PHARMACY POLICY STATEMENT **Kentucky Medicaid**	
DRUG NAME	Extavia (interferon beta-1b)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— 14 mL in 28 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Extavia (interferon beta-1b) is a **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.
3. **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 Extavia (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

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

References:

1. Extavia [package insert]. East Hanover, NJ; Novartis Pharmaceuticals Corporation: Revised May 2016.
2. Extavia. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: http://www.micromedexsolutions.com. Accessed April 7, 2017.
3. Goodin DS, Frohman EM, Garmany GP Jr, et al. Disease modifying therapies in multiple sclerosis: report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology and the MS Council for Clinical Practice Guidelines. Neurology. 2002 Jan;58(2):169-78.
4. Polman CH, Reingold SC, Banwell B, et al. Diagnostic criteria for multiple sclerosis: 2010 Revisions to the McDonald criteria. Annals of Neurology. 2011;69(2):292-302. doi:10.1002/ana.22366.

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