DR.003.E Ocrevus® (Ocrelizumab) and Ocrevus Zunovo ® (ocrelizumab-hyaluronidase ocsq)

Original Implementation Date : 06/01/2019
Version [E] Date : 10/05/2026
Last Reviewed Date: 08/19/2026

Thank you for being a valued provider for members in one or more of our health plans: Jefferson Health Plans Medicare Advantage, Jefferson Health Plans Individual and Family Plans, Jefferson Health Plans CHIP, and/or Jefferson Health Plans EverWell (our Medicaid plan).

***** NOTIFICATION OF PENDING POLICY IMPLEMENTATION *****

Please note that this Policy Bulletin will be implemented on 10/05/2026. This document provides a 30-day notification of its pending implementation and is not currently implemented.

PRODUCT VARIATIONS

This policy only applies to Jefferson Health Plans Medicare Advantage and Individual and Family Plans product lines.

POLICY STATEMENT

Jefferson Health Plans Medicare Advantage and Jefferson Health Plans Individual and Family Plans consider Ocrevus® and Ocrevus Zunovo® (Ocrelizumab-hyaluronidase ocsq) medically necessary for its FDA approved indications when the prior authorization criteria listed in this policy are met.

FDA APPROVED INDICATIONS

Ocrevus® (Ocrelizumab) and/or Ocrevus Zunovo® (ocrelizumab-hyaluronidase ocsq) are a CD20-directed cytolytic antibody used to treat:

- Adult patients with relapsing forms of multiple sclerosis (RMS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease.
- Primary progressive forms of multiple sclerosis (PPMS) in adults.

- Relapsing-remitting multiple sclerosis, in pediatric patients 10 years of age and older who weigh 25 kg or more

OFF-LABEL USE

Authorization for off-labeled use of medication will be evaluated on an individual basis. Review of an off-labeled request by the Medical Staff will be predicated on the appropriateness of treatment and full consideration of medical necessity. For off-label use, Medical Directors will review scientific literature and local practice patterns.

PRIOR AUTHORIZATION CRITERIA

INITIAL CRITERIA

*AUTHORIZATION DURATION: IF **ALL CRITERIA MET**, APPROVE FOR12 MONTHS*

1. Adults 18 years of age and older; **AND**
2. Medication is being prescribed by or in consultation with a specialist (who specializes in treatment of multiple sclerosis (MS) neurologist); **AND**
3. Patient is being treated for a diagnosis indicated in the U.S. Food and Drug Administration (FDA)-approved labeling or a medically accepted indication by a nationally recognized compendia or in peer-reviewed literature at a dose that is FDA approved
4. If patient is female and of childbearing potential, has documentation of recent negative pregnancy test; **AND**
5. For multiple sclerosis, medical records are attached showing the patient does not have a history of contraindication to Ocrevus®; **AND**
6. For relapsing forms of multiple sclerosis, medical records showing the patient tried and failed or has contraindications or intolerance to Tysabri **AND** at least 1 of preferred therapies including but not limited to (Avonex, Rebif, Betaseron®, Copaxone, Gilenya®, Tecfidera) including dates of use, dosage, directions, and treatment response. Failure of an adequate trial of therapy for multiple sclerosis is defined as follows:
    I. Having increasing relapses (defined as two or more relapses in a year, or one severe relapse associated with either poor recovery or MRI lesion progression); or
    II. Having lesion progression by MRI (increased number or volume of gadolinium-enhancing lesions, T2 hyperintense lesions or T1 hypointense lesions); or

III. The patient has worsening disability (sustained worsening of Expanded Disability Status Scale (EDSS) score or neurological examination findings); **AND**

7. Documentation that live-attenuated or live vaccines will not be administered during treatment or after discontinuation of Ocrelizumab until B-cell repletion. (Current recommendations- all necessary immunizations per guidelines should be administered at least 6 weeks prior to treatment initiation).
8. Please note: For members who are new to the plan and are already treated and stable with OCREVUS® or Ocrevus Zunovo® (records must be attached), the medication will be approved for continuation of 12 months.

RENEWAL CRITERIA

*AUTHORIZATION DURATION: **IF ALL RENEWAL CRITERIA MET**, APPROVE FOR 12 MONTHS*

1. Patient continues to meet criteria identified for initial approval; **AND**
2. The patient has had an improvement of symptoms or stabilization of MS disease course from baseline or documentation of positive clinical response. (Must attach documentation).

DOSAGE AND ADMINISTRATION

See package labeling.

RISK FACTORS/SIDE EFFECTS

See package labeling.

MONITORING

- Prior to therapy and during: Infections, liver functions (serum aminotransferases, alkaline phosphatase, and bilirubin levels), and Hepatitis B Virus screening.

- Monitor serum immunoglobulin levels at the beginning, during and after discontinuation of therapy.

- Monitor patients for
    - Signs and symptoms of progressive multifocal leukoencephalopathy (PML)
    - Immune-mediated colitis; monitor patients for new or persistent diarrhea or other gastrointestinal symptoms, and evaluate promptly if colitis is suspected
    - Signs and symptoms of any hepatic injury during treatment.

Ocrevus®, Ocrevus Zunovo (ocrelizumab-hyaluronidase ocsq) are contraindicated in patients with:

- Active hepatitis B virus infection
- History of life-threatening administration reaction to Ocrevus®, Ocrevus Zunovo (ocrelizumab-hyaluronidase ocsq)

BLACK BOX WARNING

N/A.

CLINICAL EVIDENCE

Relapsing Forms of MS

The efficacy of OCREVUS® was demonstrated in two randomized, double-blind, double-dummy, active comparator-controlled clinical trials of identical design, in patients with RMS treated for 96 weeks. The dose of OCREVUS® was 600 mg every 24 weeks (initial treatment was given as two 300 mg IV infusions administered 2 weeks apart, and subsequent doses were administered as a single 600 mg IV infusion) and placebo subcutaneous injections were given 3 times per week. The dose of REBIF (interferon beta-1a), the active comparator, was 44 mcg given as subcutaneous injections 3 times per week and placebo IV infusions were given every 24 weeks. The primary outcome of both Study 1 and Study 2 was the annualized relapse rate (ARR). Results for this outcome were as follows: 0.156 ARR for the Ocrevus® group compared to 0.292 ARR for the REBIF group in Study 1, and 0.155 ARR for the Ocrevus® group compared to 0.290 ARR for the REBIF group in Study 2 (both with a p-value under 0.0001). Of note, the MRI secondary endpoint for these two studies included the amount of new and/or enlarging T2

hyperintense lesions shown on MRI with 0.323 lesions in the Ocrevus® group and 1.413 lesions in the REBIF group.

Primary Progressive MS

Study 3 was a randomized, double-blind, placebo-controlled clinical trial in patients with PPMS. Patients were randomized 2:1 to receive either OCREVUS® 600 mg or placebo as two 300 mg intravenous infusions 2 weeks apart every 24 weeks for at least 120 weeks. In Study 3, the primary outcome was the time to onset of disability progression attributable to MS confirmed to be present at the next neurological assessment at least 12 weeks later. Disability progression occurred when the EDSS score increased by 1 point or more from the baseline EDSS if the baseline EDSS was 5.5 points or less, or by 0.5 points or more if the baseline EDSS was more than 5.5 points. Discontinuation of the study was also considered disability progression. The time to onset of disability progression confirmed at 12 weeks after onset was significantly longer for OCREVUS®-treated patients than for placebo-treated patients. With a risk reduction (RR) of 24% using a p-value of 0.0321. MRI results showed a mean decrease in T2 lesion volume for Ocrevus® of 0.39 and an increase of 0.79 for the placebo group (p-value under 0.0001). There is a limitation in this study where it is being compared to placebo and not to the standard of treatment for primary progressive MS.

BACKGROUND

N/A

CODING

***Note**: The Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), and the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) codes that may be listed in this policy are for reference purposes only. Listing of a code in this policy does not imply that the service is covered and is not a guarantee of payment. Other policies and coverage guidelines may apply. When reporting services, providers/facilities should code to the highest level of specificity using the code that was in effect on the date the service was rendered. This list may not be all inclusive.*

CPT Code	Description
N/A	N/A

HCPCS Code	Description
J2350	Injection, Ocrelizumab, 1 mg.
J2351	Injection, ocrelizumab, 1 mg and hyaluronidase-ocsq

ICD-10 Codes	Description
G35	Multiple sclerosis.

DISCLAIMER

Approval or denial of payment does not constitute medical advice and is neither intended to guide nor influence medical decision making. Policy Bulletins are developed to assist in administering plan benefits and constitute neither offers of coverage nor medical advice. This Policy Bulletin may be updated and therefore is subject to change.

POLICY HISTORY

This section provides a high-level summary of changes to the policy since the previous version.

Summary	Version	Version Date
2026 Annual review. Drug with HCPCS code added. Additions made to Policy statement and FDA indications. Revisions made to Initial and Renewal Criteria, Dosage & Administration, Risk factors and	E	08/19/2026

Side effects and Monitoring sections. References updated.		
2025 Annual review. Additions to risk factor, monitoring, clinical evidence and background sections.	D	04/24/2023
2024 Annual review. Minor revision to prior authorization criteria.	D	04/24/2023
2023 Annual review. Risk factors and reference sections were updated. (Minor revisions).	D	04/24/2023
2022 Annual review. No changes. Reissue as written.	C	04/01/2021
2021 Annual review. Prior authorization criteria made more specific to ask for trial of 3 agents including Tysabri.	C	04/01/2020
2020 Annual review. Prior Authorization criteria updated to be in alignment with FDA approved prescribing information/package labeling. Policy changed to "Medicare Only" line of business. References were updated accordingly.	B	05/01/2019
New policy.	A	06/01/2019

REFERENCES

1. Ocrevus package insert: https://www.gene.com/download/pdf/ocrevus_prescribing.pdf

2. Ocrevus® Prescribing Information. Genentech, INC. March 2023. Updated May 2026.

3. Ocrevus Zunovo package insert: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/761371s000lbl.pdf