Commercial/Healthcare Exchange PA Criteria

Effective: December 2005

Prior Authorization: Rebif

Products Affected: Rebif (interferon beta-1a, subcutaneous)

Medication Description: Interferon beta-1a is a purified glycoprotein which has an identical amino acid sequence as natural fibroblast-derived human interferon beta. Interferons are cytokines that mediate antiviral, antiproliferative, and immunomodulatory activities. The mechanism of action of interferon beta-1a in the treatment of multiple sclerosis is unknown.

Covered Uses: Rebif 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:

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

Required Medical Information: Diagnosis

Age Restrictions: 18 years of age and older

Prescriber Restrictions: Prescribed by, or in consultation with, a neurologist or physician who specializes in the treatment of 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. Rebif(R) subcutaneous injection, interferon beta-1a subcutaneous injection. EMD Serono, Inc., Rockland, MA, 2009.

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