Commercial/Healthcare Exchange PA Criteria

Effective: January 1, 2019

Prior Authorization: Betaseron

Products Affected: Betaseron (interferon beta-1b, subcutaneous)

Medication Description: Systemic interferon beta-1b is useful for reducing symptomatic exacerbation in multiple sclerosis patients with relapsing-remitting or active relapsing-progressive disease. The preparation should be considered in patients with clinically-definite or laboratory-supported definite disease. It is not indicated in those patients with primary progressive MS.

Covered Uses: Betaseron is indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.

Exclusion Criteria: Patients with a history of hypersensitivity to natural or recombinant interferon beta, Albumin (Human), or any other component of the formulation.

Required Medical Information: Diagnosis

Age Restrictions: 18 years of age or older

Prescriber Restrictions: Prescribed by, or in consultation with, a neurologist or a physician that specializes in MS.

Coverage Duration: 3 years

Other Criteria:

A. Patient has a diagnosis of any of the following relapsing forms of Multiple Sclerosis:
    a. Progressive-relapsing multiple sclerosis (PRMS); OR
    b. Relapsing-remitting multiple sclerosis (RRMS); OR
    c. Secondary progressive multiple sclerosis (SPMS) with documented relapses; OR
    d. Clinically isolated syndrome

References:

1. BETASERON subcutaneous injection, interferon beta 1b subcutaneous injection. Bayer HealthCare Pharmaceuticals Inc. (per manufacturer), Whippany, NJ, 2016.

Policy Revision history

Rev #	Type of Change	Summary of Change	Sections Affected	Date
1	New Policy	New Policy	All	01/01/2019
2	Update	Update	Coverage Duration: Update to 3 years	07/01/2019
3	Update	Adopted EH policy and template Removed from CCI MS Drug policy Updated indications (CIS) to match FDA Label	All	6/2/2020