

## Clinical Policy: Peginterferon Beta-1a (Plegridy)

Reference Number: MDN.CP.PHAR.271

Effective Date: 04.01.22

Last Review Date: 11.9.23

Line of Business: Meridian IL Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### Description

Peginterferon beta-1a (Plegridy<sup>®</sup>) is an amino acid glycoprotein.

### FDA Approved Indication(s)

Plegridy is 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<sup>®</sup> 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;
2. Prescribed by or in consultation with a neurologist;
3. Age  $\geq$  18 years;
4. Failure of TWO of the following at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated (a, b, and c):\*
  - a. Gilenya<sup>®</sup>;
  - b. Tecfidera<sup>®</sup>;
  - c. An interferon-beta agent (Betaseron<sup>®</sup>, Rebif<sup>®</sup>) or Copaxone<sup>®</sup>;  
*\*Prior authorization is required for Gilenya*
5. Plegridy is not prescribed concurrently with other disease modifying therapies for MS (see Appendix D);
6. Documentation of baseline number of relapses per year and expanded disability status scale (EDSS) score;
7. Dose does not exceed 125 mcg (1 pen or syringe) every 14 days.

**Approval duration: 6 months**

**B. Other diagnoses/indications (must meet 1 or 2):**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
  - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
  - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

**II. Continued Therapy**

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

1. Member meets one of the following (a or b):
  - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
  - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
2. 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  $\geq$  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  $\geq$  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. 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. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):

- a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
  - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

**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 policies – CP.PMN.53 for Medicaid or evidence of coverage documents;
- B. Primary progressive MS.

**IV. 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 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<sup>®</sup>, Glatopa<sup>®</sup>), interferon beta-1a (Avonex<sup>®</sup>, Rebif<sup>®</sup>), interferon beta-1b (Betaseron<sup>®</sup>, Extavia<sup>®</sup>), peginterferon beta-1a (Plegridy<sup>®</sup>), dimethyl fumarate (Tecfidera<sup>®</sup>), diroximel fumarate (Vumerity<sup>®</sup>), monomethyl fumarate (Bafiertam<sup>™</sup>), fingolimod (Gilenya<sup>®</sup>, Tascenso ODT<sup>™</sup>), teriflunomide (Aubagio<sup>®</sup>), alemtuzumab (Lemtrada<sup>®</sup>), mitoxantrone (Novantrone<sup>®</sup>), natalizumab (Tysabri<sup>®</sup>), ocrelizumab (Ocrevus<sup>®</sup>), cladribine (Mavenclad<sup>®</sup>), siponimod (Mayzent<sup>®</sup>), ozanimod (Zeposia<sup>®</sup>), ponesimod (Ponvory<sup>™</sup>), and ofatumumab (Kesimpta<sup>®</sup>).

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
Relapsing MS	SC or IM: 63 mcg on day 1, 94 mcg on day 15, and 125 mcg on day 29 and every 14 days thereafter	125 mcg/14 days

**VI. Product Availability**

- For SC administration - single-dose prefilled pen or syringe: 63 mcg/0.5 mL, 94 mcg/0.5 mL, 125 mcg/0.5 mL
- For IM administration - single-dose prefilled syringe: 125 mcg/0.5 mL

**VII. References**

1. Plegriidy Prescribing Information. Cambridge, MA: Biogen Inc.; January 2021. Available at <http://www.plegriidy.com>. Accessed February 7, 2022.
2. 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.
3. 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
J3590	Unclassified biologics
C9399	Unclassified drugs or biologicals

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created, adapted from CP.PHAR.271	04.01.22	04.22
4Q 2023 Annual Review: Template changes applied to other diagnoses/indications and continued therapy section. Coding implications added; references reviewed and updated.	11.9.23	

**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.

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**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.

**CLINICAL POLICY**  
Peginterferon Beta-1a



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