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

Authorization of 24 months may be granted to members who have been diagnosed with ANY of the following relapsing forms of multiple sclerosis:

A. progressive-relapsing multiple sclerosis (PRMS)
B. relapsing-remitting multiple sclerosis (RRMS)
C. secondary progressive multiple sclerosis (SPMS) with documented relapses

III. CONTINUATION OF THERAPY

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

IV. DOSAGE AND ADMINISTRATION

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines. The following dosing limits apply: 125 mcg every 14 days.

V. REFERENCE

1. Plegridy [package insert]. Cambridge, MA: Biogen Idec Inc.; October 2015.