AETNA BETTER HEALTH® Coverage Policy/Guideline			
Name:	Rebif	Page:	1 of 2
Effective Date:	11/1/2024	Last Review Date:	10/2024
Applies to:	☒Illinois ☒Maryland ☐Michigan	☐Florida ☒Florida Kids ☐ Virginia	☒New Jersey ☒Pennsylvania Kids ☒ Kentucky PRMD

Intent:

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

Description:

FDA-Approved Indications

Rebif 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:

Rebif

Policy/Guideline:

I. CRITERIA FOR INITIAL APPROVAL

A. Relapsing forms of multiple sclerosis

1. Authorization 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).
2. Rebif must be prescribed by or in consultation with a neurologist.
3. Members will not use Rebif concomitantly with other disease modifying multiple sclerosis agents

   Note: Ampyra and Nuedexta are not disease modifying.

B. Clinically isolated syndrome

1. Authorization may be granted to members for the treatment of clinically isolated syndrome.
2. Rebif must be prescribed by or in consultation with a neurologist.
3. Members will not use Rebif concomitantly with other disease modifying multiple sclerosis agents
   a. Ampyra and Nuedexta are not disease modifying.

II. CRITERIA FOR CONTINUATION OF THERAPY

A. For all indications:

1. Authorization may be granted to members who are experiencing disease stability or improvement while receiving Rebif.
2. Rebif must be prescribed by or in consultation with a neurologist.
3. Members will not use Rebif concomitantly with other disease modifying multiple sclerosis agents

   Note: Ampyra and Nuedexta are not disease modifying.

Approval Duration and Quantity Restrictions:

Initial and Renewal Approval:
12 months

Quantity Level Limit:

- Rebif prefilled syringe or autoinjector 22mcg/0.5mL:
  - 12 prefilled syringes or autoinjectors (6mL) per 28 days
- Rebif prefilled syringe or autoinjector 44mcg/0.5mL:
  - 12 prefilled syringes or autoinjectors (6mL) per 28 days
- Rebif titration pack w/prefilled syringes or titration pack w/autoinjectors):
  - 12 prefilled syringes or autoinjectors (4.2mL) per 28 days

References:

1. Rebif [package insert]. Rockland, MA; EMD Serono Inc.; July 2023.