CareFirst Family of health care plans

CVS caremark™

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. Malignant melanoma
2. Condylomata acuminata
3. Hairy cell leukemia
4. AIDs-related Kaposi's sarcoma
5. Chronic hepatitis B virus infection
6. Chronic hepatitis C virus infection
7. Follicular non-Hodgkin's lymphoma

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

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

II. CRITERIA FOR INITIAL APPROVAL

A. Malignant melanoma
Authorization of 12 months may be granted for treatment of malignant melanoma.

B. Non-Hodgkin's lymphoma
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. Polycythemia vera
Authorization of 12 months may be granted for treatment of polycythemia vera.

D. Renal cell carcinoma
Authorization of 12 months may be granted for treatment of renal cell carcinoma.

E. Condylomata acuminata
Authorization of 12 months may be granted for treatment of condylomata acuminata.

F. AIDs-related Kaposi's sarcoma
Authorization of 12 months may be granted for treatment of AIDS-related Kaposi's sarcoma.

G. Chronic myelogenous leukemia (CML)
Authorization of 12 months may be granted for treatment of CML.

H. Giant cell tumor of the bone
Authorization of 12 months may be granted for treatment of giant cell tumor of the bone.

I. Desmoid tumors (soft tissue sarcoma)
Authorization of 12 months may be granted for treatment of desmoid tumors.

J. Acute and chronic hepatitis C virus infection
Authorization of up to 48 weeks may be granted for treatment of acute and chronic hepatitis C virus infection.

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

L. Myeloproliferative neoplasms
Authorization of 12 months may be granted for treatment of symptomatic low-risk myelofibrosis.

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; February 2016.
2. The NCCN Drugs & Biologics Compendium® © 2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed March 22, 2017.
3. Micromedex Solutions [database online]. Ann Arbor, MI: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed March 23, 2017.
4. 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]. March 23, 2017.