Louisiana Medicaid
Ponesimod (Ponvory®)

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for ponesimod (Ponvory®).

Additional Point-of-Sale edits may apply.

*This agent may have **Black Box Warnings**, and/or may be subject to **Risk Evaluation and Mitigation Strategy (REMS)** under FDA safety Regulations. Please refer to individual prescribing information for details.*

Approval Criteria

- The recipient has a diagnosis of multiple sclerosis; **AND**
- The recipient is 18 years of age or older on the date of the request; **AND**
- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a neurologist; **AND**
- Previous use of a preferred product - **ONE** of the following is required:
    - The recipient has had a *treatment failure* with at least one preferred product (see Multiple Sclerosis – Multiple Sclerosis Agents Immunomodulatory Agents on PDL); **OR**
    - The recipient has had an *intolerable side effect* to at least one preferred product (see Multiple Sclerosis – Multiple Sclerosis Agents Immunomodulatory Agents on PDL); **OR**
    - The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated (see Multiple Sclerosis – Multiple Sclerosis Agents Immunomodulatory Agents on PDL); **OR**
    - There is *no preferred product that is appropriate* to use for the condition being treated (see Multiple Sclerosis – Multiple Sclerosis Agents Immunomodulatory Agents on PDL); **AND**
- By submitting the authorization request, the prescriber attests to the following:
    - The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements; **AND**
    - All laboratory testing and clinical monitoring recommended in the prescribing information have been completed as of the date of the request and will be repeated as recommended; **AND**
    - The recipient has no concomitant drug therapies or disease states that limit the use of the requested medication and will not be receiving the requested medication in combination with any other medication that is contraindicated or not recommended per FDA labeling.

Reauthorization Criteria

- The recipient continues to meet all initial approval criteria; **AND**

- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy.

Duration of initial and reauthorization approval: 12 months

Reference

Ponvory (ponesimod) [package insert]. Titusville, NJ: Janssen Pharmaceuticals, Inc; March 2021. https://www.janssenlabels.com/package-insert/product-monograph/prescribing-information/PONVORY-pi.pdf

Revision / Date	Implementation Date
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