**STANDARD COMMERCIAL DRUG FORMULARY**
**PRIOR AUTHORIZATION GUIDELINES**

**INTERFERON FOR MS - EXTAVIA**

| Generic | Brand | HICL | GCN | Medi-Span | Exception/Other |
|---|---|---|---|---|---|
| INTERFERON BETA-1B | EXTAVIA | 08537 | | GPI-10 (6240306050) | BRAND = EXTAVIA |

## GUIDELINES FOR USE

1. Does the patient have a diagnosis of a relapsing form of multiple sclerosis (MS), 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 trial of or contraindication to any TWO of the following preferred agents for MS: Avonex, Copaxone/Glatiramer/Glatopa, Gilenya, Plegridy, Rebif, Betaseron, dimethyl fumarate, Mavenclad, Mayzent, Vumerity, Aubagio, Kesimpta
     (Please note: other multiple sclerosis agents may also require prior authorization)

   If yes, **approve for 12 months for all NDCs or GPI-14 of Extavia 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 **INTERFERON FOR MS - EXTAVIA** requires the following rule(s) be met for approval:
   A. You have a relapsing form of multiple sclerosis (MS: a type of nerve disorder), 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 had a trial of or contraindication (harmful for) to any TWO of the following preferred medications: Avonex, Copaxone/Glatiramer/Glatopa, Gilenya, Plegridy, Rebif, Betaseron, dimethyl fumarate, Mavenclad, Mayzent, Vumerity, Aubagio, Kesimpta
      (Please note: other multiple sclerosis medications 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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## INTERFERON FOR MS - EXTAVIA

### RATIONALE

For further information, please refer to the Prescribing Information and/or Drug Monograph for Extavia.

### REFERENCES


- Extavia [Prescribing Information]. East Hanover, NJ: EMD Novartis; August 2019.


| Library | Commercial | NSA |
|---|---|---|
| Yes | Yes | No |

Part D Effective: N/A
Commercial Effective: 11/01/22
Created: 10/22
Client Approval: 10/22
P&T Approval: 01/20