AVONEX

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Generic Name</th>
<th>Length of Authorization</th>
</tr>
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<tbody>
<tr>
<td>Avonex</td>
<td>interferon beta-1A</td>
<td>Calendar Year</td>
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</tbody>
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Approvable Criteria:

Is the member’s diagnosis relapsing-remitting form of MS (Multiple Sclerosis)?

- If yes, approve Calendar Year
- If no, do not approve.

**QL = 4 syringes x 30 DAYS**

**SELF-ADMINISTERED – RX ONLY**

**SPECIALTY PHARMACY PRODUCT**

**PREFERRED DRUG**

**FDA Approved Indication:**
For the treatment of relapsing forms of MS to slow the accumulation of physical disability and decrease the frequency of clinical exacerbations. Safety and efficacy in patients with chronic progressive MS have not been established.

*References:
- Avonex prescribing information 2003.