Division: Pharmacy Policy	Subject: Prior Authorization Criteria
Original Development Date: Original Effective Date: Revision Date:	March 30, 2022; August 12, 2022; September 8, 2022

BESREMI (ropeginterferon alfa-2b-njft)

LENGTH OF AUTHORIZATION: 6 months

REVIEW CRITERIA:

- Patient must be ≥ 18 years of age.
- Patient must have a diagnosis of polycythemia vera.
- Prescriber is a physician specialized in treating polycythemia vera or is in consultation with an Oncologist or Hematologist.
- Provider documents and attests to baseline evaluation of the following:
  - Peripheral blood counts
  - Ophthalmologic exam
  - Serum triglycerides
  - Liver function tests
  - Serum creatinine
- Patient has had documented trial and failure to hydroxyurea unless contraindicated.

CONTINUATION OF THERAPY:

- Patient met the above criteria; **AND**
- Documentation of improved clinical response; **AND**
- Patient has not have experienced any treatment-restricting adverse effects; **AND**
- Dosing is appropriate as per labeling or is supported by compendia.

DOSING AND ADMINISTRATION:

- Refer to product labeling at https://www.accessdata.fda.gov/scripts/cder/daf/.
- Available as 500 mcg/mL solution in single-dose prefilled syringe.