Montana Healthcare Programs  
Drugs Prior Authorization Coverage Criteria  

Betaseron™ (interferon beta-1b) 

**Review Criteria** 

Member must meet all the following criteria: 

- Subject to Preferred Drug List 
- Member must be 18 years of age or older 
- Must be written by or in consult with a neurologist 
  - If not written by or in consult with a neurologist, copy of recent consult must be submitted 
- Member must have a diagnosis of relapsing form of multiple sclerosis (MS): 
  - Clinically isolated syndrome (CIS) 
  - Relapsing-remitting MS (RRMS) 
  - Secondary progressive MS (SPMS) 
- Approval granted for one year