CareSource

PHARMACY POLICY STATEMENT
Indiana Medicaid

DRUG NAME	Rebif (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 Avonex QUANTITY LIMIT— 12 per 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Rebif (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:** 22 mcg or 44 mcg 3 times per week.

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 Rebif (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
06/07/2017	New policy for Rebif created. Not covered diagnosis added.

References:

1. Rebif [package insert]. Rockland, MA: EMD Serono Inc.; November, 2015.
2. Rebif. 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: 11/01/2017
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