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

<table>
<thead>
<tr>
<th>DATE</th>
<th>ACTION/DESCRIPTION</th>
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</thead>
<tbody>
<tr>
<td>06/13/2017</td>
<td>New policy for Extavia created. Not covered diagnosis added.</td>
</tr>
<tr>
<td>12/06/2017</td>
<td>Confirmation of diagnosis based on McDonald criteria is no longer required.</td>
</tr>
</tbody>
</table>

References:
1. Extavia [package insert], East Hanover, NJ; Novartis Pharmaceuticals Corporation: Revised May 2016.

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