Clinical Policy: Peginterferon Beta-1a (Plegridy)
Reference Number: HIM.PA.SP18
Effective Date: 05.01.17
Last Review Date: 05.19
Line of Business: HIM

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

Description
Peginterferon beta-1a (Plegridy®) is an amino acid glycoprotein.

FDA Approved Indication(s)
Plegridy is indicated for the treatment of patients with relapsing forms of multiple sclerosis (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 Plegridy is 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 ≥ 18 years;
      4. 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®, Gilenya™, or Aubagio®;
      5. Failure of Rebit® and Betaseron® 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
      6. Plegridy is not prescribed concurrently with other disease modifying therapies for MS (see Appendix D);
      7. Dose does not exceed 125 mcg (1 pen or syringe) every 14 days.

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): HIM.PHAR.21 for health insurance marketplace.

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. Plegridy 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 125 mcg (1 pen or syringe) every 14 days.

   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): HIM.PHAR.21 for health insurance marketplace.

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 – HIM.PHAR.21 for health insurance marketplace 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.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avonex®, Rebif® (interferon beta-1a)</td>
<td>Avonex: 30 mcg IM Q week</td>
<td>Avonex: 30 mcg/week</td>
</tr>
<tr>
<td></td>
<td>Rebif: 22 mcg or 44 mcg SC TIW</td>
<td>Rebif: 44 mcg TIW</td>
</tr>
<tr>
<td>Betaseron®, Extavia® (interferon beta-1b)</td>
<td>250 mcg SC QOD</td>
<td>250 mg QOD</td>
</tr>
</tbody>
</table>
### Therapeutic Alternatives

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 or peginterferon, 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 ocreliuzumab (Ocrevus™).

### V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relapsing MS</td>
<td>63 mcg on day 1, 94 mcg on day 15, and 125 mcg on day 29 and every 14 days thereafter</td>
<td>125 mcg/14 days</td>
</tr>
</tbody>
</table>

### VI. Product Availability

Single-dose prefilled pen or syringe: 63 mcg/0.5 mL, 94 mcg/0.5 mL, 125 mcg/0.5 mL

### VII. References
Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy created.</td>
<td>01.17</td>
<td>05.17</td>
</tr>
<tr>
<td>2Q 2018 annual review: added coverage of clinically isolated syndrome and secondary progressive MS; removed MRI requirement; added age; modified preferring to require preferred interferon products plus other disease modifying therapies; references reviewed and updated.</td>
<td>01.05.18</td>
<td>05.18</td>
</tr>
<tr>
<td>2Q 2019 annual review: no significant changes; specified that generic forms of glatiramer are preferred; references reviewed and updated.</td>
<td>02.06.19</td>
<td>05.19</td>
</tr>
</tbody>
</table>

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.

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