

## **Clinical Policy: Fingolimod (Gilenya, Tascenso ODT)**

Reference Number: CP.PHAR.251

Effective Date: 09.01.16

Last Review Date: 05.26

Line of Business: Medicaid, Commercial, HIM/ICHRA

[Revision Log](#)

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

### **Description**

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

### **FDA Approved Indication(s)**

Gilenya and Tascenso ODT are 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 fingolimod, Gilenya, and Tascenso ODT are **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;
  - c. Secondary progressive MS;
2. Prescribed by or in consultation with a neurologist;
3. Age  $\geq$  10 years;
4. If request is for Tascenso ODT, member must use **Gilenya 0.25 mg or generic fingolimod 0.5 mg**, unless contraindicated, clinically significant adverse effects are experienced, or documentation supports inability to swallow capsules;\*  
*\*For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395*
5. For brand Gilenya 0.5 mg requests, member must use **generic fingolimod**, unless contraindicated or clinically significant adverse effects are experienced;
6. The requested agent is not prescribed concurrently with other disease modifying therapies for MS (*see Appendix D*);
7. At the time of request, member does not have baseline QTc interval  $\geq$  500 msec;
8. Dose does not exceed both of the following (a and b):
  - a. One of the following (i or ii):
    - i. Body weight  $>$  40 kg: 0.5 mg per day;
    - ii. Body weight  $\leq$  40 kg: 0.25 mg per day;
  - b. 1 capsule or orally disintegrating tablet per day.

**Approval duration: 12 months**

**B. 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/ICHRA) 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/ICHRA, and CP.PMN.255 for Medicaid; or
  - b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) 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/ICHRA, 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/ICHRA, 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 is responding positively to therapy;
3. The requested agent is not prescribed concurrently with other disease modifying therapies for MS (*see Appendix D*);
4. If request is for Tascenso ODT, documentation supports continued inability to swallow capsules;
5. For brand Gilenya 0.5 mg requests, member must use **generic fingolimod**, unless contraindicated or clinically significant adverse effects are experienced;
6. If request is for a dose increase, new dose does not exceed both of the following (a and b):
  - a. One of the following (i or ii):
    - i. Body weight > 40 kg: 0.5 mg per day;
    - ii. Body weight ≤ 40 kg: 0.25 mg per day;
  - b. 1 capsule or orally disintegrating tablet per day.

**Approval duration: 12 months**

**B. 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/ICHRA) 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/ICHRA, and CP.PMN.255 for Medicaid; or
  - b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) 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/ICHRA, 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/ICHRA, 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/ICHRA, 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
  - Concomitant use with other products containing fingolimod (*Tascenso ODT only*)
- Boxed warning(s): none reported

*Appendix D: General Information*

- Disease-modifying therapies for MS are: glatiramer acetate (Copaxone<sup>®</sup>, Glatopa<sup>®</sup>), interferon beta-1a (Avonex<sup>®</sup>, Rebif<sup>®</sup>), interferon beta-1b (Betaseron<sup>®</sup>, Extavia<sup>®</sup>), peginterferon beta-1a (Plegridy<sup>®</sup>), dimethyl fumarate (Tecfidera<sup>®</sup>), diroximel fumarate (Vumerity<sup>®</sup>), monomethyl fumarate (Bafiertam<sup>™</sup>), fingolimod (Gilenya<sup>®</sup>, Tascenso ODT<sup>™</sup>), teriflunomide (Aubagio<sup>®</sup>), alemtuzumab (Lemtrada<sup>®</sup>), mitoxantrone (Novantrone<sup>®</sup>), natalizumab (Tysabri<sup>®</sup>, and biosimilar Tyruko<sup>®</sup>), ocrelizumab (Ocrevus<sup>®</sup>), ocrelizumab/hyaluronidase-ocsq (Ocrevus Zunovo<sup>™</sup>), cladribine (Mavenclad<sup>®</sup>), siponimod (Mayzent<sup>®</sup>), ozanimod (Zeposia<sup>®</sup>), ponesimod (Ponvory<sup>™</sup>), ublituximab-xiiy (Briumvi<sup>™</sup>), and ofatumumab (Kesimpta<sup>®</sup>).

**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**

- Hard capsules (Gilenya): 0.25 mg, 0.5 mg\*
- Orally disintegrating tablets (Tascenso ODT): 0.25 mg, 0.5 mg

\*Available generically

**VII. References**

1. Gilenya Prescribing Information. East Hanover, NJ: Novartis Pharmaceuticals Corporation; August 2025. Available at: <http://www.gilenya.com>. Accessed January 23, 2026.
2. Tascenso ODT Prescribing Information. San Jose, CA: Handa Neuroscience, LLC; January 2025. Available at: <https://www.tascenso.com>. Accessed January 23, 2026.
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/898>. Reaffirmed on October 19, 2024.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2022 annual review: no significant changes; added legacy WellCare line of business (WCG.CP.PHAR.251 to be retired); RT4: added Tascenso ODT; references reviewed and updated.	02.07.22	05.22
Template changes applied to other diagnoses/indications and continued therapy section.	10.11.22	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2023 annual review: no significant changes; added redirection to generic for Gilenya 0.5 mg requests per SDC; RT4: for Tascenso ODT, added new 0.5 mg dosage strength and updated indication/criteria to remove prior upper age limit and weight requirement per revised FDA labeling; to be inclusive of members continuing therapy from a different benefit, revised continued approval duration to reference the duration of total treatment received rather than the number of re-authorizations; references reviewed and updated.	01.30.23	05.23
2Q 2024 annual review: no significant changes; revised policy/criteria section to also include generic fingolimod; references reviewed and updated.	01.25.24	05.24
2Q 2025 annual review: per competitor analysis, removed requirements for documentation of baseline relapses/expanded disability status score and specific measures of positive response; for continued therapy, modified approval duration from “if member has received < 1 year of total treatment – up to a total of 12 months of treatment and if member has received ≥ 1 year of total treatment – 12 months” to “12 months”; references reviewed and updated. Per SDC, removed redirection to generic Tecfidera; added Commercial and HIM lines of business (CP.PCH.38 to be retired).	04.10.25	05.25
Added step therapy bypass for IL HIM per IL HB 5395.	06.25.25	
2Q 2026 annual review: no significant changes; extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated. Added ICHRA line of business.	03.31.26	05.26

**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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