Criteria-Based Consultation Prescribing Program
CRITERIA FOR DRUG COVERAGE
Interferon beta-1a (Avonex)

Notes:
* Intolerance excludes adverse drug reactions that are expected, mild in nature, resolve with continued treatment, and do not require medication discontinuation

Initiation (new start) criteria: Non-formulary **interferon beta-1a (Avonex)** will be covered on the prescription drug benefit for 12 months when the following criteria are met:

- Prescribed by a Neurologist
- Diagnosis of Relapsing form of Multiple Sclerosis (MS) on the Problem list, including:
  - Non-Progressive Relapsing MS
  - Progressive Relapsing MS
  - Relapsing Remitting MS
- Patient has failed an adequate trial of, or patient has an allergy or intolerance to at least 2 of the following medications:
  - Glatiramer acetate (Copaxone or Glatopa)
  - Interferon-beta1b (Extavia or Betaseron)
  - Dimethyl fumarate

Criteria for *current Kaiser Permanente members* already taking the medication who have not been reviewed previously: Non-formulary **interferon beta-1a (Avonex)** will be covered on the prescription drug benefit for 12 months when the following criteria are met:

- Prescribed by a Neurologist
- Diagnosis of Multiple Sclerosis (MS) on the Problem list
- Patient has failed an adequate trial of, or patient has an allergy or intolerance to at least 2 of the following medications:
  - Glatiramer acetate (Copaxone or Glatopa)
  - Interferon-beta1b (Extavia or Betaseron)
  - Dimethyl fumarate

Criteria for *new members* entering Kaiser Permanente already taking the medication who have not been reviewed previously. Non-formulary **interferon beta-1a (Avonex)** will be covered on the prescription drug benefit for 12 months when the following criteria are met:

- Diagnosis of Multiple Sclerosis (MS)

Criteria-Based Consultation Prescribing Program
CRITERIA FOR DRUG COVERAGE
Interferon beta-1a (Avonex)

- Patient has failed an adequate trial of, or patient has an allergy or intolerance to at least 2 of the following medications:
  - Glatiramer acetate (Copaxone or Glatopa)
  - Interferon-beta1b (Extavia or Betaseron)
  - Dimethyl fumarate

Continued use criteria for patients stable on the medication: Non-formulary **interferon beta-1a (Avonex)** will continue to be covered on the prescription drug benefit for 12 months when the following criteria are met:

- Prescribed by a Neurologist
- Patient has failed an adequate trial of, or patient has an allergy or intolerance to at least 2 of the following medications:
  - Glatiramer acetate (Copaxone or Glatopa)
  - Interferon-beta1b (Extavia or Betaseron)
  - Dimethyl fumarate
- Patient has completed the following laboratory monitoring within the last 6 months:
  - Complete blood count with differential (CBC w/ diff)
  - Liver function test (alanine aminotransferase, ALT)
- Patient is NOT using interferon beta-1a (Avonex) with another disease modifying treatment (i.e., glatiramer, interferon beta-1b, natalizumab, fingolimod, teriflunomide, dimethyl fumarate, rituximab)