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CareSource™

PHARMACY POLICY STATEMENT **Kentucky Medicaid**	
DRUG NAME	Plegridy (peginterferon beta-1a)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— 2 per 28 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Plegridy (peginterferon beta-1a) 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 based; AND
3. Documentation of trial and failure of or contraindication to Avonex, Copaxone/Glatopa, Extavia, or Rebif for at least 30 days submitted with chart notes.
4. **Dosage allowed:** Initial, 63 mcg subcutaneously on day 1, then 94 mcg on day 15, then 125 mcg on day 29; continue 125 mcg every 14 days 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 Plegridy (peginterferon 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:

- Clinically Isolated Syndrome (CIS) in Multiple Sclerosis

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

References:

1. Plegridy [package insert]. Cambridge, MA; Biogen Inc.: Revised July 2016.
2. Plegridy. 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