Premier Health Plan

POLICY AND PROCEDURE

POLICY TITLE: ***Alferon N (interferon alfa-n3)***
DEPARTMENT: **Clinical Pharmacy Services- Utilization Management**
ORIGINAL DATE: ***September 2013 (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 Alferon N (interferon alfa-n3).

Alferon N (interferon alfa-n3) is indicated for the intralesional treatment of refractory or recurring external condylomata acuminata in patients 18 years of age or older.

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 drug, Alferon N (interferon alfa-n3), is subject to the prior authorization process.

PROCEDURE

Initial Authorization Criteria:

Must meet all of the criteria listed below:

- Must be age 18 years or older
- Must have a diagnosis of refractory or recurring external condylomata acuminata
- Must have an adequate trial and failure of a chemical agent (podophyllin, trichloroacetic acid, or 5-fluoruracil epinephrine gel) AND imiquimod with an inadequate response or significant side effects/toxicity or must have a contraindication to these therapies

Reauthorization Criteria:

All prior authorization renewals are reviewed on a case-by-case basis to determine the Medical Necessity for continuation of therapy. Authorization may be extended for an additional 2-month course based upon chart documentation from the prescriber that the member's condition has recurred and requires additional treatment.

Limitations:

Length of Authorization (if above criteria met)	
Initial Authorization	Up to 2 months
Reauthorization	Up to 2 months

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

REFERENCES

1. Alferon N [prescribing information]. Hemispherx Biopharma, Inc. http://www.hemispherx.net/content/products/alferon_insert.htm. Accessed July 26, 2013.
2. Friedman-Kien, AE; Eron, LJ; Conant, M; et al., JAMA 1988; 259:533-538.
3. Kirby, P, (editorial comment), JAMA 1988; 259:570-572.
4. Friedman-Kien, AE; Plasse, TF; et al., Papilloma Viruses: Molecular and Clinical Aspects [Howley, PM, Broker, TR (eds)], New York, Alan R. Liss, Inc.; 1986; 217-233.
5. Geffen, JR; Klein, RJ; Friedman-Kien, AE, J. Infect. Dis. 1984; 150:612-615.
6. Breen E and Bleday R. Condylomata acuminata (anogenital warts). UpToDate. Accessed 7/31/2013

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	*02/17, 02/18*