SPECIALTY GUIDELINE MANAGEMENT

SYLATRON (peginterferon 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 Indication:
   1. Sylatron is indicated for the adjuvant treatment of melanoma with microscopic or gross nodal involvement within 84 days of definitive surgical resection including complete lymphadenectomy.

B. Compendial Use:
   1. Low-risk myelofibrosis
   2. Polycythemia vera
   3. Essential thrombocythemia

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

II. CRITERIA FOR INITIAL APPROVAL

A. Melanoma
Authorization of 12 months may be granted for the treatment of melanoma.

B. Myelofibrosis
Authorization of 12 months may be granted for the treatment of myelofibrosis.

C. Polycythemia Vera
Authorization of 12 months may be granted for the treatment of polycythemia vera.

D. Essential Thrombocythemia
Authorization of 12 months may be granted for the treatment of essential thrombocythemia.

III. CONTINUATION OF THERAPY

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

IV. REFERENCES

1. Sylatron [package insert]. Whitehouse Station, NJ: Schering Corporation; September 2015.

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