SPECIALTY GUIDELINE MANAGEMENT

PLEGRIDY (peginterferon beta-1a)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications are considered covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indication: Plegridy is indicated for the treatment of patients with relapsing forms of multiple sclerosis.

All other indications are considered experimental/investigational and are not covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

Authorization of 24 months may be granted to members who have been diagnosed with a relapsing form of multiple sclerosis.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCE

1. Plegridy [package insert]. Cambridge, MA: Biogen Idec Inc.; October 2015.