

**Clinical Policy: Fingolimod (Gilenya)**

Reference Number: CP.PHAR.251

Effective Date: 09.01.16

Last Review Date: 05.21

Line of Business: Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

**Description**

Fingolimod (Gilenya<sup>®</sup>) is a sphingosine 1-phosphate receptor modulator.

**FDA Approved Indication(s)**

Gilenya is indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in patients 10 years of age and older.

**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<sup>®</sup> that Gilenya is **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;
  - b. Relapsing-remitting MS, and failure of generic dimethyl fumarate at up to maximally indicated doses, unless contraindicated, clinically significant adverse effects are experienced, or member has highly active MS;
  - c. Secondary progressive MS;
2. Prescribed by or in consultation with a neurologist;
3. Age  $\geq$  10 years;
4. Gilenya is not prescribed concurrently with other disease modifying therapies for MS (*see Appendix D*);
5. Documentation of baseline number of relapses per year and expanded disability status scale (EDSS) score;
6. At the time of request, member does not have baseline QTc interval  $\geq$  500 msec;
7. Dose does not exceed one of the following (a or b):
  - a. Body weight  $>$  40 kg: 0.5 mg (1 capsule) per day;
  - b. Body weight  $\leq$  40 kg: 0.25 mg (1 capsule) 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  $\geq 1$  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  $\geq 2$  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. Gilenya 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 one of the following (a or b):
  - a. Body weight > 40 kg: 0.5 mg (1 capsule) per day;
  - b. Body weight  $\leq 40$  kg: 0.25 mg (1 capsule) 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.*

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
dimethyl fumarate (Tecfidera®)	<u>Initial:</u> 120 mg PO BID for 7 days <u>Maintenance:</u> 240 mg PO BID	480 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):
  - Recent myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure with hospitalization, or Class III/IV heart failure
  - History of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless patient has a pacemaker
  - Baseline QTc interval  $\geq$  500 msec
  - Cardiac arrhythmias requiring anti-arrhythmic treatment with Class Ia or Class III anti-arrhythmic drugs
  - Hypersensitivity to fingolimod or its excipients
- 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®), ozanimod (Zeposia®), and ofatumumab (Kesimpta®).
- Per the American Academy of Neurology 2018 MS practice guidelines, definitions of highly active MS vary and can include measures of relapsing activity and MRI markers of disease activity, such as numbers of gadolinium-enhanced lesions.

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
Relapsing MS	Adults and pediatric patients 10 years of age and older weighing > 40 kg: 0.5 mg PO QD  Pediatric patients 10 years of age and older weighing $\leq$ 40 kg: 0.25 mg PO QD	0.5 mg/day

**VI. Product Availability**

Capsules: 0.25 mg, 0.5 mg

**VII. References**

1. Gilenya Prescribing Information. East Hanover, NJ: Novartis Pharmaceuticals Corporation; December 2019. Available at <http://www.gilenya.com>. Accessed February 8, 2021.
2. 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
Added age requirement. Removed MRI requirement. Removed the following contraindications: active infection and hypersensitivity. Removed reasons to discontinue.	07.17	08.17
2Q 2018 annual review: no significant changes from previously approved corporate policy; policies combined for Medicaid, HIM and Commercial lines of business; age added; Medicaid: removed the following contraindications per safety guidance endorsed by Centene Medical Affairs: recent myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure with hospitalization, or Class III/IV heart failure; history of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless patient has a pacemaker; 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
No significant changes: updated policy with new pediatric age limit/language and new dosage form.	06.28.18	
2Q 2019 annual review: no significant changes; removed requirement for no concurrent use of Class Ia or III anti-arrhythmic drugs based on updated contraindication in FDA label; references reviewed and updated.	02.04.19	05.19
RT4: updated FDA Approved Indication(s) and initial approval criteria sections to include clinically isolated syndrome and SPMS per updated FDA labeling; references reviewed and updated.	09.23.19	
2Q 2020 annual review: clarified max dosing requirement per body weight; modified Commercial approval durations from Length of Benefit to 6/12 months; references reviewed and updated.	01.27.20	05.20
Added requirements for documentation of baseline relapses/EDSS and objective measures of positive response upon re-authorization; modified continued approval duration to 6 months for the first re-	05.27.20	08.20

Reviews, Revisions, and Approvals	Date	P&T Approval Date
authorization and 12 months for second/subsequent re-authorizations; references reviewed and updated.		
Per November SDC and prior clinical guidance, removed Commercial and HIM LOB from policy (CP.PCH.38 created); added requirement for trial of generic dimethyl fumarate for Medicaid LOB, unless member has highly active MS.	11.11.20	
Per November SDC and prior clinical guidance, modified to reflect that trial of generic dimethyl fumarate applies only to RRMS.	02.09.21	
2Q 2021 annual review: no significant changes; references reviewed and updated.	02.10.21	05.21

**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.

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**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.

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