



## Commercial/Healthcare Exchange PA Criteria *Effective: January 1, 2019*

**Prior Authorization:** Avonex

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

**Medication Description:** Avonex (interferon beta-1a) is indicated for the treatment of relapsing forms of multiple sclerosis to slow the accumulation of physical disability and decrease the frequency of clinical exacerbations. Efficacy has been demonstrated in patients including those who have experienced a first clinical episode and have MRI features consistent with multiple sclerosis.

**Covered Uses:** Avonex is for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults

**Exclusion Criteria:** Concurrent use of other disease-modifying agents used for multiple sclerosis (MS)

**Required Medical Information:** Diagnosis

**Age Restrictions:** 18 years of age or older

**Prescriber Restrictions:** Prescribed by, or in consultation with, a neurologist or physician who specializes in the treatment of MS.

**Coverage Duration:** 3 years

**Other Criteria:**

- A. Patient has a diagnosis of any of the following relapsing forms of Multiple Sclerosis:
  - a. Progressive-relapsing multiple sclerosis (PRMS); OR
  - b. Relapsing-remitting multiple sclerosis (RRMS); OR
  - c. Secondary progressive multiple sclerosis (SPMS) with documented relapses; OR
  - d. Clinically isolated syndrome

**References:**

1. AVONEX intramuscular injection, interferon beta-1a intramuscular injection. Biogen Idec Inc. (per manufacturer), Cambridge, MA, 2015.



Policy Revision history

Rev #	Type of Change	Summary of Change	Sections Affected	Date
1	New Policy	New Policy	All	01/01/2019
2	Update	Update	Coverage Duration: Update to 3 years	07/01/2019
3	Update	Adopted EH Policy and template; Removed from CCI MS Drugs Policy; Updated indication to include CIS	All	6/2/2020