Premier Health Plan

POLICY AND PROCEDURE

POLICY TITLE: **Multiple Sclerosis Interferons**
DEPARTMENT: **Clinical Pharmacy Services – Utilization Management**
ORIGINAL DATE: ***September 2018***

Last P & T Committee Approval Date: *September 2018*

Product Applicability: *mark all applicable products below:*

COMMERCIAL	[ ] HMO	[ ] PPO	*Products*: [ ] Small [ ] Indiv. [ ] Large	*Exchange*: [ ] Shop [ ] Indiv.	[x] All
OTHER	[x] Self-funded/ASO				

PURPOSE

The purpose of this policy is to define the prior authorization process for formulary interferons used in the treatment of multiple sclerosis.

Avonex® (interferon beta-1a) is indicated for the treatment of patients with relapsing forms of multiple sclerosis to slow the accumulation of physical disability and decrease the frequency of clinical exacerbations. Patients with multiple sclerosis in whom efficacy has been demonstrated include patients who have experienced a first clinical episode and have MRI features consistent with multiple sclerosis.

Rebif® (interferon beta-1a) is indicated for the treatment of patients with relapsing forms of multiple sclerosis to decrease the frequency of clinical exacerbations and delay the accumulation of physical disability.

Betaseron® (interferon beta-1b) is indicated for the treatment of relapsing forms of multiple sclerosis to reduce the frequency of clinical exacerbations. Patients with multiple sclerosis in whom efficacy has been demonstrated include patients who have experienced a first clinical episode and have MRI features consistent with multiple sclerosis.

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Plegridy® (peginterferon beta-1a) is indicated for the treatment of patients with relapsing forms of multiple sclerosis.

DEFINITIONS

N/A

POLICY

It is the policy of the Health Plan to maintain a prior authorization process that promotes appropriate utilization of specific drugs with potential for misuse or limited indications. This process involves a review using Food and Drug Administration (FDA) criteria to make a determination of Medical Necessity, and approval by the Pharmacy & Therapeutics Committee of the criteria for prior authorization, as described in RX.002 Pharmacy and Therapeutics Committee and RX.003-Prior Authorization Process.

The formulary interferons used in the treatment of multiple sclerosis are subject to the prior authorization process.

Please Note: Betaseron is covered without prior authorization on the exchange formularies

PROCEDURE

Initial Authorization Criteria:

Must meet all of the criteria listed below:

- Must be prescribed by or in consultation with a neurologist
- Must have a diagnosis of relapsing form of multiple sclerosis
- Must be age 18 years or older
- Must not be receiving concomitant therapy with another disease-modifying therapy (DMT)

Reauthorization Criteria:

All prior authorization renewals are reviewed to determine the Medical Necessity for continuation of therapy. Authorization may be extended based upon:

- Documentation from the provider that the member's disease course has stabilized or improved based upon the prescriber's assessment while on therapy
- Documentation that the member's complete blood count (CBC) and liver function tests (LFTs) are being monitored consistently
- Documentation that the member is not receiving concomitant therapy with

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another disease-modifying therapy (DMT)

Limitations:

Length of Authorization (if above criteria met)	
Initial Authorization	Up to 6 months
Reauthorization	Up to 1 year
Quantity Level Limit	
Avonex	1 kit (4 vials/syringes/pens) per 28 days
Betaseron	15 vials per 30 days
Plegridy	2 syringes/pens (1 mL) per 28 days
Plegridy Starter Pack	1 pack (1 mL) per lifetime
Rebif	12 syringes/pens (6 mL) per 28 days
Rebif titration pack	1 pack (4.2 mL) per lifetime

If the established criteria are not met, the request is referred to a Medical Director for review.

REFERENCES

1. Avonex (interferon beta-1a) [prescribing information]. Cambridge, MA: Biogen Idec Inc; March 2016.
2. Betaseron (interferon beta-1b) [prescribing information]. Whippany, NJ: Bayer HealthCare Pharmaceuticals Inc; August 2018.
3. Plegridy (peginterferon beta-1a) [prescribing information]. Cambridge, MA: Biogen Idec Inc; July 2016.
4. Rebif (interferon beta-1a) [prescribing information]. Rockland, MA: EMD Serono Inc; November 2015.

RECORD RETENTION
Records Retention for Evolent Health documents, regardless of medium, are provided within the Evolent Health records retention policy and as indicated in CORP.028.E Records Retention Policy and Procedure.

REVIEW HISTORY

DESCRIPTION OF REVIEW / REVISION	DATE APPROVED
New Policy	*09/18 (effective 1/1/19)*

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