

EXTAVIA PA SUMMARY

PREFERRED	Avonex (interferon beta-1a), Betaseron (interferon beta-1b), Rebif (interferon beta-1a)
NON-PREFERRED	Extavia (interferon beta-1b)

LENGTH OF AUTHORIZATION: Initial: 3 months; Renewal: 12 months

PA CRITERIA:

- ❖ Approvable for relapsing forms of multiple sclerosis (relapsing MS)
AND
- ❖ Physician should submit a written letter of medical necessity stating the reason(s) Betaseron (preferred product) is not appropriate for the member.

EXCEPTIONS:

- ❖ Exceptions to these conditions of coverage are considered through the prior authorization process.
- ❖ The Prior Authorization process may be initiated by calling **SXC Health Solutions at 1-866-525-5827**.

PA and Appeal Process:

- ❖ For online access to the PA process please go to www.mmis.georgia.gov/portal, highlight the pharmacy link on the top right side of the page, and click on “prior approval process”.

Quantity Level Limitations:

- ❖ For online access to the current Quantity Level Limits please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services Part II and select that manual.