



## Commercial/Healthcare Exchange PA Criteria *Effective: October 2014*

**Prior Authorization:** Plegridy

**Products Affected:** Plegridy (peginterferon beta-1a injection, subcutaneous)

**Medication Description:** Plegridy is an interferon beta indicated 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.

**Covered Uses:** Treatment of relapsing forms of multiple sclerosis (to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease) to reduce the frequency of clinical exacerbations

**Exclusion Criteria:**

1. Patients with a history of hypersensitivity to natural or recombinant interferon beta or peginterferon, or any other component of the formulation.
2. Concurrent use of Plegridy with 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 a physician that specializes in 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 (CIS)

**References:**

1. PLEGRIDY(TM) subcutaneous injection solution, peginterferon beta-1a subcutaneous injection solution. Biogen Idec Inc. (per FDA), Cambridge, MA, 2014.



**Policy Revision history**

<b>Rev #</b>	<b>Type of Change</b>	<b>Summary of Change</b>	<b>Sections Affected</b>	<b>Date</b>
1	New Policy	New Policy	All	01/01/2019
2	Update	Update	Coverage Duration: Update to 3 years	07/01/2019
3	Update	CCI Adoption of EH policy and template	All	6/8/2020