Clinical Policy: Peginterferon Beta-1a (Plegridy)

Reference Number: ERX.SPA.115
Effective Date: 10.01.16
Last Review Date: 05.22
Line of Business: Commercial, Medicaid

Revision Log

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), 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.

Health plan approved formularies should be reviewed for all coverage determinations. Requirements to use preferred alternative agents apply only when such requirements align with the health plan approved formulary.

It is the policy of health plans affiliated with Envolve Pharmacy Solutions™ 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, and member is contraindicated to all, or has experienced clinically significant adverse effects to two, of the following: Aubagio®, glatiramer (Copaxone®, Glatopa®), an interferon-beta agent (*Avonex®, Betaseron®, and Rebif® are preferred*);*
   b. Relapsing-remitting MS, and failure of two of the following, unless clinically significant adverse effects are experienced or all are contraindicated: Aubagio, dimethyl fumarate, Gilenya®, glatiramer (Copaxone, Glatopa), an interferon-beta agent (*Avonex, Betaseron, and Rebif are preferred*), Kesimpta®, Mayzent®, Ocrevus®, Tysabri®, Vumerity®, Zeposia®;*
      **Prior authorization is required for all disease modifying therapies for MS*
   c. Secondary progressive MS;
2. Prescribed by or in consultation with a neurologist;
3. Age ≥ 18 years;
4. Plegridy is not prescribed concurrently with other disease modifying therapies for MS (*see Appendix D)*;
5. Documentation of baseline number of relapses per year and expanded disability status scale (EDSS) score;
6. Dose does not exceed 125 mcg (1 pen or syringe) every 14 days.

Approval duration: 6 months

B. Other diagnoses/indications

1. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

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

1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions or member has previously met initial approval criteria;
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 ≥ 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. 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: first re-authorization: 6 months**; second and subsequent re-authorizations:** 12 months

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

1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

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 – ERX.PA.01 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
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Avonex® (interferon beta-1a)	30 mcg IM q week	30 mcg/week
Rebif® (interferon beta-1a)	22 mcg or 44 mcg SC TIW	44 mcg TIW
Betaseron® (interferon beta-1b)	250 mcg SC QOD	250 mg QOD
glatiramer acetate (Copaxone®, Glatopa®)	20 mg SC QD or 40 mg SC TIW	20 mg/day or 40 mg TIW
Aubagio® (teriflunomide)	7 mg or 14 mg PO QD	14 mg/day
Gilenya® (fingolimod)	0.5 mg PO QD	0.5 mg/day
Mayzent® (siponimod)	*All patients:* Day 1 and 2: 0.25 mg PO QD Day 3: 0.5 mg PO QD	2 mg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	Day 4: 0.75 mg PO QD *CYP2C9 genotypes *1/*1, *1/*2, or *2/*2:* Day 5: 1.25 mg PO QD Day 6 and onward: 2 mg PO QD *CYP2C9 genotypes *1/*3 or *2/*3:* Day 5 and onward: 1 mg PO QD	
dimethyl fumarate (Tecfidera®)	120 mg PO BID for 7 days, followed by 240 mg PO BID	480 mg/day
Tysabri® (natalizumab)	300 mg IV every 4 weeks	300 mg/4 weeks
Ocrevus® (ocrelizumab)	Initial 300 mg IV infusion with a second 300 mg IV infusion two weeks later, followed by subsequent doses of 600 mg via IV infusion every 6 months	600 mg/6 months
Kesimpta® (ofatumumab)	20 mg SC at weeks 0, 1, and 2, followed by 20 mg SC monthly starting at week 4	20 mg
Zeposia® (ozanimod)	Days 1-4: 0.23 mg PO QD Days 5-7: 0.46 mg PO QD Day 8 and thereafter: 0.92 mg PO QD	0.92 mg/day
Vumerity® (diroximel fumarate)	Starting: 231 mg PO BID for 7 days Maintenance: 462 mg PO BID	924 mg/day

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®), diroximel fumarate (Vumerity®), monomethyl fumarate (Bafiertam™), fingolimod (Gilenya®, Tascenso ODT™), teriflunomide (Aubagio®), alemtuzumab (Lemtrada®), mitoxantrone (Novantrone®), natalizumab (Tysabri®), and ocrelizumab (Ocrevus®), cladribine (Mavenclad®), siponimod (Mayzent®), ozanimod (Zeposia®), ponesimod (Ponvory™), and ofatumumab (Kesimpta®).
- Of the disease-modifying therapies for MS that are FDA-labeled for clinically isolated syndrome, only the interferon products, glatiramer, and Aubagio have demonstrated any efficacy in decreasing the risk of conversion to MS compared to placebo. This is supported by the American Academy of Neurology 2018 MS guidelines.

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. Plegridy Prescribing Information. Cambridge, MA: Biogen Inc.; November 2021. Available at http://www.plegridy.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.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2018 annual review: Added coverage for SPMS per AAN guidelines. References reviewed and updated	01.05.18	05.18
2Q 2019 annual review: no significant changes; added Tysabri as a step-through option per its formulary status; references reviewed and updated.	02.06.19	05.19
RT4: updated FDA Approved Indication(s) section to include CIS and 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	
2Q 2020 annual review: no significant changes; updated re-directions per current formulary status; 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 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
2Q 2021 annual review: no significant changes; updated re-directions per current formulary status; RT4: added new IM dosage form and updated Dosing and Administration to indicate that Plegridy can be administered SC or IM; references reviewed and updated.	02.08.21	05.21
2Q 2022 annual review: no significant changes; updated re-directions per current formulary status; references reviewed and updated.	02.07.22	05.22

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.

This Clinical Policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. 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.