Reference number(s)
1840-A

SPECIALTY GUIDELINE MANAGEMENT

BETASERON (interferon beta-1b)
EXTAVIA (interferon beta-1b)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered covered benefits provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications: Betaseron and Extavia are indicated for the treatment of relapsing forms of multiple sclerosis to reduce the frequency of clinical exacerbations. Patients with multiple sclerosis in whom efficacy has been demonstrated include patients who have experienced a first clinical episode and have MRI features consistent with multiple sclerosis.

All other indications are considered experimental/investigational and are not covered benefits.

II. CRITERIA FOR INITIAL APPROVAL

A. Relapsing forms of multiple sclerosis
Authorization of 12 months may be granted to members who have been diagnosed with a relapsing form of multiple sclerosis.

B. First clinical episode of multiple sclerosis
Authorization of 12 months may be granted to members for the treatment of a first clinical episode of multiple sclerosis.

III. CONTINUATION OF THERAPY

For all indications: Authorization of 12 months may be granted for members who are experiencing disease stability or improvement while receiving Betaseron or Extavia.

IV. OTHER CRITERIA

Members will not use Betaseron or Extavia concomitantly with other medications used for the treatment of multiple sclerosis, excluding Ampyra.

V. REFERENCES

1. Betaseron [package insert]. Whippany, NJ: Bayer HealthCare Pharmaceuticals Inc.; August 2018.
2. Extavia [package insert]. Whippany, NJ: Bayer HealthCare Pharmaceuticals Inc.; December 2018.

3. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; http://online.lexi.com/lco/action/index/dataset/complete_ashp [available with subscription]. Accessed (April 2019).