AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Avonex	Page:	1 of 2
Effective Date:	10/25/2023	Last Review Date:	10/2023

Applies to:	☒Illinois	☐Florida	☐Florida Kids
	☐New Jersey	☐Maryland	☐Michigan
	☐Pennsylvania Kids	☐Virginia	☐Kentucky PRMD

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Avonex under the patient's prescription drug benefit.

Description:

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.

Applicable Drug List:

Avonex

Policy/Guideline:

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

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) and patient is unable to take the required number of formulary alternatives (3) for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication.

B. Clinically isolated syndrome
Authorization of 12 months may be granted to members for the treatment of clinically isolated syndrome of multiple sclerosis and patient unable to take the required number of formulary alternatives (3) for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication.

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.

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

Approval Duration and Quantity Restrictions:
Approval: 12 months

Quantity Level Limit:
- Avonex prefilled syringe: 1 box (4 syringes) per 28 days
- Avonex pen: 1 box (4 pens) per 28 days

References:
1. Avonex [package insert]. Cambridge, MA: Biogen Inc.; November 2021.