

Clinical Policy: Ozanimod (Zeposia)

Reference Number: CP.PHAR.462

Effective Date: 03.25.20

Last Review Date: 05.22

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

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

Description

Ozanimod (Zeposia[®]) is a sphingosine 1-phosphate receptor modulator.

FDA Approved Indication(s)

Zeposia 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 adults.
- Moderately to severely active ulcerative colitis (UC) 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 Zeposia 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, and 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[®]/Extavia[®]†, Rebif[®], or Plegridy[®]), glatiramer (Copaxone[®], Glatopa[®]);
 - b. Relapsing-remitting MS, and failure of all of the following at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated (i, ii, iii, and iv):
 - i. Dimethyl fumarate (generic Tecfidera[®]);
 - ii. Aubagio[®];
 - iii. Gilenya[®];
 - iv. An interferon-beta agent (Avonex, Betaseron/Extavia[†], Rebif, or Plegridy) or glatiramer (Copaxone, Glatopa);
2. Prescribed by or in consultation with a neurologist;
3. Age ≥ 18 years;

**Prior authorization is required for all disease modifying therapies for MS*

†Betaseron is preferred for the Commercial and HIM lines of business; Extavia is preferred for the Medicaid line of business

4. Zeposia 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. Dose does not exceed 0.92 mg (1 capsule) per day.

Approval duration: 6 months

B. Ulcerative Colitis – *FOR MEDICAID ONLY** (must meet all):

**Refer to CP.CPA.194 Biologic DMARDs for commercial and HIM.PA.SP60 Biologic DMARDs for HIM*

1. Diagnosis of UC;
2. Prescribed by or in consultation with a gastroenterologist;
3. Age \geq 18 years;
4. Documentation of a Mayo Score \geq 6 (*see Appendix E*);
5. Failure of an 8-week trial of systemic corticosteroids, unless contraindicated or clinically significant adverse effects are experienced;
6. Failure of BOTH* of the following, each used for \geq 3 consecutive months, unless clinically significant adverse effects are experienced or both are contraindicated (a and b):
 - a. Humira[®] or Amjevita[™];
 - b. Simponi[®];
7. Dose does not exceed 0.92 mg (1 capsule) per day.

**Prior authorization may be required for Humira, Amjevita, and Simponi*

Approval duration: 6 months

C. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Multiple Sclerosis (must meet all):

1. Member meets one of the following (a or b):
 - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
 - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
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. Zeposia 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 0.92 mg (1 capsule) per day.

Approval duration: first re-authorization: 6 months; second and subsequent re-authorizations: 12 months

B. Ulcerative Colitis – **FOR MEDICAID ONLY*** (must meet all):

**Refer to CP.CPA.194 Biologic DMARDs for commercial and HIM.PA.SP60 Biologic DMARDs for HIM*

1. Currently Member meets one of the following (a or b):
 - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
 - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed 0.92 mg (1 capsule) per day.

Approval duration: 12 months

C. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business:

- CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
- b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 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.PA.154 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

EDSS: expanded disability status scale

FDA: Food and Drug Administration

MS: multiple sclerosis

UC: ulcerative colitis

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)	MS 7 mg or 14 mg PO QD	14 mg/day
Avonex [®] , Rebif [®] (interferon beta-1a)	MS Avonex: 30 mcg IM Q week Rebif: 22 mcg or 44 mcg SC TIW	Avonex: 30 mcg/week Rebif: 44 mcg TIW
Betaseron [®] , Extavia [®] (interferon beta-1b)	MS 250 mcg SC QOD	250 mg QOD
Plegridy [®] (peginterferon beta-1a)	MS 125 mcg SC Q2 weeks	125 mcg/2 weeks
glatiramer acetate (Copaxone [®] , Glatopa [®])	MS 20 mg SC QD or 40 mg SC TIW	20 mg/day or 40 mg TIW
Gilenya [®] (fingolimod)	MS 0.5 mg PO QD	0.5 mg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose												
dimethyl fumarate (Tecfidera [®])	MS 120 mg PO BID for 7 days, followed by 240 mg PO BID	480 mg/day												
corticosteroids	UC budesonide (Uceris [®]) 9 mg PO QD	budesonide 9 mg/day												
Humira [®] , Amjevita [™] (adalimumab)	<p>UC</p> <p><u>Initial dose:</u> <i>Adults:</i> 160 mg SC on Day 1, then 80 mg SC on Day 15</p> <p><i>Pediatrics:</i></p> <table border="1"> <thead> <tr> <th>Weight</th> <th>Days 1 through 15</th> </tr> </thead> <tbody> <tr> <td>20 kg to less than 40 kg</td> <td>Day 1: 80 mg Day 8: 40 mg Day 15: 40 mg</td> </tr> <tr> <td>40 kg and greater</td> <td>Day 1: 160 mg (single dose or split over two consecutive days) Day 8: 80 mg Day 15: 80 mg</td> </tr> </tbody> </table> <p><u>Maintenance dose:</u> <i>Adults:</i> 40 mg SC every other week starting on Day 29</p> <p><i>Pediatrics:</i></p> <table border="1"> <thead> <tr> <th>Weight</th> <th>Starting on Day 29*</th> </tr> </thead> <tbody> <tr> <td>20 kg to less than 40 kg</td> <td>40 mg every other week or 20 mg every week</td> </tr> <tr> <td>40 kg and greater</td> <td>80 mg every other week or 40 mg every week</td> </tr> </tbody> </table> <p><i>*Continue the recommended pediatric dosage in patients who turn 18 years of age and who are well-controlled on Humira regimen.</i></p>	Weight	Days 1 through 15	20 kg to less than 40 kg	Day 1: 80 mg Day 8: 40 mg Day 15: 40 mg	40 kg and greater	Day 1: 160 mg (single dose or split over two consecutive days) Day 8: 80 mg Day 15: 80 mg	Weight	Starting on Day 29*	20 kg to less than 40 kg	40 mg every other week or 20 mg every week	40 kg and greater	80 mg every other week or 40 mg every week	UC 40 mg every week
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20 kg to less than 40 kg	Day 1: 80 mg Day 8: 40 mg Day 15: 40 mg													
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Weight	Starting on Day 29*													
20 kg to less than 40 kg	40 mg every other week or 20 mg every week													
40 kg and greater	80 mg every other week or 40 mg every week													
Simponi [®] (golimumab)	<p>UC</p> <p><u>Initial dose:</u> 200 mg SC at week 0, then 100 mg SC at week 2</p> <p><u>Maintenance dose:</u> 100 mg SC every 4 weeks</p>	UC 100 mg every 4 weeks												

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): history of any of the following in the last 6 months: myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III or IV heart failure; presence of Mobitz type II second-degree or third degree atrioventricular (AV) block, sick sinus syndrome, or sinoatrial block, unless the patient has a functioning pacemaker; severe untreated sleep apnea; concomitant use of a monoamine oxidase inhibitor
- 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[®], Tascenso ODT[™]), teriflunomide (Aubagio[®]), alemtuzumab (Lemtrada[®]), mitoxantrone (Novantrone[®]), natalizumab (Tysabri[®]), ocrelizumab (Ocrevus[®]), siponimod (Mayzent[®]), cladribine (Mavenclad[®]), ozanimod (Zeposia[®]), ponesimod (Ponvory[™]), and ofatumumab (Kesimpta[®]).
- The American Academy of Neurology 2018 MS guidelines recommend the use of Gilenya, Tysabri, and Lemtrada for patients with highly active MS. 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.
- Of the disease-modifying therapies for MS that 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 American Academy of Neurology 2018 MS guidelines.

Appendix E: Mayo Score

- Mayo Score: evaluates UC stage, based on four parameters: stool frequency, rectal bleeding, endoscopic evaluation and Physician’s global assessment. Each parameter of the score ranges from zero (normal or inactive disease) to 3 (severe activity) with an overall score of 12.

Score	Decoding
0 – 2	Remission
3 – 5	Mild activity
6 – 10	Moderate activity
>10	Severe activity

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
MS, UC	Days 1-4: 0.23 mg PO QD Days 5-7: 0.46 mg PO QD Day 8 and thereafter: 0.92 mg PO QD If a dose of Zeposia is missed during the first 2 weeks of treatment, reinitiate treatment using the titration	0.92 mg/day

Indication	Dosing Regimen	Maximum Dose
	regimen. If a dose of Zeposia is missed after the first 2 weeks of treatment, continue with the treatment as planned.	

VI. Product Availability

Capsules: 0.23 mg, 0.46 mg, 0.92 mg

VII. References

1. Zeposia Prescribing Information. Summit, NJ: Celgene Corporation; December 2021. Available at: <https://www.zeposia.com>. Accessed February 8, 2022.
2. Cohen JA, Comi G, Selmaj KW, et al. Safety and efficacy of ozanimod versus interferon beta-1a in relapsing multiple sclerosis (RADIANCE): a multicentre, randomised, 24-month, phase 3 trial. *Lancet Neurol.* 2019; 18 (11): 1021-1033. <https://www.ncbi.nlm.nih.gov/pubmed/31492652>. doi:10.1016/S1474-4422(19)30238-8.
3. Comi G, Kappos L, Selmaj KW, et al. Safety and efficacy of ozanimod versus interferon beta-1a in relapsing multiple sclerosis (SUNBEAM): a multicentre, randomised, minimum 12-month, phase 3 trial. *Lancet Neurol.* 2019; 18 (11): 1009-1020. <https://www.ncbi.nlm.nih.gov/pubmed/31492651>. doi:10.1016/S1474-4422(19)30239-X.
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>.
5. Feuerstein JD, Isaacs KL, Schneider Y, et al. AGA Clinical practice guidelines on the management of moderate to severe ulcerative colitis. *Gastroenterology* 2020;158:1450–1461. <https://doi.org/10.1053/j.gastro.2020.01.006>

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	01.21.20	02.20
Drug is now FDA approved - criteria updated per FDA labeling; modified CIS re-direction to include glatiramer per SDC; 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-authorization and 12 months for second/subsequent re-authorizations; added primary progressive MS as a diagnosis not covered; references reviewed and updated.	05.12.20	08.20
Per November and December SDC and prior clinical guidance, removed redirection to Mayzent; for RRMS modified redirection to require generic dimethyl fumarate, Aubagio, Gilenya, and either an interferon-beta agent or glatiramer.	01.11.21	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2021 annual review: no significant changes; references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.	10.09.20	02.21
2Q 2021 annual review: no significant changes; references reviewed and updated.	02.08.21	05.21
RT4: added criteria for newly FDA-approved indication for ulcerative colitis based on previously P&T-approved clinical guidance; references reviewed and updated.	06.14.21	08.21
Per August SDC and prior clinical guidance, for UC modified redirection to require Humira and Simponi.	08.25.21	11.21
2Q 2022 annual review: no significant changes; references reviewed and updated.	02.08.22	05.22
Template changes applied to other diagnoses/indications and continued therapy section.	09.28.22	
Per February SDC, added Amjevita as an alternative option to Humira for UC.	02.13.23	

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.

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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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