Premier Health Plan

POLICY AND PROCEDURE

POLICY TITLE: ***Rebif (interferon beta-1a) and Betaseron (interferon beta-1b) Step***
DEPARTMENT: **Clinical Pharmacy Services- Utilization Management**
ORIGINAL DATE: ***April 2011 (as adopted from UPMC Health Plan)***

Last P & T Committee Approval Date: *February 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 Rebif (interferon beta-1a) and Betaseron (interferon beta-1b).

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.

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 drugs, Rebif (interferon beta-1a) and Betaseron (interferon beta-1b), are subject to the prior authorization process.

PROCEDURE

Initial Authorization Criteria:

Must meet all of the criteria listed under the applicable header:

- For automated coverage of the requested interferon product, must have a documented pharmacy claim history of prior therapy with ONE of the following multiple sclerosis therapies:
  - glatiramer (Copaxone®)
  - Dimethyl fumarate (Tecfidera)

- For members without a documented claim history of one of the above listed therapies, the following criteria must be met:
  - Must have chart documentation which shows that the member has failed or has an intolerance to ONE of the following multiple sclerosis therapies:
  - glatiramer (Copaxone)
  - Dimethyl fumarate (Tecfidera)

Limitations:

Length of Authorization (if above criteria met)	
Initial Authorization	Up to duration of member's membership with plan
Reauthorization	N/A
Quantity Level Limit	
Rebif	12 pre-filled syringes per month
Rebif titration pack	1 pack per lifetime
Betaseron	1 box of 15 vials per month

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

REFERENCES

1. Goodin, DS, Frohman EM, Garmany GP, et al. Disease modifying therapies in multiple sclerosis: Report of the Therapeutics and Technology Assessment Subcommottee of the American Academy of Neurology and the MS Council for Clinical Practice Guidelines. Neurology 2002;58:170-178.
2. Betaseron [package insert]. Montville, NJ: Bayer HealthCare Pharmaceuticals; May 2010.
3. Copaxone [package insert]. Kansas City, MO: TEVA Pharmaceuticals; February 2009.
4. Rebif [package insert]. New York, NY: Pfizer Inc;September 2009.

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
Annual review	*02/16, 02/17, 02/18*
Criteria update	*10/16, 01/18*