Reference number(s) 1844-A

SPECIALTY GUIDELINE MANAGEMENT

PLEGRIDY (peginterferon beta-1a)

POLICY

I. INDICATIONS

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

FDA-Approved Indication:

Plegridy is indicated for the treatment of patients with relapsing forms of multiple sclerosis.

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

II. CRITERIA FOR INITIAL APPROVAL

Multiple Sclerosis

Authorization of 24 months may be granted to members who have been diagnosed with a relapsing form of multiple sclerosis.

III. CONTINUATION OF THERAPY

pharmaceutical manufacturers that are not affiliated with CVS Caremark.

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

IV. REFERENCE

1. Plegridy [package insert]. Cambridge, MA: Biogen, Inc.; July 2016.

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