Premier Health Plan

POLICY AND PROCEDURE

POLICY TITLE: **Glatiramer Products (Copaxone®, Glatopa®, glatiramer)**
DEPARTMENT: **Clinical Pharmacy Services – Utilization Management**
ORIGINAL DATE: ***September 2018***

Last P & T Committee Approval Date: *September 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 Copaxone®, Glatopa®, and glatiramer acetate.

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

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.

Copaxone®, Glatopa®, and glatiramer acetate are 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
- Must have a diagnosis of relapsing form of multiple sclerosis
- Must be age 18 years or older
- Must not be receiving concomitant therapy with another disease-modifying therapy (DMT)

Reauthorization Criteria:

All prior authorization renewals are reviewed to determine the Medical Necessity for continuation of therapy. Authorization may be extended based upon:

- Documentation from the provider that the member's disease course has stabilized or improved based upon the prescriber's assessment while on therapy
- Documentation that the member is not receiving concomitant therapy with another disease-modifying therapy (DMT)

Limitations:

Length of Authorization (if above criteria met)	
Initial Authorization	Up to 6 months
Reauthorization	Up to 1 year
Quantity Level Limit	
Copaxone 20mg; Glatopa 20mg; glatiramer acetate 20m	30 mL per 30 days
Copaxone 40mg; Glatopa 40mg; glatiramer acetate 40mg	12 mL per 28 days

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

REFERENCES

1. Copaxone (glatiramer acetate) [prescribing information]. North Wales, PA: Teva Pharmaceuticals; January 2018.
2. Glatopa (glatiramer acetate) [prescribing information]. Princeton, NJ: Sandoz Inc; January 2018.

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
New Policy	*09/18 (effective 1/1/19)*