

**PART B STEP THERAPY CRITERIA FOR APPROVAL**

**Lemtrada (alemtuzumab), Ocrevus (ocrelizumab), and Tysabri (natalizumab)** will be approved when BOTH of the following are met:

1. ONE of the following:
  - A. The patient has an FDA labeled indication for the requested agent  
**OR**
  - B. The patient has an indication that is supported in CMS approved compendia for the requested agent
- AND**
2. ONE of the following:
  - A. There is evidence of a claim that the patient is currently being treated with the requested agent within the past 365 days  
**OR**
  - B. The prescriber states the patient is currently being treated with the requested agent  
**OR**
  - C. The patient's medication and/or medical history includes use of the cost-effective preferred agent(s) within the past 90 days  
**OR**
  - D. The patient has a documented intolerance, ineffective treatment response, FDA labeled contraindication, or hypersensitivity to the cost-effective preferred agent(s)  
**OR**
  - E. The prescriber has submitted documentation to support the use of the non-preferred agent for the patient's diagnosis over the cost-effective preferred agent(s)

**Length of Approval:** up to 12 months

<b>Targeted Part B Agent</b>	<b>Preferred Agent(s) *</b>
Lemtrada (alemtuzumab)	<b>Part D</b> - Aubagio (teriflunomide), Avonex (interferon beta-1a), Betaseron (interferon beta-1b), Gilenya (fingolimod), glatiramer (Copaxone, Glatopa), Mayzent (simponimod), Plegridy (peginterferon beta-1a), and Tecfidera (dimethyl fumarate)
Ocrevus (ocrelizumab)	<b>Part D</b> - Aubagio (teriflunomide), Avonex (interferon beta-1a), Betaseron (interferon beta-1b), Gilenya (fingolimod), glatiramer (Copaxone, Glatopa), Mayzent (simponimod), Plegridy (peginterferon beta-1a), and Tecfidera (dimethyl fumarate)
Tysabri (natalizumab) for MS	<b>Part D</b> - Aubagio (teriflunomide), Avonex (interferon beta-1a), Betaseron (interferon beta-1b), Gilenya (fingolimod), glatiramer (Copaxone, Glatopa), Mayzent (simponimod), Plegridy (peginterferon beta-1a), and Tecfidera (dimethyl fumarate)
Tysabri (natalizumab) for Crohn's Disease	<b>Part D</b> - Corticosteroids, methotrexate, and immunomodulators, such as azathioprine or 6-mercaptopurine

\*Preferred agent(s) may vary based upon indication.

NOTES:

- Prerequisite drugs may require prior review under Medicare Part D or Medicare Part B. Medicare Part D prerequisites will not be required for Medical Only members.
- Length of approval may be shorter due to provider network participation status.
- Coverage of one Medicare Part B Step Therapy drug could equate to multiple drug authorizations when they share the same Medicare Part B Step Therapy criteria.
- LCD/NCD criteria review completed, if applicable, in addition to the Plan's Medicare Part B Step Therapy criteria.