

Clinical Policy: Glatiramer Acetate (Copaxone, Glatopa)

Reference Number: CP.PHAR.252

Effective Date: 08.01.16

Last Review Date: 05.18

Line of Business: HIM, Medicaid

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Glatiramer (Copaxone[®], Glatopa[®]) is a polypeptide.

FDA Approved Indication(s)

Copaxone and Glatopa are indicated for the treatment of patients with relapsing forms of multiple sclerosis (MS).

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation[®] that Copaxone and Glatopa are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Multiple Sclerosis (must meet all):

1. Diagnosis of relapsing-remitting MS;
2. Prescribed by or in consultation with a neurologist;
3. Age \geq 18 years;
4. If Copaxone 20 mg is requested, member is contraindicated or has clinically significant adverse effects to excipients in Glatopa 20 mg;
5. Glatiramer is not prescribed concurrently with other disease modifying therapies for MS (*see Appendix C*);
6. Dose does not exceed 20 mg/mL per day (1 prefilled syringe/day) or 40 mg/mL three times per week (3 prefilled syringes/week).

Approval duration: 6 months

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Multiple Sclerosis (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;

2. Member is responding positively to therapy;
3. Glatiramer is not prescribed concurrently with other disease modifying therapies for MS (*see Appendix C*);
4. If request is for a dose increase, new dose does not exceed 20 mg/day (1 prefilled syringe/day) or 40 mg three times per week (3 prefilled syringes/week).

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2):

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid or evidence of coverage documents;
- B. Primary progressive MS.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration

MS: multiple sclerosis

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
glatiramer acetate (Glatopa)	20 mg SC QD	20 mg/day

Therapeutic alternatives are listed as Brand name[®] (generic) when the drug is available by brand name only and generic (Brand name[®]) when the drug is available by both brand and generic.

Appendix C: General Information

- Disease-modifying therapies for MS are: daclizumab (Zinbryta[®]), glatiramer acetate (Copaxone[®], Glatopa[®]), interferon beta-1a (Avonex[®], Rebif[®]), interferon beta-1b (Betaseron[®], Extavia[®]), peginterferon beta-1a (Plegridy[®]), dimethyl fumarate (Tecfidera[®]), fingolimod (Gilenya[™]), teriflunomide (Aubagio[®]), alemtuzumab (Lemtrada[®]), mitoxantrone (Novantrone[®]), natalizumab (Tysabri[®]), and ocrelizumab (Ocrevus[™]).

V. Dosage and Administration

Drug Name	Dosing Regimen	Maximum Dose
Glatiramer acetate (Copaxone)	20 mg SC QD or 40 mg SC TIW	20 mg/day or 40 mg TIW
Glatiramer acetate (Glatopa)	20 mg SC QD	20 mg/day

VI. Product Availability

Drug Name	Availability
Glatiramer acetate (Copaxone)	Single-dose, prefilled syringe: 20 mg/mL, 40 mg/mL
Glatiramer acetate (Glatopa)	Single-dose, prefilled syringe: 20 mg/mL

VII. References

1. Copaxone Prescribing Information. North Wales, PA: TEVA Pharmaceuticals USA, Inc.; August 2016. Available at <https://www.copaxone.com/>. Accessed January 5, 2018.
2. Glatopa Prescribing Information. Princeton, NJ: Sandoz, Inc; April 2016. Available at <https://www.glatopa.com/>. Accessed January 5, 2018.
3. Goodin DS, Frohman EM, Garmany GP, et al. Disease modifying therapies in multiple sclerosis: Subcommittee of the American Academy of Neurology and the MS Council for Clinical Practice Guidelines. Neurology. 2002; 58(2): 169-178.
4. Costello K, Halper J, Kalb R, Skutnik L, Rapp R. The use of disease-modifying therapies in multiple sclerosis, principles and current evidence – a consensus paper by the Multiple Sclerosis Coalition. March 2017. Accessed January 5, 2018.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J1595	Injection, glatiramer acetate, 20 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy split from CP.PHAR.18 MS Treatments. Criteria: added max dosing, clarified monotherapy restriction, removed re-authorization requirement for documented adherence, added contraindications and reasons to discontinue, modified efficacy criteria from “No increase in neurologic dysfunction/disability as a result of relapses or progressive disease, including a change in diagnostic status from RRMS to SPMS” to “Responding positively to therapy”. Changed renewal approval duration to 12 months.	06.16	08.16
Added age requirement. Removed MRI requirement. Removed contraindication from initial and re-auth criteria.	07.17	08.17

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2018 annual review: no significant changes from previously approved corporate policy; policies combined for Centene Medicaid and HIM lines of business; HIM: MRI requirement removed; age added; modified requirement for “failure” of Glatopa 20 to “contraindications or adverse effects to excipients” as it is the same active ingredient as Copaxone 20; references reviewed and updated.	01.05.18	05.18

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note:

For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy.

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