Missouri Pharmacy Program – Preferred Drug List

Multiple Sclerosis Agents

Effective 02/01/2006
Revised 10/04/2018

Preferred Agents

- Aubagio® Tablets
- Avonex® Dose Pack
- Avonex® Pen/Syringe
- Betaseron® Kit
- Copaxone® 20mg Syringe
- Gilenya® Capsules
- Rebif® Syringe
- Rebif Rebidose® Pen

Non-Preferred Agents

- Copaxone® 40mg Syringe
- Extavia® Kit
- Glatopa® 20mg Syringe
- **Glatiramer 20 mg/ml**
- **Glatiramer 40 mg/ml**
- Lemtrada® (IV)
- Ocrevus® (IV)
- Plegridy® Pen/Syringe
- Tecfidera® Capsules
- Tysabri® (IV)
- Zinbryta® Syringe

Approval Criteria

- Trial on 2 preferred agents with failure to achieve desired therapeutic outcomes as evidenced by one or more of the following:
  - ONE or more relapses;
  - ONE or more new MRI lesions;
  - Patient demonstrates increased disability on a clinical rating scale such as the Expanded Disability Status Scale (EDSS) or the Functional Systems Score (FSS);
  - Documented trial period (6 months) for preferred agents
  - Documented ADE/ADR to preferred agents
- Documented compliance on current therapy regimen
- GILENYA and AUBAGIO Oral Therapy Available
  - After documented trial on ONE injectable biologic agent
- **Ocrevus Available**
  - **With a diagnosis of Primary Progressive Multiple Sclerosis and a documented trial on ONE injectable biologic agent**

Denial Criteria

- Lack of adequate trial on required preferred agents
- Therapy will be denied if no approval criteria are met
- Drug Prior Authorization Hotline: (800) 392-8030