

	
AETNA BETTER HEALTH® Coverage Policy/Guideline	
Name: Vumerity	Page: 1 of 2
Effective Date: 1/13/2025	Last Review Date: 12/2/2024
Applies to: <input checked="" type="checkbox"/> Illinois <input checked="" type="checkbox"/> Maryland <input checked="" type="checkbox"/> Florida Kids <input checked="" type="checkbox"/> Pennsylvania Kids <input checked="" type="checkbox"/> New Jersey	

### Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Vumerity under the patient's prescription drug benefit.

### Description:

#### FDA-Approved Indications

Vumerity is indicated for the treatment of relapsing forms of multiple sclerosis, to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.

All other indications are considered experimental/investigational and not medically necessary.

### Applicable Drug List:

Vumerity

### Policy/Guideline:

## I. CRITERIA FOR INITIAL APPROVAL

### A. Relapsing forms of multiple sclerosis

1. The patient is unable to take the required number of preferred formulary alternatives (3) for the given diagnosis due to a trial and inadequate treatment response, intolerance, or a contraindication.
2. Authorization may be granted to members who have been diagnosed with a relapsing form of multiple sclerosis (including relapsing-remitting and secondary progressive disease for those who continue to experience relapse).
  - a. Pediatric members less than 18 years of age may be granted authorization when benefits outweigh risks
3. Vumerity must be prescribed by or in consultation with a neurologist.
4. Members will not use Vumerity concomitantly with other disease modifying multiple sclerosis agents

Note: Ampyra and Nuedexta are not disease modifying.

### B. Clinically isolated syndrome

1. The patient is unable to take the required number of preferred formulary alternatives (3) for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication.



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2. Authorization may be granted to members for the treatment of clinically isolated syndrome.
  - a. Pediatric members less than 18 years of age may be granted authorization when benefits outweigh risks
3. Vumerity must be prescribed by or in consultation with a neurologist.
4. Members will not use Vumerity concomitantly with other disease modifying multiple sclerosis agents
  - a. Ampyra and Nuedexta are not disease modifying.

## II. CRITERIA FOR CONTINUATION OF THERAPY

### A. For all indications:

1. Authorization may be granted to members who are experiencing disease stability or improvement while receiving Vumerity.
2. Vumerity must be prescribed by or in consultation with a neurologist.
3. Members will not use Vumerity concomitantly with other disease modifying multiple sclerosis agents

Note: Ampyra and Nuedexta are not disease modifying.

### Approval Duration and Quantity Restrictions:

**Initial and Renewal Approval:** 12 months

**Quantity Level Limit:** 120 capsules per 30 days

### References:

1. Vumerity [package insert]. Cambridge, MA: Biogen; February 2023.