Betaseron (interferon beta-1b) is a **non-preferred** product and will only be considered for coverage under the pharmacy benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

### RELAPSING-REMITTING MULTIPLE SCLEROSIS, SECONDARY PROGRESSIVE MULTIPLE SCLEROSIS

For **initial** authorization:
1. Medication must be prescribed by, or in consultation with, or under the guidance of a neurologist; AND
2. Chart notes have been provided confirming diagnosis of Multiple Sclerosis; AND
3. Documentation of trial and failure of or contraindication to Avonex, Copaxone/Glatopa, Extavia, or Rebif for at least 90 days submitted with chart notes.
4. **Dosage allowed:** Start 0.0625 mg (0.25 mL) subcutaneously every other day for week 1 and 2; then 0.125 mg (0.5 mL) subcutaneously every other day for week 3 and 4; then 0.1875 mg (0.75 mL) subcutaneously every other day week 5 and 6; then 0.25 mg (1 mL) subcutaneously every other day for week 7 and thereafter.

*If member meets all the requirements listed above, the medication will be approved for 12 months.*

For **reauthorization**:
1. Member has documented biological response to treatment.

*If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.*

CareSource considers Betaseron (interferon beta-1b) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Clinically Isolated Syndrome (CIS) in Multiple Sclerosis

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**DATE** | **ACTION/DESCRIPTION**
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06/13/2017 | New policy for Betaseron created. Not covered diagnosis added.
12/06/2017 | Confirmation of diagnosis based on McDonald criteria is no longer required.
References:


Effective date: 12/20/2017
Revised date: 12/06/2017