

Reference number(s)
1837-A

# SPECIALTY GUIDELINE MANAGEMENT

## AVONEX (interferon beta-1a)

### 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

Avonex is 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 the 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 Avonex.

#### V. OTHER CRITERIA

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

#### VI. REFERENCES

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1. Avonex [package insert]. Cambridge, MA: Biogen Inc.; December 2020.
2. AHFS DI (Adult and Pediatric) [database online]. Hudson, OH: Lexi-Comp, Inc.; [http://online.lexi.com/lco/action/index/dataset/complete\\_ashp](http://online.lexi.com/lco/action/index/dataset/complete_ashp) [available with subscription]. Accessed (March 30, 2021).