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 (immune system eats away at protective covering of nerves and you have new or increasing symptoms), to include clinically isolated syndrome, relapsing-remitting disease (symptoms return and go away) 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, Tecfidera, Mavenclad, Mayzent, Vumerity, Aubagio. (**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 (immune system eats away at protective covering of nerves and you have new or increasing symptoms), to include clinically isolated syndrome, relapsing-remitting disease (symptoms return and go away) and active secondary progressive disease (advanced disease)
   B. You are 18 years of age or older
   C. You had a previous trial of any **TWO** of the following formulary preferred drugs, unless there is a medical reason why you cannot (contraindication): Avonex, Copaxone/Glatiramer/Glatopa, Gilenya, Plegridy, Rebif, Betaseron, Tecfidera, Mavenclad, Mayzent, Vumerity, Aubagio. (**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.

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