Clinical Policy: Interferon Beta-1b (Betaseron, Extavia)
Reference Number: CP.PHAR.256
Effective Date: 08.01.16
Last Review Date: 08.20
Line of Business: Commercial, HIM, Medicaid

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Interferon beta-1b (Betaseron®, Extavia®) is an amino acid glycoprotein.

FDA Approved Indication(s)
Betaseron and Extavia are indicated for the treatment of patients with relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Betaseron and Extavia are medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Multiple Sclerosis (must meet all):
      1. Diagnosis of one of the following (a, b, or c):
         a. Clinically isolated syndrome, and:
            i. If request is for Extavia, member is contraindicated to both or has experienced clinically significant adverse effects to one of the following at up to maximally indicated doses: an interferon-beta agent (Avonex®, Betaseron®, Rebif®, or Plegridy®), glatiramer (Copaxone®, Glatopa®);
         b. Relapsing-remitting MS, and:
            i. If request is for Extavia, failure of all of the following at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated (1, 2, 3, and 4):*
               1. Dimethyl fumarate (generic Tecfidera®);
               2. Aubagio®;
               3. Gilenya™;
               4. An interferon-beta agent (Avonex, Betaseron, Rebif, or Plegridy) or glatiramer (Copaxone, Glatopa);
            *Prior authorization is required for all disease modifying therapies for MS
         c. Secondary progressive MS;
      2. Prescribed by or in consultation with a neurologist;
      3. Age ≥ 12 years;
4. Interferon beta-1b is not prescribed concurrently with other disease modifying therapies for MS (see Appendix D);
5. Documentation of baseline number of relapses per year and expanded disability status scale (EDSS) score;
6. Dose does not exceed 0.25 mg (1 vial) every other day.

**Approval duration:**
- Medicaid/HIM – 6 months
- Commercial – 6 months or to the member’s renewal date, whichever is longer

**B. Other diagnoses/indications**
1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

**II. Continued Therapy**

**A. Multiple Sclerosis (must meet all):**
1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member meets one of the following (a or b):
   a. If member has received < 1 year of total treatment: Member is responding positively to therapy;
   b. If member has received ≥ 1 year of total treatment: Member meets one of the following (i, ii, iii, or iv):
      i. Member has not had an increase in the number of relapses per year compared to baseline;
      ii. Member has not had ≥ 2 new MRI-detected lesions;
      iii. Member has not had an increase in EDSS score from baseline;
      iv. Medical justification supports that member is responding positively to therapy;
3. Interferon beta-1b is not prescribed concurrently with other disease modifying therapies for MS (see Appendix D);
4. If request is for a dose increase, new dose does not exceed 0.25 mg (1 vial) every other day.

**Approval duration:**
- Medicaid/HIM – first re-authorization: 6 months; second and subsequent re-authorizations: 12 months
- Commercial – 6 months or to the member’s renewal date, whichever is longer

**B. Other diagnoses/indications (must meet 1 or 2):**
1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   **Approval duration:** Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is
III. Diagnoses/Indications for which coverage is NOT authorized:
   A. Non-FDA approved indications, which are not addressed in this policy, unless there is
      sufficient documentation of efficacy and safety according to the off label use policy –
      CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and
      CP.PMN.53 for Medicaid or evidence of coverage documents;
   B. Primary progressive MS.

IV. Appendices/General Information
   Appendix A: Abbreviation/Acronym Key
   EDSS: expanded disability status scale
   FDA: Food and Drug Administration
   MS: multiple sclerosis

   Appendix B: Therapeutic Alternatives
   This table provides a listing of preferred alternative therapy recommended in the approval
   criteria. The drugs listed here may not be a formulary agent for all relevant lines of business
   and may require prior authorization.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aubagio® (teriflunomide)</td>
<td>7 mg or 14 mg PO QD</td>
<td>14 mg/day</td>
</tr>
<tr>
<td>Avonex®, Rebif® (interferon beta-1a)</td>
<td>Avonex: 30 mcg IM Q week</td>
<td>Avonex: 30 mcg/week</td>
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<td></td>
<td>Rebif: 22 mcg or 44 mcg SC TIW</td>
<td>Rebif: 44 mcg TIW</td>
</tr>
<tr>
<td>Plegridy® (peginterferon beta-1a)</td>
<td>125 mcg SC Q2 weeks</td>
<td>125 mcg/2 weeks</td>
</tr>
<tr>
<td>glatiramer acetate (Copaxone®, Glatopa®)</td>
<td>20 mg SC QD or 40 mg SC TIW</td>
<td>20 mg/day or 40 mg TIW</td>
</tr>
<tr>
<td>Gilenya™ (fingolimod)</td>
<td>0.5 mg PO QD</td>
<td>0.5 mg/day</td>
</tr>
<tr>
<td>dimethyl fumarate (Tecfidera®)</td>
<td>120 mg PO BID for 7 days, followed by 240 mg PO BID</td>
<td>480 mg/day</td>
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</table>

   Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only
   and generic (Brand name®) when the drug is available by both brand and generic.

   Appendix C: Contraindications/Boxed Warnings
   • Contraindication(s): history of hypersensitivity to natural or recombinant interferon beta,
     albumin or mannitol
   • Boxed warning(s): none reported

   Appendix D: General Information
   • Disease-modifying therapies for MS are: glatiramer acetate (Copaxone®, Glatopa®),
     interferon beta-1a (Avonex®, Rebif®), interferon beta-1b (Betaseron®, Extavia®),
     peginterferon beta-1a (Plegridy®), dimethyl fumarate (Tecfidera®), diroximel fumarate
     (Vumerity™), monomethyl fumarate (Bafiertam™), fingolimod (Gilenya™),
     teriflunomide (Aubagio®), alemtuzumab (Lemtrada®), mitoxantrone (Novantrone®),
natalizumab (Tysabri®), ocrelizumab (Ocrevus™), cladribine (Mavenclad®), siponimod (Mayzent®,) and ozanimod (Zeposia®).

- Of the disease-modifying therapies for MS that are FDA-labeled for CIS, only the interferon products, glatiramer, and Aubagio have demonstrated any efficacy in decreasing the risk of conversion to MS compared to placebo. This is supported by the AAN 2018 MS guidelines.

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interferon beta-1b</td>
<td>Generally start at 0.0625 mg SC every other day, and increase over a six-week period to 0.25 mg SC every other day</td>
<td>0.25 mg QOD</td>
</tr>
<tr>
<td>(Betaseron)</td>
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VI. Product Availability

<table>
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<tr>
<th>Drug Name</th>
<th>Availability</th>
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<tr>
<td>Interferon beta-1b</td>
<td>Single-use vial: 0.3 mg</td>
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<td></td>
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<tr>
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VII. References

Coding Implications
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>J1830</td>
<td>Injection interferon beta-1b, 0.25 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)</td>
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Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Date</th>
<th>P&amp;T Approval Date</th>
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<tr>
<td>08.16</td>
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<tr>
<td>the first re-authorization and 12 months for second/subsequent re-authorizations; references reviewed and updated.</td>
<td></td>
</tr>
<tr>
<td>Per November and December SDC and prior clinical guidance, removed redirection to Mayzent; for RRMS modified redirection to require generic dimethyl fumarate, Aubagio, Gilenya, and either an interferon-beta agent or glatiramer.</td>
<td>01.11.21</td>
</tr>
</tbody>
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**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.
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Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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