



Missouri Pharmacy Program – Preferred Drug List



Multiple Sclerosis Agents

Effective 02/01/2006

Revised 01/05/2012

Preferred Agents

- Avonex® Kit/Administration Pack
- Copaxone®
- Betaseron®
- Rebif®

Non-Preferred Agents

- Extavia®
- **Gilenya®**

<u>Approval Criteria</u>	<u>Denial Criteria</u>
Failure to achieve desired therapeutic outcomes with trial on 2 preferred agents	Lack of adequate trial on required preferred agents
Documented trial period for preferred agents	Therapy will be denied if no approval criteria are met
Documented ADE/ADR to preferred agents.	
Documented compliance on current therapy regimen.	Drug Prior Authorization Hotline: (800) 392-8030