### Kesimpta (ofatumumab)
**Effective 03/01/2021**

<table>
<thead>
<tr>
<th>Plan</th>
<th>Program Type</th>
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<tbody>
<tr>
<td>☐ MassHealth</td>
<td>☒ Prior Authorization</td>
</tr>
<tr>
<td>☒ Commercial/Exchange</td>
<td>☒ Quantity Limit</td>
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<th>Benefit</th>
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<tr>
<td>☒ Pharmacy Benefit</td>
<td>☒ Prior Authorization</td>
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<tr>
<td>☐ Medical Benefit (NLX)</td>
<td>☒ Quantity Limit</td>
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| Specialty Limitations | This medication has been designated specialty and must be filled at a contracted specialty pharmacy. |

<table>
<thead>
<tr>
<th>Specialty Medications</th>
<th>Non-Specialty Medications</th>
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<tbody>
<tr>
<td>All Plans Phone: 866-814-5506 Fax: 866-249-6155</td>
<td>MassHealth Phone: 877-433-7643 Fax: 866-255-7569</td>
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<tr>
<td>Commercial Phone: 800-294-5979 Fax: 888-836-0730</td>
<td>Exchange Phone: 855-582-2022 Fax: 855-245-2134</td>
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<th>Medical Specialty Medications (NLX)</th>
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<tr>
<td>All Plans Phone: 844-345-2803 Fax: 844-851-0882</td>
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### Overview
Kesimpta 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.

### Coverage Guidelines
Authorization may be reviewed for members new to AllWays Health Partners who are currently receiving treatment with Kesimpta excluding when the product is obtained as samples or via manufacturer’s patient assistance programs.

**OR**
Authorization may be granted for members when ALL the following criteria are met, and documentation is provided:

1. The member has a diagnosis of relapsing forms of multiple sclerosis (including relapsing-remitting and secondary progressive disease who continue to experience relapse) OR clinically isolated syndrome
2. The member is ≥ 18 years of age
3. The member is not using Kesimpta with other disease modifying multiple sclerosis agents. (See Appendix A) (Note: Ampyra and Neudexta are not disease modifying)

### Continuation of Therapy
Reauthorization requires physician documentation of disease stability or improvement of member’s condition (ex. Decrease in relapses).

### Limitations
1. Initial approvals and reauthorizations will be for 12 months.
2. The following quantity limits apply:
Appendix

Appendix A: Disease Modifying Agents used for Multiple Sclerosis

1. Natalizumab (Tysabri)
2. Alemtuzumab (Lemtrada)
3. Ocrelizumab (Ocrevus)
4. Mitoxantrone (Novantrone)
5. Dimethyl fumarate (Tecfidera)
6. Diroximel fumarate (Vumerity)
7. Monomethyl fumarate (Bafiertam)
8. Teriflunomide (Aubagio)
9. Fingolimod (Gilenya)
10. Siponimod (Mayzent)
11. Ozanimod (Zeposia)
12. Cladribine (Mavenclad)
13. Interferon beta-1a (Avonex, Rebif)
14. Pegylated Interferon beta-1a (Plegridy)
15. Interferon beta-1b (Betaseron)
16. Glatiramer acetate (Copaxone, Glatopa)

References

Review History
01/23/2021 – Created and review Jan P&T; Effective 03/01/21

Disclaimer
AllWays Health Partners complies with applicable federal civil rights laws and does not discriminate or exclude people on the basis of race, color, national origin, age, disability, or sex.