Mass General Brigham
Health Plan

Tascenso (fingolimod)
Effective 11/01/2025

Plan	☐ MassHealth UPPL ☒Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit		
Specialty Limitations	N/A		
Contact Information	**Medical and Specialty Medications** All Plans | Phone: 877-519-1908 | Fax: 855-540-3693		
	Non-Specialty Medications All Plans | Phone: 800-711-4555 | Fax: 844-403-1029		
Exceptions	N/A		

Overview
Tascenso (fingolimod) ODT (orally disintegrating tablet) is a sphingosine 1-phosphate receptor modulator 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 pediatric patients 10 years of age and older.

Coverage Guidelines
Authorization may be granted for members new to the plan within the past 90 days who are currently receiving treatment with the requested medication, excluding when the product is obtained as samples or via manufacturer's patient assistance programs.
OR
Approval will be granted if the member meets all of the following criteria:

1. Member is 10 years of age or older
2. Member has one of the following diagnoses:
    a. Clinically isolated syndrome
    b. Relapsing-remitting disease
    c. Active secondary progressive disease
3. Requested medication is prescribed by or in consultation with a neurologist
4. Member has had inadequate response, adverse reaction, or contraindication to fingolimod capsules

<u>Continuation of Therapy</u>
Requests for reauthorization will be approved when the following criteria are met:

1. Documentation the member is experiencing disease stability or improvement on the requested medication

Limitations

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

Drug Name and Dosage Form	Quantity Limit
Tascenso orally disintegrating tablet (ODT)	2 tablets per day

References

1. Tascenso ODT (fingolimod) [prescribing information]. Swindon, UK: Catalent Pharma Solutions; January 2025.

Review History

01/11/2023 – Created and Reviewed at January P&T. Effective 02/01/23
07/11/2025 – Reviewed and Updated at July P&T. Removed minimum weight requirement to align with updated FDA approved package labeling. Updated language for specialist prescribers. Updated reauthorization criteria to require documentation of improvement or disease stability. Effective 11/01/2025.