INTERFERONS FOR MULTIPLE SCLEROSIS
Pharmacy Coverage Policy

Policy type: PA with QL, QL only
Program type: Standard
Specialty: Yes
Line of Business: Commercial

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Generic Name</th>
<th>GPI</th>
<th>Drug Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avonex, Rebif</td>
<td>Interferon beta-1a</td>
<td>6240306045****</td>
<td>Multiple sclerosis agents</td>
</tr>
<tr>
<td>Betaseron, Extavia</td>
<td>Interferon beta-1b</td>
<td>6240306050****</td>
<td></td>
</tr>
<tr>
<td>Plegridy</td>
<td>Peginterferon beta-1a</td>
<td>6240307530****</td>
<td></td>
</tr>
</tbody>
</table>

CRITERIA FOR COVERAGE/NONCOVERAGE

Interferon beta and peginterferon beta injection will be considered for coverage under the pharmacy benefit program when the following criteria are met:

- Diagnosis of a relapsing form of multiple sclerosis (relapsing-remitting multiple sclerosis, progressive-relapsing multiple sclerosis and secondary progressive multiple sclerosis) OR
- Patient has experienced a first clinical episode and has MRI features consistent with multiple sclerosis

AND
- For EXTAVIA® only: Patient has experienced intolerance to therapy with the preferred interferon beta-1b, BETASERON®

Quantity Limit:
Interferon beta-1b (BETASERON, EXTAVIA) is subject to a quantity limit of one vial every other day. Interferon beta-1a (AVONEX) is subject to a quantity limit of one vial or syringe per week. Interferon beta-1a (REBIF) is subject to a quantity limit of three syringes per week and 1 starter pack/year. Peginterferon beta 1a (PLEGRIDY) is subject to a quantity limit of two pens or syringes per month and 1 starter pack/year.

Reauthorization Criteria and Duration:
Authorization for continued use shall be reviewed at least every 12 months to confirm the patient has an objective response to therapy (i.e. no or slowed progression of disease).

Interferon beta and peginterferon beta is considered experimental/investigational for conditions not listed in this coverage policy section.