

Clinical Policy: Interferon Beta-1b (Betaseron, Extavia)

Reference Number: NH.PHAR.256

Effective Date: 06.24

Last Review Date: 04.25

Line of Business: Medicaid

[Coding Implications](#)

[Revision Log](#)

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

Description

Interferon beta-1b (Betaseron[®], Extavia[®]) is an amino acid glycoprotein.

FDA Approved Indication(s)

Betaseron and Extavia are 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[®] that Betaseron and Extavia are **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. Age \geq 12 years;
3. If request is for Extavia, trial and failure of three (3) preferred products, unless contraindicated or clinically significant adverse effects are experienced;
4. Interferon beta-1b is not prescribed concurrently with other disease modifying therapies for MS (*see Appendix D*);
5. Dose does not exceed 0.25 mg (1 vial) every other day.

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 PDL, the no coverage criteria policy: CP.PMN.255; or
 - b. For drugs NOT on the PDL, the non-formulary policy: CP.PMN.16; or

CLINICAL POLICY

Interferon Beta-1b

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: CP.PMN.53.

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 ≥ 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. Interferon beta-1b 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 0.25 mg (1 vial) every other day.

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 PDL, the no coverage criteria policy: CP.PMN.255; or
 - b. For drugs NOT on the PDL, the non-formulary policy: CP.PMN.16; 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: CP.PMN.53.

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

IV. Appendices/General Information

CLINICAL POLICY

Interferon Beta-1b

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 for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
teriflunomide (Aubagio [®])	7 mg or 14 mg PO QD	14 mg/day
Avonex [®] , Rebif [®] (interferon beta-1a)	Avonex: 30 mcg IM Q week Rebif: 22 mcg or 44 mcg SC TIW	Avonex: 30 mcg/week Rebif: 44 mcg TIW
Plegridy [®] (peginterferon beta-1a)	125 mcg SC Q2 weeks	125 mcg/2 weeks
glatiramer acetate (Copaxone [®] , Glatopa [®])	20 mg SC QD or 40 mg SC TIW	20 mg/day or 40 mg TIW
fingolimod (Gilenya [®])	0.5 mg PO QD	0.5 mg/day
dimethyl fumarate (Tecfidera [®])	120 mg PO BID for 7 days, followed by 240 mg PO BID	480 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, albumin or mannitol
- 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[®]), ocrelizumab (Ocrevus[®]), cladribine (Mavenclad[®]), siponimod (Mayzent[®]), ozanimod (Zeposia[®]), ponesimod (Ponvory[™]), ublituximab-xiiv (Briumvi[™]), and ofatumumab (Kesimpta[®])
- Of the disease-modifying therapies for MS that are FDA-labeled for CIS, only the interferon products, glatiramer, and teriflunomide 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

CLINICAL POLICY

Interferon Beta-1b

Drug Name	Dosing Regimen	Maximum Dose
Interferon beta-1b (Betaseron)	Generally start at 0.0625 mg SC every other day, and increase over a six-week period to 0.25 mg SC every other day	0.25 mg QOD
Interferon beta-1b (Extavia)	Generally start at 0.0625 mg SC every other day, and increase over a six-week period to 0.25 mg SC every other day	0.25 mg QOD

VI. Product Availability

Drug Name	Availability
Interferon beta-1b (Betaseron)	Single-use vial: 0.3 mg
Interferon beta-1b (Extavia)	Single-use vial: 0.3 mg

VII. References

1. Betaseron Prescribing Information. Whippany, NJ: Bayer HealthCare Pharmaceuticals Inc.; November 2021. Available at <http://www.betaseron.com>. Accessed January 30, 2023.
2. Extavia Prescribing Information. East Hanover, NJ: Novartis Pharmaceuticals Corporation; November 2021. Available at <http://www.extavia.com/>. Accessed January 30, 2023.
3. 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.
4. European Medicines Agency: Betaferon: EPAR – Product Information; January 2023. Available at: <https://www.ema.europa.eu/en/medicines/human/EPAR/betaferon>. Accessed January 30, 2023.
5. European Medicines Agency: Extavia: EPAR – Product Information; January 2023. Available at: <https://www.ema.europa.eu/en/medicines/human/EPAR/extavia>. Accessed January 30, 2023.
6. 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>. Reaffirmed on September 18, 2021.

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
J1830	Injection interferon beta-1b, 0.25 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)

CLINICAL POLICY
Interferon Beta-1b

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	06.24	06.24
2Q 2025 annual review: per competitor analysis, removed requirements for documentation of baseline relapses/expanded disability status score and specific measures of positive response; for continued therapy, modified approval duration from “if member has received < 1 year of total treatment – up to a total of 12 months of treatment and if member has received > 1 year of total treatment – 12 months” to “12 months”	04.25	04.25

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.

CLINICAL POLICY

Interferon Beta-1b

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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.

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