Clinical Policy: Dimethyl Fumarate (Tecfidera), Diroximel Fumarate (Vumerity)

Reference Number: CP.PHAR.249
Effective Date: 09.01.16
Last Review Date: 05.20
Line of Business: Commercial, HIM, Medicaid

Revision Log

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 two of the following at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated: Aubagio®, Tecfidera®, Gilenya™, an interferon-beta agent (Avonex, Betaseron, Rebif, or Plegridy), glatiramer (Copaxone, Glatopa), Mayzent®;

      **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. The requested agent is not prescribed concurrently with other disease modifying therapies for MS (*see Appendix D*);

5. 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.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and 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 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: 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.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and 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.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents;

B. Primary progressive MS.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
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.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Aubagio® (teriflunomide)	7 mg or 14 mg PO QD	14 mg/day
Avonex®, Rebif® (interferon beta-1a)	*Avonex*: 30 mcg IM Q week *Rebif*: 22 mcg or 44 mcg SC TIW	*Avonex*: 30 mcg/week *Rebif*: 44 mcg TIW
Betaseron® (interferon beta-1b)	250 mcg SC QOD	250 mg QOD
Plegridy® (peginterferon beta-1a)	125 mcg SC Q2 weeks	125 mcg/2 weeks
glatiramer acetate (Copaxone®, Glatopa®)	20 mg SC QD or 40 mg SC TIW	20 mg/day or 40 mg TIW
Gilenya™ (fingolimod)	0.5 mg PO QD	0.5 mg/day
Tecfidera® (dimethyl fumarate)	120 mg PO BID for 7 days, followed by 240 mg PO BID	480 mg/day
Mayzent® (siponimod)	*All patients:* Day 1 and 2: 0.25 mg PO QD Day 3: 0.5 mg PO QD Day 4: 0.75 mg PO QD *CYP2C9 genotypes *1/*1, *1/*2, or *2/*2:* Day 5: 1.25 mg PO QD Day 6 and onward: 2 mg PO QD *CYP2C9 genotypes *1/*3 or *2/*3:* Day 5 and onward: 1 mg PO QD	2 mg/day

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™), fingolimod (Gilenya™), teriflunomide (Aubagio®), alemtuzumab (Lemtrada®), mitoxantrone (Novantrone®), natalizumab (Tysabri®), ocrelizumab (Ocrevus™), cladribine (Mavenclad®), and siponimod (Mayzent®).

- Although many disease-modifying therapies for MS 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

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

VI. Product Availability

Drug Name	Availability
Dimethyl fumarate (Tecfidera)	Delayed-release capsules: 120 mg, 240 mg
Diroximel fumarate (Vumerity)	Delayed-release capsules: 231 mg

VII. References

1. Tecfidera Prescribing Information. Cambridge, MA: Biogen Inc.; December 2019. Available at http://www.tecfidera.com. Accessed January 27, 2020.
2. Vumerity Prescribing Information. Cambridge, MA: Biogen Inc.; October 2019. Available at http://www.vumerity.com. Accessed January 27, 2020.
3. 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. Updated June 2019. Accessed January 27, 2020.
4. Rae-Grant A, Day GS, Marrie RA, et al. Practice guideline recommendations summary: disease-modifying therapies for adults with multiple sclerosis: report of the Guideline Development, Dissemination, and Implementation Subcommittee of the American Academy of Neurology. Neurology. 2018; 90(17): 777-788. Full guideline available at: https://www.aan.com/Guidelines/home/GetGuidelineContent/904.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy split from CP.PHAR.18 MS Treatments. Criteria: added max dosing, clarified monotherapy restriction, removed re-authorization requirement for documented adherence, updated reasons to discontinue, modified efficacy criteria from "No increase in neurologic dysfunction/disability as a result of relapses or progressive disease, including a change in diagnostic status from RRMS to SPMS" to "Responding positively to therapy". Changed renewal approval duration to 12 months.	06.16	08.16
Added age requirement. Removed MRI requirement. Removed contraindication as it constitutes a hypersensitivity reaction. Removed reasons to discontinue.	07.17	08.17

Reviews, Revisions, and Approvals	Date	P&T Approval Date
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.	01.05.18	05.18
2Q 2019 annual review: no significant changes; references reviewed and updated.	02.04.19	05.19
RT4: added coverage for CIS and SPMS per updated FDA labeling; references reviewed and updated.	08.02.19	
RT4: added newly approved agent Vumerity.	12.03.19	
2Q 2020 annual review: modified CIS re-direction for Vumerity to include glatiramer per SDC; references reviewed and updated.	01.27.20	05.20

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.