

Clinical Policy: Fingolimod (Gilenya)

Reference Number: CP.PHAR.251

Effective Date: 08.01.16

Last Review Date: 05.19

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

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

Description

Fingolimod (Gilenya[®]) is a sphingosine 1-phosphate receptor modulator.

FDA Approved Indication(s)

Gilenya is indicated for the treatment of relapsing forms of multiple sclerosis (MS) 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[®] that Gilenya is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Multiple Sclerosis (must meet all):

1. Diagnosis of relapsing-remitting 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. At the time of request, member does not have baseline QTc interval \geq 500 msec;
6. Dose does not exceed 0.5 mg (1 capsule) per day.

Approval duration:

Medicaid/HIM – 6 months

Commercial – Length of Benefit

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. 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 0.5 mg (1 capsule) per day.

Approval duration:

Medicaid/HIM – 12 months

Commercial – Length of Benefit

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

Not applicable

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[®]), fingolimod (Gilenya[™]), teriflunomide (Aubagio[®]), alemtuzumab (Lemtrada[®]), mitoxantrone (Novantrone[®]), natalizumab (Tysabri[®]), and ocrelizumab (Ocrevus[™]).

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	0.5 mg/day
	Pediatric patients 10 years of age and older weighing ≤ 40 kg: 0.25 mg PO QD	

VI. Product Availability

Capsule: 0.25 mg, 0.5 mg

VII. References

1. Gilenya Prescribing Information. East Hanover, NJ: Novartis Pharmaceuticals Corporation; January 2019. Available at <http://www.gilenya.com>. Accessed February 4, 2019.
2. 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. March 2017. Accessed February 4, 2019.
3. 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 contraindications and 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”. Removed requirement for MRI confirmation of MS. Changed renewal approval duration to 12 months	06.16	08.16
Added age requirement. Removed MRI requirement. Removed the following contraindications: active infection and hypersensitivity. 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; 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

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.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy.

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