Drug Therapy Guidelines

Multiple Sclerosis (MS) Self-Injectable Agents: Avonex®, Betaseron®, Copaxone®, Extavia®, glatopa™, Plegridy™, Rebif®

<table>
<thead>
<tr>
<th>Medical Benefit</th>
<th>Effective: 7/19/16</th>
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<tbody>
<tr>
<td>Pharmacy- Formulary 1</td>
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<td>Pharmacy- Formulary 2</td>
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<tr>
<td>Pharmacy- Formulary 4/AON</td>
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<tr>
<td>Pharmacy- Medicaid</td>
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I. Medication Description

Interferons are cytokines that mediate antiviral, antiproliferative and immunomodulatory activities in response to viral infection and other biological inducers. Three major interferons have been distinguished: alpha, beta, and gamma. Interferon beta inhibits the expression of pro-inflammatory cytokines including INF-G, which is believed to be a major factor responsible for triggering the autoimmune reaction leading to multiple sclerosis.

Glatiramer acetate is thought to act by modifying immune processes that are believed to be responsible for the pathogenesis of multiple sclerosis. The exact mechanism of action is unknown; however it is proposed that the drug serves as a decoy to locally-generated autoantibodies. These antibodies, along with certain T-cells, are thereby neutralized before they can cause tissue damage.

II. Position Statement

**Formulary 1**: Coverage of Avonex, Copaxone, glatopa, Plegridy, or Rebif is provided immediately when prescribed by a neurologist.

**Formulary 2**: Coverage of Avonex, Copaxone, glatopa, or Rebif is provided immediately when prescribed by a neurologist.

**Formulary 3/Exclusive**: Coverage of Avonex, Copaxone, glatopa, or Rebif is provided immediately when prescribed by a neurologist.

**Formulary 4/AON**: Coverage of Avonex, Copaxone, glatopa, or Rebif is provided immediately when prescribed by a neurologist.

**Medicaid**: Coverage is provided immediately when prescribed by a neurologist.

Coverage for all other requests is determined through a prior authorization process with supporting clinical documentation.

III. Policy

**Formulary 1**: See Sections A, C, and E

**Formulary 2**: See Sections A, B, and D

**Formulary 3/Exclusive**: See Sections A, B, and D

**Formulary 4/AON**: See Sections A, B, and D

**Medicaid**: See Section A

A. Coverage is provided when one of the following is true:
• Medication is prescribed by a neurologist for the treatment of a relapsing form of multiple sclerosis (MS) OR
• A neurology consult documenting a diagnosis of a relapsing form of MS is provided

B. Coverage of Betaseron or Plegridy is provided when the patient has had a documented trial with at least one preferred agent (Avonex, Copaxone, glatopa, or Rebif) that has resulted in treatment failure or intolerable side effects.

C. Coverage of Betaseron is provided when the patient has had a documented trial with at least one preferred agent (Avonex, Copaxone, glatopa, Plegridy, or Rebif) that has resulted in treatment failure or intolerable side effects.

D. Coverage of Extavia is provided when:
   • Member has had a documented trial with at least one preferred agent (Avonex, Copaxone, glatopa, or Rebif) that has resulted in treatment failure or intolerable side effects **AND**
   • Member has had a documented intolerance or contraindication to Betaseron (that would not be expected to pertain to Extavia)

E. Coverage of Extavia is provided when:
   • Member has had a documented trial with at least one preferred agent (Avonex, Copaxone, glatopa, Plegridy, or Rebif) that has resulted in treatment failure or intolerable side effects **AND**
   • Member has had a documented intolerance or contraindication to Betaseron (that would not be expected to pertain to Extavia)

IV. **Quantity Limitations**

Quantities are available for up to the maximum FDA-approved dosage of each individual agent.

V. **Coverage Duration**

Coverage is provided indefinitely. Approval for only one agent in this policy will be granted at a time.

VI. **Coverage Renewal Criteria**

n/a

VII. **Billing/Coding Information**

Pertinent diagnosis: Multiple sclerosis (G35)

VIII. **Summary of Policy Changes**

• 7/1/11: Addition of step therapy criteria to Extavia and Rebif
• 6/15/12: Rebif moved to preferred status; Betaseron moved to non-preferred status
• 6/15/13: referred to individual PI for most warning information
• 7/1/13: Medicaid/FHP criteria differentiated
• 8/15/13: Medicaid/FHP prescriptions written by a neurologist do not require prior authorization.
The Plan fully expects that only appropriate and medically necessary services will be rendered. The Plan reserves the right to conduct pre-payment and post-payment reviews to assess the medical appropriateness of the above-referenced therapies.

Drug therapy initiated with samples will not be considered as meeting medical necessity for coverage for non-preferred or prior authorized medications.

The preceding policy applies only to members for whom the above named pharmacy benefit medications are included on their covered formulary. Members with closed formulary benefits are subject to trying all appropriate formulary alternatives before a coverage exception for a non-formulary agent will be considered.

The preceding policy is a guideline to allow for coverage of the pertinent medication/product, and is not meant to serve as a clinical practice guideline.

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<th>Last Review Date: 6/2016</th>
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<tbody>
<tr>
<td>• 6/15/14: no policy changes</td>
<td>• 10/31/14: Plegridy added to policy</td>
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<tr>
<td>• 7/1/15: formulary distinctions made</td>
<td>• 9/15/15: no policy changes</td>
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<tr>
<td>• 10/1/15: glatopa added to policy; ICD9 references removed</td>
<td>• 7/19/16: no policy changes</td>
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IX. References