

Pharmacy Policy Bulletin: J-1203 Interferon Beta - Commercial and Healthcare Reform	
Number: J-1203	Category: Prior Authorization
Line(s) of Business: ☒ Commercial ☒ Healthcare Reform ☐ Medicare	Benefit(s): Commercial: Prior Authorization (1.): 1. Miscellaneous Specialty Drugs Injectable = Yes w/ Prior Authorization Healthcare Reform: Not Applicable
Region(s): ☒ All ☐ Delaware ☐ New York ☐ Pennsylvania ☐ West Virginia	Additional Restriction(s): None
Version: J-1203-005	Original Date: 04/06/2022
Effective Date: 04/25/2025	Review Date: 04/09/2025

Drugs Product(s):	• Avonex (interferon beta-1a) • Betaseron (interferon beta-1b) • Plegridy (peginterferon beta-1a) • Rebif (interferon beta-1a)
FDA-Approved Indication(s):	• Treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults

Background:	• The mechanism by which interferon beta exerts its effects in patients with multiple sclerosis is unknown. • Clinically isolated syndrome is the first episode of neurological symptoms caused by inflammation and demyelination in the central nervous system. Relapsing-remitting MS (RRMS) is characterized by clearly defined attacks of new or increasing neurologic symptoms. The attacks are followed by periods of partial or complete recovery (remissions). Secondary progressive disease follows an initial relapsing remitting course, with disability gradually increasing over time. • Prescribing Considerations: ○ Analgesics and/or antipyretics on treatment days may help ameliorate flu-like symptoms.
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Approval Criteria

I. Initial Authorization

A. Avonex, Betaseron, Plegridy, and Rebif

When a benefit, coverage of Avonex, Betaseron, Plegridy, or Rebif may be approved when all of the following criteria are met **(1. and 2.)**:

1. The member is 18 years of age or older.
2. The member has a diagnosis of multiple sclerosis (ICD-10: G35), classified as one (1) of the following **(a., b., or c.)**:
 - a. Clinically isolated syndrome

- b. Relapsing-remitting disease
- c. Active secondary progressive disease

II. Reauthorization

When a benefit, reauthorization of Avonex, Betaseron, Plegridy, or Rebif may be approved when the following criterion is met **(A.)**:

- A. The prescriber attests that the member has experienced a therapeutic response defined as one (1) of the following **(1., 2., or 3.)**:
 - 1. Disease stability
 - 2. Disease improvement
 - 3. Delayed disease progression

- III. An exception to some or all of the criteria above may be granted for select members and/or circumstances based on state and/or federal regulations.

Limitations of Coverage

- I. Coverage of drug(s) addressed in this policy for disease states outside of the FDA-approved indications should be denied based on the lack of clinical data to support effectiveness and safety in other conditions unless otherwise noted in the approval criteria.
- II. For Commercial or HCR members with a closed formulary, a non-formulary product will only be approved if the member meets the criteria for a formulary exception in addition to the criteria outlined within this policy.

Authorization Duration

- Commercial and HCR Plans: If approved, up to a 12 month authorization may be granted.

Automatic Approval Criteria

None

References:

- 1. Avonex [package insert]. Cambridge, MA: Biogen Inc; July 2023.
- 2. Betaseron [package insert]. Whippany, NJ: Bayer HealthCare Pharmaceuticals Inc.; July 2023.
- 3. Plegridy [package insert]. Cambridge, MA: Biogen Inc.; July 2023.
- 4. Rebif [package insert]. Rockland, MA: EMD Serono, Inc.; July 2023.
- 5. National Multiple Sclerosis Society. Types of MS. Available at: <https://www.nationalmssociety.org/What-is-MS/Types-of-MS>. Accessed February 12, 2025.

Pharmacy policies do not constitute medical advice, nor are they intended to govern physicians' prescribing or the practice of medicine. They are intended to reflect the plan's coverage and reimbursement guidelines. Coverage may vary for individual members, based on the terms of the benefit contract.

The plan retains the right to review and update its pharmacy policy at its sole discretion. These guidelines are the proprietary information of the plan. Any sale, copying or dissemination of the pharmacy policies is prohibited; however, limited copying of pharmacy policies is permitted for individual use.