AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Ponvory	Page:	1 of 2
Effective Date:	3/6/2025	Last Review Date:	2/2025

Applies to:	☐Illinois ☐Maryland ☐Michigan	☐Florida ☐Florida Kids ☐Virginia	☒New Jersey ☐Pennsylvania Kids

Intent:

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

Description:

FDA-Approved Indications

Ponvory 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:

Ponvory

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 (2) 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. Ponvory must be prescribed by or in consultation with a neurologist.
4. Members will not use Ponvory 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 (2) for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication.

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. Ponvory must be prescribed by or in consultation with a neurologist.
4. Members will not use Ponvory 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 Ponvory.
2. Ponvory must be prescribed by or in consultation with a neurologist.
3. Members will not use Ponvory 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:
Starter Pack: 1 Starter Pack (14 tablets) per 14 days
Maintenance dose: 20 mg tablet, 30 tablets per 30 days

References:

1. Ponvory [package insert]. Titusville, NJ: Janssen Pharmaceuticals, Inc; June 2024.