

Reference number(s)
1840-A

## SPECIALTY GUIDELINE MANAGEMENT

### BETASERON (interferon beta-1b) EXTAVIA (interferon beta-1b)

#### 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.

##### FDA-Approved Indication

Betaseron and Extavia are indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.

All other indications are considered experimental/investigational and not medically necessary.

##### II. PRESCRIBER SPECIALTIES

This medication must be prescribed by or in consultation with a neurologist.

##### III. CRITERIA FOR INITIAL APPROVAL

###### A. Relapsing forms of multiple sclerosis

Authorization of 12 months may be granted to members who have been diagnosed with a relapsing form of multiple sclerosis (including relapsing-remitting and secondary progressive disease for those who continue to experience relapse).

###### B. Clinically isolated syndrome

Authorization of 12 months may be granted to members for treatment of clinically isolated syndrome of multiple sclerosis.

##### IV. CONTINUATION OF THERAPY

For all indications: Authorization of 12 months may be granted for members who are experiencing disease stability or improvement while receiving Betaseron or Extavia.

##### V. OTHER

Members will not use Betaseron or Extavia concomitantly with other disease modifying multiple sclerosis agents (Note: Ampyra and Nuedexta are not disease modifying).

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## VI. REFERENCES

1. Betaseron [package insert]. Whippany, NJ: Bayer HealthCare Pharmaceuticals Inc.; July 2023.
2. Extavia [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; July 2023.