Clinical Policy: Interferon Beta-1a (Avonex, Rebif)

Reference Number: CP.PHAR.255
Effective Date: 08.01.16
Last Review Date: 05.19
Line of Business: Medicaid

Coding Implications
Revision Log

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

Description

Interferon beta-1a (Avonex®, Rebif®) is an amino acid glycoprotein.

FDA Approved Indication(s)

Avonex and Rebif are indicated for the treatment of patients with relapsing forms of multiple sclerosis (MS) to decrease the frequency of clinical exacerbations and delay the accumulation of physical disability. Patients with MS in whom efficacy has been demonstrated include patients who have experienced a first clinical episode and have magnetic resonance imaging (MRI) features consistent with MS.

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 Avonex and Rebif 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;
   b. Relapsing-remitting MS;
   c. Secondary progressive MS, and member has active relapsing disease;
2. Prescribed by or in consultation with a neurologist;
3. Age ≥ 2 years (for Rebif requests) or ≥ 18 years (for Avonex requests);
4. For Rebif requests for members ≥ 18 years, member meets the following (a and b):
   a. If relapsing-remitting MS, failure of one of the following at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced: glatiramer (*generic [including Glatopa®] is preferred*), Tecfidera®, or Gilenya™;
   b. Failure of Avonex and Plegridy® at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;

   **Prior authorization is required for all disease modifying therapies for MS*
5. Not prescribed concurrently with other disease modifying therapies for MS (*see Appendix D*);
6. Dose does not exceed one of the following (a or b):
   a. Avonex: 30 mcg per week (1 vial/syringe/autoinjector per week);

b. Rebif: 44 mcg three times per week (1 syringe/autoinjector three times per week).

Approval duration: 6 months

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.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 is responding positively to therapy;
3. 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 one of the following (a or b):
   a. Avonex: 30 mcg per week (1 vial/syringe/autoinjector per week);
   b. Rebif: 44 mcg three times per week (1 syringe/autoinjector three times per week).

Approval duration: 12 months

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 NOT authorized): CP.PMN.53 for Medicaid.

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.PMN.53 for Medicaid or evidence of coverage documents;

B. Primary progressive MS.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
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.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Avonex® (interferon beta-1a)	30 mcg IM Q week	30 mcg/week
Plegridy® (peginterferon beta-1a)	125 mcg SC Q2 weeks	125 mcg/2 weeks
glatiramer acetate (Copaxone®, Glatopa®)	20 mg SC QD or 40 mg SC TIW	20 mg/day or 40 mg TIW
Gilenya™ (fingolimod)	0.5 mg PO QD	0.5 mg/day
Tecfidera® (dimethyl fumarate)	120 mg PO BID for 7 days, followed by 240 mg PO BID	480 mg/day

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 any other component of the formulation
- 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®), fingolimod (Gilenya™), teriflunomide (Aubagio®), alemtuzumab (Lemtrada®), mitoxantrone (Novantrone®), natalizumab (Tysabri®), and ocreliuzmab (Ocrevus™).

V. Dosage and Administration

Drug Name	Dosing Regimen	Maximum Dose
Interferon beta-1a (Avonex)	30 mcg IM Q week; may be titrated starting with 7.5 mcg for the first week, increased by 7.5 mcg each week for 3 weeks until target of 30 mcg is reached	30 mcg/week
Interferon beta-1a (Rebif)	Initial dose at 20% of prescribed dose TIW increased over 4 weeks to the targeted dose of either 22 mcg or 44 mcg SC TIW	44 mcg TIW

VI. Product Availability

Drug Name	Availability
Interferon beta-1a (Avonex)	Single-use vial: 30 mcg Single-use prefilled autoinjector or syringe: 30 mcg/0.5 mL
Interferon beta-1a (Rebif)	Single-dose autoinjector or prefilled syringe: 8.8 mcg/0.2 mL, 22 mcg/0.5 mL, 44 mcg/0.5 mL

VII. References

1. Avonex Prescribing Information. Cambridge, MA: Biogen Inc.; March 2016. Available at http://www.avonex.com. Accessed February 7, 2019.
2. Rebif Prescribing Information. Rockland, MA: EMD Serono, Inc; November 2015. Available at http://www.rebif.com. Accessed February 7, 2019.

3. Goodin DS, Frohman EM, Garmany GP, et al. Disease modifying therapies in multiple sclerosis: Subcommittee of the American Academy of Neurology and the MS Council for Clinical Practice Guidelines. Neurology. 2002; 58(2): 169-178.
4. Costello K, Halper J, Kalb R, Skutnik L, Rapp R. The use of disease-modifying therapies in multiple sclerosis, principles and current evidence – a consensus paper by the Multiple Sclerosis Coalition. March 2017. Accessed February 4, 2019.
5. European Medicines Agency: Avonex: EPAR – Product Information; November 2018. Available at: https://www.ema.europa.eu/documents/product-information/avonex-epar-product-information_en.pdf. Accessed February 7, 2019.
6. European Medicines Agency: Rebif: EPAR – Product Information; December 2018. Available at: https://www.ema.europa.eu/documents/product-information/rebif-epar-product-information_en.pdf. Accessed February 7, 2019.
7. Rae-Grant A, Day GS, Marrie RA, et al. Practice guideline recommendations summary: disease-modifying therapies for adults with multiple sclerosis: report of the Guideline Development, Dissemination, and Implementation Subcommittee of the American Academy of Neurology. Neurology. 2018; 90(17): 777-788. Full guideline available at: https://www.aan.com/Guidelines/home/GetGuidelineContent/904.

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.

HCPCS Codes	Description
J1826	Injection, interferon beta-1a, 30 mcg
Q3027	Injection, interferon beta-1a, 1 mcg for intramuscular use
Q3028	Injection, interferon beta-1a, 1 mcg for subcutaneous use

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy split from CP.PHAR.18 MS Treatments. Criteria: added max dosing, clarified monotherapy restriction, removed re-authorization requirement for documented adherence, updated reasons to discontinue, modified efficacy criteria to "Responding positively to therapy". Modified renewal approval duration to 12 months. Added requirement for the trial and failure of at least 2 preferred regimens from different classes with one being Avonex or plegridy; Removed specific strength requirement from glatiramer.	08.16	08.16
Added age requirement as safety and efficacy have not been established in pediatric populations. Removed MRI requirement, contraindication, and reasons to discontinue.	07.17	08.17

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2018 annual review: added coverage for SPMS per AAN guidelines; added age restriction for Avonex per prescribing information; added redirection to 2 preferred INF agents; references reviewed and updated.	01.05.18	05.18
2Q 2019 annual review: no significant changes; specified that generic forms of glatiramer are preferred; references reviewed and updated.	02.07.19	05.19

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.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

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.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.