Premier Health Plan

POLICY AND PROCEDURE

POLICY TITLE: ***Vimpat (lacosamide)***
DEPARTMENT: **Clinical Pharmacy Services- Utilization Management**
ORIGINAL DATE: ***March 2009 (as adopted from UPMC Health Plan)***

Last P & T Committee Approval Date: *January 2018*

Product Applicability: *mark all applicable products below:*

COMMERCIAL	[ ] HMO [ ] PPO *Products*: [ ] Small [ ] Indiv. [ ] Large *Exchange*: [ ] Shop [ ] Indiv. [x] All
OTHER	[x] Self-funded/ASO

PURPOSE

The purpose of this policy is to define the prior authorization process for Vimpat (lacosamide).

Vimpat (lacosamide) is indicated as monotherapy or adjunctive therapy in the treatment of partial-onset seizures in patients with epilepsy aged 4 years and older; the injection for intravenous use is indicated as monotherapy or adjunctive therapy in the treatment of partial-onset seizures in patients with epilepsy aged 17 years and older when oral administration is temporarily not feasible.

DEFINITIONS

N/A

POLICY

It is the policy of the Health Plan to maintain a prior authorization process that promotes appropriate utilization of specific drugs with potential for misuse or limited indications. This process involves a review using Food and Drug Administration (FDA) criteria to make a determination of Medical Necessity, and approval by the Pharmacy &

Therapeutics Committee of the criteria for prior authorization, as described in RX.002 Pharmacy and Therapeutics Committee and RX.003-Prior Authorization Process.

The drug, Vimpat (lacosamide), is subject to the prior authorization process.

PROCEDURE

Initial Authorization Criteria:

Must meet all of the criteria listed below:

- Must be prescribed by or in consultation with a neurologist
- Oral tablet and solution: Must be age 4 years or older
- Injection: Must be age 17 years or older
- Must have a diagnosis of partial-onset seizures
- Must be using lacosamide (Vimpat) as monotherapy or adjunctive therapy to other anti-epileptic drugs (AEDs)
- Must have had an inadequate response or intolerance to at least 2 generic antiepileptic medications for both monotherapy or adjunctive therapy indication

Limitations:

Length of Authorization (if above criteria met)	
Initial Authorization	Up to duration of member's membership with plan
Reauthorization	N/A

If the established criteria are not met, the request is referred to a Medical Director for review.

REFERENCES

1. Vimpat [package insert].Smyrna, GA: UCB, Inc.; November 2017.
2. Wechsler RT, Li G, French J et al. Conversion to lacosamide monotherapy in the treatment of focal epilepsy: Results from a historical-controlled, multicenter, double-blind study. Epilepsia. 2014;55:1088-1098.

RECORD RETENTION

Records Retention for Evolent Health documents, regardless of medium, are provided within the Evolent Health records retention policy and as indicated in CORP.028.E Records Retention Policy and Procedure.

REVIEW HISTORY

DESCRIPTION OF REVIEW / REVISION	DATE APPROVED
Annual review	*02/16, 02/17*
Criteria Update	*01/18*