ROFERON A

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Generic Name</th>
<th>Length of Authorization</th>
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<tbody>
<tr>
<td>Roferon A</td>
<td>interferon alfa-2A</td>
<td>6 months</td>
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Approvable Criteria:

1. Is the member 18 years of age or older?
   - If yes, continue to #2.
   - If no, do not approve.
2. Is the member diagnosed with one of the following conditions?
   b. Chronic Myelogenous Leukemia (CML).
   c. AIDS-related Kaposi’s sarcoma.
   d. Chronic hepatitis C with compensated (not acutely ill; stable) liver disease.
      - If yes, approve for 6 months
      - If no, do not approve.

SELF-ADMINISTERED – RX ONLY

SPECIALTY PHARMACY PRODUCT

FDA Approved Indication:

Chronic myelogenous leukemia (CML): In chronic phase, Philadelphia chromosome (Ph) positive CML patients who are minimally pretreated (within 1 year of diagnosis).

Hairy-cell leukemia: In patients ≥ 18 years of age with hairy-cell leukemia.

AIDS-related Kaposi’s sarcoma: In select patients ≥ 18 years of age with AIDS-related Kaposi’s sarcoma.

Chronic hepatitis C: In patients ≥ 18 years of age with compensated liver disease and a history of blood or blood product exposure, or patients who are HCV-antibody-positive.

References:

- Roferon prescribing information 2003