



AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name: Plegridy

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Effective Date: 10/25/2023

Last Review Date: 10/2023

Applies to:	<input type="checkbox"/> Illinois	<input type="checkbox"/> Florida	<input type="checkbox"/> Florida Kids
	<input checked="" type="checkbox"/> New Jersey	<input type="checkbox"/> Maryland	<input type="checkbox"/> Michigan
	<input type="checkbox"/> Pennsylvania Kids	<input type="checkbox"/> Virginia	<input type="checkbox"/> Kentucky PRMD

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Plegridy 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 Indication¹

Plegridy is 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.

All other indications are considered experimental/investigational and not medically necessary.

Applicable Drug List:

Plegridy

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 sclerosis¹

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 (2) for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication.

B. Clinically isolated syndrome¹

Authorization of 12 months may be granted to members for the treatment of clinically isolated syndrome of multiple sclerosis and patient is unable to take the required



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number of formulary alternatives (2) 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 Plegridy.

Other Criteria:

Members will not use Plegridy 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 Limits:

- Plegridy pen or prefilled syringe 125mcg/0.5mL: 1 carton (2 pens or prefilled syringes) per 28 days
- Plegridy Starter Pack pen or prefilled syringe: 1 Starter Pack/1 Titration kit (2 pens or prefilled syringes) per 28 days
- Plegridy Titration kit prefilled syringe for intramuscular use: 1 Titration kit (2 prefilled syringes) per 28 days

References:

1. Plegridy [package insert]. Cambridge, MA: Biogen, Inc.; March 2022.