Prior Authorization Approval Criteria
Department of Pharmacy Services

Generic Name: Interferon beta-1a

Brand Name: Rebif

Medication Class: Immunomodulator

FDA Approved Uses: treatment of relapsing forms of multiple sclerosis.

Usual Dose: 22-44mcg subcutaneously three times per week.

Duration of Therapy: Indefinitely

Criteria for Use: ***(bullet points below are all inclusive unless otherwise noted)***
- Clinically diagnosed multiple sclerosis.
- Failed/intolerant to Avonex.
- Failed/intolerant to Betaseron.

Contraindications:
- Hypersensitivity to natural or recombinant interferon, human albumin, or any other component of the formulation.

Not Approved if:
- Patient has any contraindications to the use of Rebif.
- Patient does not meet the above stated criteria.

P&T Approval: ______________________________ Date: ________________