Beta Interferon Injectable
Prior Approval Criteria
December 2017

Avonex (interferon beta-1a)
Betaseron (interferon beta-1b)
Extavia (interferon beta-1b)
Plegridy (peginterferon beta-1a)
Rebif (interferon beta-1a)

OVERVIEW
Beta interferons are approved to be used for relapsing forms of Multiple Sclerosis (MS). The exact mechanism of action is unknown. Beta interferons are proteins and therefore injectable products. Beta interferons addressed in this policy include Avonex, Betaseron, Extavia, Plegridy, and Rebif. Dosing frequency varies between beta interferon products.

POLICY STATEMENT
Prior authorization is recommended for prescription benefit coverage of any of the above listed beta interferon products for MS. The above products may also follow the Multiple Sclerosis Preferred Specialty Management.

RECOMMENDED AUTHORIZATION CRITERIA
Coverage of is recommended in those who meet the following criteria.

1. **Relapsing Forms of Multiple Sclerosis (MS) in Patients Who Are Not Currently Receiving a Beta Interferon.** Approve for patients who meet the following criteria (a, b, and c):
   a) Patient is 18 years of age or older; AND
   b) The patient has a relapsing form of MS OR secondary progressive multiple sclerosis (SPMS) and the patient is experiencing relapses OR the current (first) clinical episode is consistent with multiple sclerosis, including the presence of demyelination, and magnetic resonance imaging (MRI) findings demonstrate a high probability of clinically definite multiple sclerosis (CDMS); AND
   c) The agent is prescribed by, or in consultation with, a neurologist or a physician who specializes in the treatment of MS.

2. **Relapsing Forms of Multiple Sclerosis (MS) in Patients Who Are Currently Receiving a Beta Interferon or Who Have Received the requested Beta Interferon in the Past.** Approve if the patient meets the following criteria (a, b, c and d):
   a) Patient is 18 years of age or older; AND
   b) The patient has a relapsing form of MS, secondary progressive multiple sclerosis (SPMS) and the patient is experiencing relapses OR the current (first) clinical episode is consistent with multiple sclerosis, including the presence of demyelination, and magnetic resonance imaging (MRI) findings demonstrate a high probability of clinically definite multiple sclerosis (CDMS)
c) The agent is prescribed by, or in consultation with, a neurologist or a physician who specializes in the treatment of MS.

d) The patient has had beneficial response to the requested medication.

**CONDITIONS NOT RECOMMENDED FOR APPROVAL**

Coverage of beta interferons is recommended in circumstances that are listed above. The following provides rationale for specific Exclusions. This is not an exhaustive list of Exclusions.

1. Concurrent use of a Beta Interferon with Other Disease-Modifying Agents Used for Multiple Sclerosis (MS) (e.g., another interferon beta-1a injection [Avonex®, Plegridy®, Rebif®] or interferon beta-1b injection [Betaseron®, Extavia®], glatiramer acetate injection [Copaxone®, Glatopa™], natalizumab injection for intravenous use [Tysabri®], teriflunomide tablets [Aubagio®], alemtuzumab injection for intravenous use [Lemtrada®], daclizumab [Zinbryta®], ocrelizumab [Ocrevus®], and dimethyl fumarate delayed-release capsules [Tecfidera®]). These agents are not indicated for use in combination. Studies regarding combination use of beta interferons with other disease-modifying agents used for MS have not been done.

**Approval Duration**

Approval = 365 days (1 year)

**References**

- Extavia® injection for subcutaneous use [prescribing information]. East Hanover, NJ: Novartis; May 2016.