Reference number(s)
5060-A

SPECIALTY GUIDELINE MANAGEMENT

BESREMI (ropeginterferon alfa-2b-njft)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications
Besremi is indicated for the treatment of adults with polycythemia vera.

All other indications are considered experimental/investigational and not medically necessary.

II. CRITERIA FOR INITIAL APPROVAL

Polycythemia Vera
Authorization of 12 months may be granted for treatment of polycythemia vera.

III. CONTINUATION OF THERAPY

Authorization of 12 months may be granted if the member is experiencing benefit from therapy as evidenced by improvement in symptoms and/or disease markers (e.g., morphological response, reduction or stabilization in spleen size, improvement of thrombocytosis/leukocytosis, etc.)

IV. REFERENCES

1. Besremi [package insert]. Burlington, MA: PharmaEssentia USA Corporation; November 2021.