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

Reference Number: IN.PHAR.255
Effective Date: 09.01.16
Last Review Date: 08.21
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 include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.

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 for Rebif (a, b, or c):
   a. Clinically isolated syndrome;
   b. Relapsing-remitting MS;
   c. Secondary progressive MS;
2. Age ≥ 2 years (for Rebif requests)
3. For Rebif: Interferon beta-1a is not prescribed concurrently with other disease modifying therapies for MS (*see Appendix D*);
4. For Rebif: Documentation of baseline number of relapses per year and expanded disability status scale (EDSS) score;
5. Dose does not exceed one of the following (a or b):
   a. Avonex: 30 mcg per week (1 syringe/autoinjector per week);
   b. Rebif: 44 mcg three times per week (1 syringe/autoinjector three times per week).

Approval duration:
Medicaid – 12 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.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Multiple Sclerosis (must meet all)**:**

1. For Avonex: Member has history of requested agent in the past 90 days
2. For Rebif: Member meets one of the following (a or b):
   a. If member has received < 1 year of total treatment: Member is responding positively to therapy;
   b. If member has received ≥ 1 year of total treatment: Member meets one of the following (i, ii, iii, or iv):
      i. Member has not had an increase in the number of relapses per year compared to baseline;
      ii. Member has not had ≥ 2 new MRI-detected lesions;
      iii. Member has not had an increase in EDSS score from baseline;
      iv. Medical justification supports that member is responding positively to therapy;
3. For Rebif: Interferon beta-1a 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 one of the following (a or b):
   a. Avonex: 30 mcg per week (1 syringe/autoinjector per week);
   b. Rebif: 44 mcg three times per week (1 syringe/autoinjector three times per week).

Approval duration:
Medicaid – 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.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
EDSS: expanded disability status scale
FDA: Food and Drug Administration
MS: multiple sclerosis

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): history of hypersensitivity to natural or recombinant interferon beta, albumin* or any other component of the formulation
  **The formerly available lyophilized vial formulation of Avonex is contraindicated in patients with a history of hypersensitivity to albumin (human). This contraindication does not apply to the other Avonex formulations.*
- 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®), diroximel fumarate (Vumerity®), monomethyl fumarate (Bafiertam™), fingolimod (Gilenya®), teriflunomide (Aubagio®), alemtuzumab (Lemtrada®), mitoxantrone (Novantrone®), natalizumab (Tysabri®), ocrelizumab (Ocrevus®), cladribine (Mavenclad®), siponimod (Mayzent®), ozanimod (Zeposia®), and ofatumumab (Kesimpta®).

IV. 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

V. Product Availability

Drug Name	Availability
Interferon beta-1a (Avonex)	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

VI. References

1. Avonex Prescribing Information. Cambridge, MA: Biogen Inc.; March 2020. Available at http://www.avonex.com. Accessed February 8, 2021.

2. Rebif Prescribing Information. Rockland, MA: EMD Serono, Inc; October 2020. Available at http://www.rebif.com. Accessed February 8, 2021.
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. European Medicines Agency: Avonex: EPAR – Product Information; September 2020. Available at: https://www.ema.europa.eu/en/medicines/human/EPAR/avonex. Accessed February 8, 2021.
5. European Medicines Agency: Rebif: EPAR – Product Information; January 2021. Available at: https://www.ema.europa.eu/en/medicines/human/EPAR/rebif. Accessed February 8, 2021.
6. 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
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
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
RT4: updated FDA Approved Indication(s) section to include SPMS per updated FDA labeling; SPMS: removed requirement that member has active relapsing disease per current SPMS management approach; references reviewed and updated.	08.02.19	
Removed all re-directions per SDC and prior clinical guidance; added COM and HIM lines of business (CP.CPA.330 and HIM.PA.SP14 retired).	01.21.20	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2020 annual review: no significant changes; references reviewed and updated.	01.27.20	05.20
Added requirements for documentation of baseline relapses/EDSS and objective measures of positive response upon re-authorization; modified Medicaid/HIM continued approval duration to 6 months for the first re-authorization and 12 months for second/subsequent re-authorizations; references reviewed and updated.	05.27.20	08.20
PA Criteria alignment with FFS IN Medicaid for Avonex.	08/21	OMPP Approved

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.