Peginterferon Beta-1a (Plegridy®)

Goal(s):

- Approve therapy for covered diagnosis which are supported by the medical literature.

Length of Authorization:

- Up to 12 months

Requires PA:

- Non-preferred drugs

Covered Alternatives:

- Preferred alternatives listed at www.orpdl.org

Approval Criteria		
1. What diagnosis is being treated?	Record ICD10 code.	
2. Does the patient have a diagnosis of relapsing-remitting Multiple Sclerosis?	**Yes:** Go to #3.	**No:** Pass to RPH; Deny for medical appropriateness.
3. Will the prescriber consider a change to a Preferred MS product?	**Yes:** Inform provider of covered alternatives in the class. Additional information can be found at www.orpdl.org.	**No:** Go to #4.
4. Is the medication being prescribed by or in consultation with a neurologist?	**Yes:** Go to #5.	**No:** Pass to RPH; Deny for medical appropriateness.
5. Does the patient have any of the following: • Adherence issues necessitating less frequent administration • Dexterity issues limiting ability to administer subcutaneous injections	**Yes:** Approve for up to one year.	**No:** Pass to RPH; Deny for medical appropriateness.

P&T / DUR Action: *11/17 (DM); 9/23/14*
Implementation: *10/15*