Reference number(s)
1703-A

SPECIALTY GUIDELINE MANAGEMENT

INTRON A (interferon alfa-2b)

POLICY

I. INDICATIONS

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

A. FDA-Approved Indications[1]
1. Malignant melanoma
2. Condylomata acuminata
3. Hairy cell leukemia
4. AIDS-related Kaposi sarcoma
5. Chronic hepatitis B virus infection
6. Chronic hepatitis C virus infection
7. Follicular non-Hodgkin's lymphoma

B. Compendial Uses[2-5]
1. Non-Hodgkin's lymphoma
   i. Adult T-cell leukemia/lymphoma (ATLL)[2]
   ii. Mycosis fungoides (MF)/Sezary syndrome (SS)[2-4]
2. Myeloproliferative neoplasms[2-5]
   i. Essential thrombocythemia
   ii. Myelofibrosis
   iii. Polycythemia vera
3. Renal cell carcinoma[2-4]
4. Chronic myelogenous leukemia (CML)[3,4]
5. Giant cell tumor of the bone[2]
6. Acute hepatitis C virus infection[3]
7. Desmoid tumors (soft tissue sarcoma)[2]

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

II. CRITERIA FOR INITIAL APPROVAL

A. Malignant melanoma[1,2]
Authorization of 12 months may be granted for treatment of malignant melanoma.

B. Non-Hodgkin's lymphoma[1-4]
Authorization of 12 months may be granted for treatment of NHL with any of the following subtypes:
1. Adult T-cell leukemia/lymphoma (ATLL)
2. Mycosis fungoides (MF)/Sezary syndrome (SS)
3. Hairy cell leukemia
4. Follicular lymphoma (clinically aggressive)

C. Renal cell carcinoma[2-4]
Authorization of 12 months may be granted for treatment of renal cell carcinoma.

D. Condylomata acuminata[1]
Authorization of 12 months may be granted for treatment of condylomata acuminata.

E. AIDs-related Kaposi sarcoma[1]
Authorization of 12 months may be granted for treatment of AIDS-related Kaposi sarcoma.

F. Chronic myelogenous leukemia (CML)[3,4]
Authorization of 12 months may be granted for treatment of CML.

G. Giant cell tumor of the bone[2]
Authorization of 12 months may be granted for treatment of giant cell tumor of the bone.

H. Desmoid tumors (soft tissue sarcoma)[2]
Authorization of 12 months may be granted for treatment of desmoid tumors.

I. Acute and chronic hepatitis C virus infection[1,3]
Authorization of up to 48 weeks may be granted for treatment of acute and chronic hepatitis C virus infection.

J. Chronic hepatitis B (including hepatitis D virus co-infection) virus infection[1]
Authorization of 48 weeks may be granted for treatment of chronic hepatitis B (including hepatitis D virus co-infection) virus infection.

K. Myeloproliferative neoplasms[2-5]
Authorization of 12 months may be granted for treatment of symptomatic low-risk myelofibrosis, essential thrombocythemia, and polycythemia vera.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Intron A [package insert]. Whitehouse Station, NJ: Schering Corporation; October 2017.
2. The NCCN Drugs & Biologics Compendium® © 2018 National Comprehensive Cancer Network, Inc. https://www.nccn.org. Accessed March 30, 2018.
3. Micromedex Solutions [database online]. Truven Health Analytics, Greenwood Village, Colorado, USA. Available at: http://www.micromedexsolutions.com/. Accessed March 30, 2018.
4. Lexicomp Online®, AHFS® Drug Information, Hudson, Ohio: Wolters Kluwer Clinical Drug Information, Inc.; http://online.lexi.com [available with subscription]. Accessed March 30, 2018.
5. Clinical Consult. CVS Caremark Clinical Programs Review: Focus on Hematology-Oncology Clinical Programs. September 12, 2012.