STANDARD COMMERCIAL DRUG FORMULARY
PRIOR AUTHORIZATION GUIDELINES

INTERFERONS FOR MULTIPLE SCLEROSIS

Generic	Brand	HICL	GCN	Medi-Span	Exception/Other
INTERFERON BETA-1A	AVONEX, AVONEX PEN	11253		GPI-10 (6240306045)	
INTERFERON BETA-1A/ALBUMIN	AVONEX, REBIF, REBIF REBIDOSE	23353			
INTERFERON BETA-1B	BETASERON, EXTAVIA	08537		GPI-10 (6240306050)	
PEGINTERFERON BETA-1A	PLEGRIDY, PLEGRIDY PEN	41331		GPI-10 (6240307530)	

****Please use the criteria for the specific drug requested ****

GUIDELINES FOR USE

PLEGRIDY, AVONEX, REBIF, BETASERON

1. Does the patient have a diagnosis of a relapsing form of multiple sclerosis, to include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease **AND** meet the following criterion?
   - The patient is 18 years of age or older

   If yes, **approve the requested drug as follows:**
   PLEGRIDY: Enter two prior authorizations by GPID or GPI-14 as follows:
   - **Plegridy injection starter pack: approve for 1 month with a quantity limit of 1mL (#2 prefilled pens or syringes), then**
   - **Plegridy Pen/Syringe: approve for 12 months with a quantity limit of 1mL (#2 125mcg prefilled pens or syringes) per 28 days.**

   (Approval directions continued on next page)

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INTERFERONS FOR MULTIPLE SCLEROSIS

GUIDELINES FOR USE - PLEGRIDY, AVONEX, REBIF, BETASERON (CONTINUED)

REBIF, AVONEX, or BETASERON: Approve for 12 months by GPID or GPI-14 as follows:

- **Rebif: 6mL (#12 syringes) per 28 days.**
- **Rebif Rebidose: 6mL (#12 syringes) per 28 days.**
- **Rebif for new starts only: approve for a total of 12 months by GPID or GPI-14 and enter two prior authorizations as follows:**
  - **Rebif Titration Pack: 1 month of 4.2mL (#12 syringes) per 28 days, then**
  - **Rebif: 6mL (#12 syringes) per 28 days (total approval duration is 12 months).**
  OR
  - **Rebif Rebidose Titration Pack: 1 month of 4.2mL (#12 syringes) per 28 days, then**
  - **Rebif Rebidose: 6mL (#12 syringes) per 28 days (total approval duration is 12 months).**
- **Avonex Administration Pack: #4 kits per 28 days.**
- **Avonex: #1 kit per 28 days or 2mL (#4 syringes) per 28 days.**
- **Avonex Pen: #1 pen injector kit per 28 days or 2mL (#4 syringes) per 28 days.**
- **Betaseron: #14 vials or kits per 28 days.**

If no, do not approve.
DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

Our guideline named **INTERFERONS FOR MULTIPLE SCLEROSIS (Plegridy, Avonex, Rebif, Betaseron)** requires the following rule(s) be met for approval:

A. You have a relapsing form of multiple sclerosis (MS: immune system eats away at protective covering of the nerves), to include clinically isolated syndrome (disease occurs once), relapsing-remitting disease (symptoms go away and return) and active secondary progressive disease (advanced disease)
B. You are 18 years of age or older

Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

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INTERFERONS FOR MULTIPLE SCLEROSIS

GUIDELINES FOR USE (CONTINUED)

EXTAVIA

1. Does the patient have a diagnosis of a relapsing form of multiple sclerosis, to include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease and meet **ALL** of the following criteria?
   - The patient is 18 years of age or older
   - The patient had a previous trial of or contraindication to any **TWO** of the following formulary preferred agents for MS: Avonex, Copaxone/Glatiramer/Glatopa, Gilenya, Plegridy, Rebif, Betaseron, dimethyl fumarate, Mavenclad, Mayzent, Vumerity, Aubagio, Kesimpta. (**Please note:** other MS agents may also require prior authorization)

   If yes, **approve Extavia for 12 months by GPID or GPI-14 for #14 vials or kits per 28 days.** If no, do not approve.
   DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

   Our guideline named **INTERFERONS FOR MULTIPLE SCLEROSIS (Extavia)** requires the following rule(s) be met for approval:
   A. You have a relapsing form of multiple sclerosis (MS: immune system eats away at protective covering of the nerves), to include clinically isolated syndrome (disease occurs once), relapsing-remitting disease (symptoms go away and return) and active secondary progressive disease (advanced disease)
   B. You are 18 years of age or older
   C. You have previously tried any TWO of the following preferred formulary drugs, unless there is a medical reason why you cannot (contraindication): Avonex, Copaxone/Glatiramer/Glatopa, Gilenya, Plegridy, Rebif, Betaseron, dimethyl fumarate, Mavenclad, Mayzent, Vumerity, Aubagio, Kesimpta (**Please note:** other MS agents may also require prior authorization)

   Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

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INTERFERONS FOR MULTIPLE SCLEROSIS

RATIONALE

For further information, please refer to the Prescribing Information and/or Drug Review for interferon products used for multiple sclerosis (MS).

REFERENCES

- Plegridy [Prescribing Information]. Cambridge, MA: Biogen Inc.; July 2019.
- Rebif [Prescribing Information]. Rockland, MA: EMD Serono, Inc.; July 2019.
- Avonex [Prescribing Information]. Cambridge, MA: Biogen Inc.; July 2019.
- Betaseron [Prescribing Information]. Whippany, NJ: Bayer; August 2019.
- Extavia [Prescribing Information]. East Hanover, NJ: EMD Novartis; August 2019.

Library	Commercial	NSA
Yes	Yes	No

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