



## PHARMACY POLICY STATEMENT Kentucky Medicaid

DRUG NAME	Avonex (interferon beta-1a)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) Alternative preferred product includes Rebif QUANTITY LIMIT – 120 mcg per month
LIST OF DIAGNOSES CONSIDERED <b>NOT</b> MEDICALLY NECESSARY	<a href="#">Click Here</a>

Avonex (interferon beta-1a) 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 based on McDonald Diagnostic Criteria.
3. **Dosage allowed:** 30 mcg once weekly.

***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 Avonex (interferon beta-1a) 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:**

- Multiple Sclerosis - Clinically isolated syndrome (CIS)

DATE	ACTION/DESCRIPTION
06/13/2017	New policy for Avonex created. Not covered diagnosis added.

References:

1. Avonex [package insert]. Cambridge, MA: Biogen Inc.; March 2016.



2. Avonex. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: <http://www.micromedexsolutions.com>. Accessed March 16, 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: 08/09/2017

Revised date: 06/13/2017