

Clinical Policy: Sodium Oxybate (Xyrem)

Reference Number: CP.PMN.42

Effective Date: 05.01.11

Last Review Date: 05.18

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

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

Description

Sodium oxybate (Xyrem[®]) is a central nervous system (CNS) depressant.

FDA Approved Indication(s)

Xyrem is indicated for the treatment of:

- Cataplexy in narcolepsy
- Excessive daytime sleepiness (EDS) in narcolepsy

Limitation(s) of use: Xyrem may only be dispensed to patients enrolled in the Xyrem REMS Program.

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 Xyrem is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Narcolepsy with Cataplexy (must meet all):

1. Prescribed for the treatment of cataplexy in narcolepsy;
2. Age \geq 18 years;
3. Failure of 2 of the following antidepressants: venlafaxine, fluoxetine, tricyclic antidepressant (e.g., protriptyline, clomipramine), each tried for \geq 1 month, unless all are contraindicated or clinically significant adverse effects are experienced;
4. Dose does not exceed 9 grams/day (18 mL/day).

Approval duration:

Medicaid/HIM - 6 months

Commercial - Length of Benefit

B. Narcolepsy with Excessive Daytime Sleepiness (must meet all):

1. Diagnosis of narcolepsy with EDS;
2. Age \geq 18 years;
3. Failure of a 1 month trial of one of the following CNS stimulants: amphetamine immediate release (IR), amphetamine; dextroamphetamine IR, dextroamphetamine, methylphenidate IR, or Metadate ER at up to maximally indicated doses unless

- contraindicated or clinically significant adverse effects are experienced; **Note: CNS stimulants may require prior authorization.*
4. Failure of a 1 month trial of armodafinil or modafinil at up to maximally indicated doses unless contraindicated or clinically significant adverse effects are experienced; **Note: Armodafinil and modafinil require prior authorization*
 5. Dose does not exceed 9 grams/day (18 mL/day).

Approval duration:

Medicaid/HIM - 6 months

Commercial - Length of Benefit

C. 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): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (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 (e.g., reduction in frequency of cataplexy attacks, reported daytime improvements in wakefulness);
3. If request is for a dose increase, new dose does not exceed 9 grams/day (18 mL/day).

Approval duration:

Medicaid/HIM - 12 months

Commercial - Length of Benefit

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 12 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): CP.CPA.09 for commercial, 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 – CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CNS: central nervous system

EDS: excessive daytime sleepiness

FDA: Food and Drug Administration
IR: immediate release

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
Cataplexy		
Venlafaxine (Effexor [®]) [†]	75–150 mg PO BID, or 75–150 mg (extended release) PO QAM	375 mg/day* (IR tablets); 225* mg/day (extended release)
Fluoxetine (Prozac [®]) [†]	20 to 80 mg PO QAM	80 mg/day
Clomipramine (Anafranil [®]) [†]	10 to 150 mg PO as a single dose every morning or in divided doses	250 mg/day*
Protriptyline (Vivactil [®]) [†]	5 to 60 mg PO as a single dose every morning or in divided doses	60 mg/day
Excessive daytime sleepiness		
Evekeo [®] (amphetamine)	5 to 60 mg/day PO in divided doses	60 mg/day
amphetamine/dextroamphetamine (Adderall [®])		
dextroamphetamine ER (Dexedrine [®] Spansule [®])		
dextroamphetamine IR (Zenedi [®] , Procentra [®])		
methylphenidate IR (Ritalin [®] , Methylin [®])	10 to 60 mg/day PO in 2 to 3 divided doses	60 mg/day
armodafinil (Nuvigil [®])	150 mg to 250 mg orally once a day	250 mg/day
modafinil (Provigil [®])	200 mg PO QD as a single dose in the morning	400 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.

**Non-indication specific (maximum dose for the drug)*

[†]Off-label indication

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Cataplexy in narcolepsy EDS in narcolepsy	The recommended starting dose is 4.5 grams (g) per night administered orally in two equal, divided doses: 2.25 g at bedtime and 2.25 g taken 2.5 to 4 hours later. Increase the dose by 1.5 g per night at weekly intervals (additional 0.75 g at bedtime and 0.75 g taken 2.5 to 4 hours later) to the effective dose range of 6 g to 9 g per night orally	9 g per night

VI. Product Availability

Oral solution: 0.5 g per mL

VII. References

1. Xyrem Prescribing Information. Palo Alto, CA: Jazz Pharmaceuticals, Inc.; November 2017. Available at: <https://www.xyrem.com/>. Accessed January 22, 2018.
2. Morgenthaler TI, Kapur VK, Brown T, et al. Practice Parameters for the Treatment of Narcolepsy and other Hypersomnias of Central Origin An American Academy of Sleep Medicine Report: An American Academy of Sleep Medicine Report. Sleep. 2007;30(12):1705-1711.
3. Wise MS, Arand DL, Auger RR, Brooks SN, Watson NF. Treatment of Narcolepsy and other Hypersomnias of Central Origin: An American Academy of Sleep Medicine Review. Sleep. 2007;30(12):1712-1727.
4. Scammell TE. The neurobiology, diagnosis and treatment of narcolepsy. Ann Neurol. 2003;53:154 –166.
5. Swick TJ. Treatment paradigms for cataplexy in narcolepsy: past, present, and future. Nat Sci Sleep. 2015; 7:159-169.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Updated Approval to include recommended dosing information. References updated.	05.14	05.14
References updated.	05.15	05.15
Converted into new policy template Removed requirement for proof of diagnosis based on DSM-V criteria and requirement of polysomnogram as this subjective and not within scope of practice for pharmacist to accurately interpret or measure results of sleep study; Removed bullet point #C as this subjective and not within scope of practice for accurate measure or interpretation by pharmacist as reviewer of sleep study results no measure to verify requirements; Created separate bullet point for trial and failure of SSRI or TCA if member intolerant to venlafaxine;	02.16	05.16

Reviews, Revisions, and Approvals	Date	P&T Approval Date
<p>Removed concomitant stimulant plus antidepressant therapy as research did not reflect two classes must be used together; Removed use of alcohol because although a safety requirement, no accurate means to measure alcohol use therefore considered subjective; Added that sedative hypnotic use will be reviewed by pharmacy claim history as this is an objective measure ; Removed renewal criteria requiring show of improvement of daytime wakefulness and Epworth Sleepiness Scale as this is subjective; Added the following to renewal criteria: Member must be currently on medication AND Dose does not exceed FDA approved limit; Updated background section to include mechanism of action and FDA approved indications. Updated reference to reflect current literature search.</p>		
<p>-Created separate criteria for diagnosis of narcolepsy with cataplexy and diagnosis of narcolepsy with EDS -Narcolepsy with cataplexy: removed requirements related to trial and failure of stimulants and armodafinil/modafinil for narcolepsy with cataplexy since these agents used to treat excessive sleepiness have little effect on cataplexy per American Academy of Sleep Medicine report; modified criteria to require trial and failure of 2 antidepressants, instead of 1 for cataplexy -Narcolepsy with EDS: modified criteria to require failure of one CNS stimulant indicated for narcolepsy at up to maximally indicated doses instead of failure of 2 stimulants, one from each class (amphetamine and methylphenidate) -Converted to new template -Removed requirements related to age restriction and “No concurrent use of sedative hypnotics as evidenced by review of pharmacy claim history” per template update, and since age is not an absolute contraindication per PI and safety concerns are addressed by Xyrem REMS Program -Added “documentation of positive response to therapy” for re-auth -Updated references</p>	03.17	05.17
<p>2Q 2018 annual review: no significant changes from previously approved corporate policy; policies combined for commercial, HIM, and Medicaid lines of business; added age requirement as safety and effectiveness in pediatric patients have not been established per PI; Commercial: Cataplexy: added requirement related to trial and failure of antidepressants; EDS: added requirements related to stimulant and armodafinil or modafinil trial; HIM and Medicaid:</p>	01.23.18	05.18

Reviews, Revisions, and Approvals	Date	P&T Approval Date
modified initial approval duration from 3 to 6 months; Medicaid: added quantity limit of 18 mL/day; references reviewed and updated.		

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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