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 Indication

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.

Besremi 5060-A SGM P2024.docx

pharmaceutical manufacturers that are not affiliated with CVS Caremark.

© 2024 CVS Caremark. All rights reserved.



This document contains confidential and proprietary information of CVS Caremark and cannot be reproduced, distributed or printed without written permission from CVS Caremark. This document contains prescription brand name drugs that are trademarks or registered trademarks of