AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Betaseron-Extavia	Page:	1 of 2
Effective Date:	11/1/2024	Last Review Date:	10/2024

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 Betaseron and Extavia 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 Indications
Betaseron and Extavia are 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:

Betaseron
Extavia

Policy/Guideline:

Prescriber Specialties:
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). Requests for Betaseron require that the 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. Requests for Betaseron require that the 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.

Continuation of Therapy:
For all indications: Authorization of 12 months may be granted for members who are experiencing disease stability or improvement while receiving Betaseron or Extavia.

Other Criteria:
Members will not use Betaseron or Extavia 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:
- Betaseron: 14 vials per 28 days
- Extavia: 15 vials per 30 days

References:
1. Betaseron [package insert]. Whippany, NJ: Bayer HealthCare Pharmaceuticals Inc.; July 2023.
2. Extavia [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; July 2023.