatiramer per SDC; modified Commercial approval durations from Length of Benefit to 6/12 months; references reviewed and updated.

05.27.20   08.20  

Added requirements for documentation of baseline relapses/EDSS and objective measures of positive response upon re-authorization; modified all continued approval duration to 6 months for the first re-authorization and 12 months for second/subsequent re-authorizations; references reviewed and updated.

09.22.20

Per September (for Medicaid) SDC and prior clinical guidance, added generic dimethyl fumarate redirection for Tecfidera and Vumerity requests; Commercial/HIM line of business removed from policy with separate CP.PCH.34 policy created.

10.06.20

Per October (for Commercial/HIM) SDC and prior clinical guidance, added Commercial/HIM line of business to policy (retire CP.PCH.34).

01.11.21

Per November and December SDC and prior clinical guidance, removed redirection to Mayzent; for RRMS modified redirection for Vumerity requests to require generic dimethyl fumarate, Aubagio, Gilenya, and either an interferon-beta agent or glatiramer; removed Commercial and HIM line of business from policy.

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.