Commercial/Healthcare Exchange PA Criteria

Effective: October 2014

Prior Authorization: Plegridy

Products Affected: Plegridy (peginterferon beta-1a injection, subcutaneous)

Medication Description: Plegridy is an interferon beta 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.

Covered Uses: Treatment of relapsing forms of multiple sclerosis (to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease) to reduce the frequency of clinical exacerbations

Exclusion Criteria:

1. Patients with a history of hypersensitivity to natural or recombinant interferon beta or peginterferon, or any other component of the formulation.
2. Concurrent use of Plegridy with other disease-modifying agents used for multiple sclerosis (MS).

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 (CIS)

References:

1. PLEGRIDY(TM) subcutaneous injection solution, peginterferon beta-1a subcutaneous injection solution. Biogen Idec Inc. (per FDA), Cambridge, MA, 2014.

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	CCI Adoption of EH policy and template	All	6/8/2020