



# AmeriHealth.

**Policy Title** Peginterferon alfa-2b (Sylatron)

**Policy Number** FS.CLIN.

**Application of pharmacy policy is determined by benefits and contracts. Benefits may vary based on product line, group, or contract. Some medications may be subject to precertification and age, gender or quantity restrictions. Individual member benefits must be verified.**

**This pharmacy policy document describes the status of pharmaceutical information and/or technology at the time the document was developed. Since that time, new information relating to drug efficacy, interactions, contraindications, dosage, administration routes, safety, or FDA approval may have changed. If the Medical/Pharmacy Reviewer is aware of any new information on the subject of this document, please provide it promptly to the Medical/Pharmacy Policy Department. This information may include new FDA approved indications, withdrawals or other FDA alerts. This type of information is relevant not only when considering whether this policy should be updated, but also when applying it to current requests for coverage.**

**Members are advised to use participating pharmacies in order to receive the highest level of benefits.**

**Policy** **Peginterferon alfa-2b (Sylatron)** is indicated for the adjuvant treatment of melanoma with microscopic or gross nodal involvement within 84 days of definitive surgical resection including complete lymphadenectomy.

The use of Peginterferon alfa-2b (Sylatron) requires prior authorization (ie, clinical pharmacy and/or Medical Director review).

**Policy description** **Peginterferon alfa-2b (Sylatron)** is a pleiotropic cytokine; the mechanism by which it exerts its effects in patients with melanoma is unknown.

**Policy guideline inclusion** **Peginterferon alfa-2b (Sylatron)** is approved when the following inclusion criteria is met:

- Documentation of use for adjuvant treatment of melanoma with microscopic or gross nodal involvement within 84 days of definitive surgical resection including complete lymphadenectomy

**Policy guideline exclusion** **Peginterferon alfa-2b (Sylatron)** is denied when the following exclusion criteria is present:

- No documentation of use for adjuvant treatment of melanoma with microscopic or gross nodal involvement within 84 days of definitive surgical resection including complete lymphadenectomy

**Policy List of Applicable Drugs**

Brand Name	Generic Name
Sylatron	Peginterferon alfa-2b

**Dosing and administration** Refer to the specific manufacturer's prescribing information for administration and dosage details, contraindications, and Black Box warnings.

<b>Policy references</b>	<p>Inteleos website [Sylatron]. Available at <a href="http://www.inteleos.com">www.inteleos.com</a>. Accessed April 29, 2011.</p> <p>Facts and Comparisons website. [Sylatron]. Available at <a href="http://www.factsandcomparisons.com">www.factsandcomparisons.com</a>. Accessed April 29, 2011.</p> <p>Sylatron [package insert] Kenilworth NJ. Schering Corporation. 2011.</p>
<b>Policy link to related policies</b>	
<b>Version effective date</b>	October 1, 2011

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