

Clinical Policy: Glatiramer Acetate (Copaxone, Glatopa)

Reference Number: CP.PHAR.252

Effective Date: 09.01.16

Last Review Date: 05.24

Line of Business: Commercial, HIM, Medicaid

[Coding Implications](#)

[Revision Log](#)

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

Description

Glatiramer acetate (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), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.

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 glatiramer acetate, 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 one of the following (a, b, or c):
 - a. Clinically isolated syndrome;
 - b. Relapsing-remitting MS;
 - c. Secondary progressive MS;
2. Prescribed by or in consultation with a neurologist;
3. Age \geq 18 years;
4. If request is for brand Copaxone, member must use **generic glatiramer** (including Glatopa), unless contraindicated or clinically significant adverse effects are experienced;
5. Glatiramer is not prescribed concurrently with other disease modifying therapies for MS (*see Appendix D*);
6. Documentation of both baseline number of relapses per year and expanded disability status scale (EDSS) score;
7. Dose does not exceed one of the following (a or b):
 - a. 20 mg per day (1 prefilled 20 mg syringe per day);
 - b. 40 mg three times per week (3 prefilled 40 mg syringes per week).

Approval duration:

Medicaid/HIM – 6 months

Commercial – 6 months or to the member's renewal date, whichever is longer

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Multiple Sclerosis (must meet all):

1. Member meets one of the following (a or b):
 - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
 - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
2. Member meets one of the following (a or b):
 - a. If member has received < 1 year of total treatment: Member is responding positively to therapy;
 - b. If member has received \geq 1 year of total treatment: Member meets one of the following (i, ii, iii, or iv):
 - i. Member has not had an increase in the number of relapses per year compared to baseline;
 - ii. Member has not had \geq 2 new MRI-detected lesions;
 - iii. Member has not had an increase in EDSS score from baseline;
 - iv. Medical justification supports that member is responding positively to therapy;
3. If request is for brand Copaxone, member must use **generic glatiramer** (including Glatopa), unless contraindicated or clinically significant adverse effects are experienced;
4. Glatiramer is not prescribed concurrently with other disease modifying therapies for MS (*see Appendix D*);
5. If request is for a dose increase, new dose does not exceed one of the following (a or b):
 - a. 20 mg per day (1 prefilled 20 mg syringe per day);
 - b. 40 mg three times per week (3 prefilled 40 mg syringes per week).

Approval duration:

Medicaid/HIM –

If member has received < 1 year of total treatment – up to a total of 12 months of treatment

If member has received ≥ 1 year of total treatment – 12 months

Commercial – 6 months or to the member’s renewal date, whichever is longer

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 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.PA.154 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

EDSS: expanded disability status scale

FDA: Food and Drug Administration

MS: multiple sclerosis

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): known hypersensitivity to glatiramer acetate or mannitol
- Boxed warning(s): none reported

Appendix D: General Information

- Disease-modifying therapies for MS are: glatiramer acetate (Copaxone[®], Glatopa[®]), interferon beta-1a (Avonex[®], Rebif[®]), interferon beta-1b (Betaseron[®], Extavia[®]), peginterferon beta-1a (Plegridy[®]), dimethyl fumarate (Tecfidera[®]), diroximel fumarate (Vumerity[®]), monomethyl fumarate (Bafiertam[™]), fingolimod (Gilenya[®], Tascenso ODT[™]), teriflunomide (Aubagio[®]), alemtuzumab (Lemtrada[®]), mitoxantrone (Novantrone[®]), natalizumab (Tysabri[®], and biosimilar Tyruko[®]), ocrelizumab (Ocrevus[®]), cladribine (Mavenclad[®]), siponimod (Mayzent[®]), ozanimod (Zeposia[®]), ponesimod (Ponvory[™]), ublituximab-xiyy (Briumvi[™]), and ofatumumab (Kesimpta[®]).

V. Dosage and Administration

| Indication | Dosing Regimen | Maximum Dose |
|--------------|-----------------------------|------------------------|
| Relapsing MS | 20 mg SC QD or 40 mg SC TIW | 20 mg/day or 40 mg TIW |

VI. Product Availability

Single-dose, prefilled syringes: 20 mg/mL, 40 mg/mL

VII. References

1. Copaxone Prescribing Information. North Wales, PA: TEVA Pharmaceuticals USA, Inc.; November 2023. Available at <https://www.copaxone.com>. Accessed January 10, 2024.
2. Glatopa Prescribing Information. Princeton, NJ: Sandoz, Inc; December 2023. Available at <https://www.glatopa.com>. Accessed January 25, 2024.
3. Glatiramer Acetate 20 mg/mL Prescribing Information. Morgantown, WV: Mylan Pharmaceuticals Inc.; January 2024. Available at: <https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=f38b5606-d2d7-44ec-912f-46882aa2fa7b>. Accessed January 25, 2024.
4. Glatiramer Acetate 40 mg/mL Prescribing Information. Morgantown, WV: Mylan Pharmaceuticals Inc.; January 2024. Available at: <https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=456a34c7-8511-4000-99a7-ad8f8de6d35e>. Accessed January 25, 2024.
5. 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.
6. Rae-Grant A, Day GS, Marrie RA, et al. Practice guideline recommendations summary: disease-modifying therapies for adults with multiple sclerosis: report of the Guideline Development, Dissemination, and Implementation Subcommittee of the American Academy of Neurology. *Neurology*. 2018; 90(17): 777-788. Full guideline available at: <https://www.aan.com/Guidelines/home/GetGuidelineContent/904>. Reaffirmed on September 18, 2021.

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 |
|---|----------|-------------------|
| 2Q 2020 annual review: modified Commercial approval durations to “6 months or to the member’s renewal date, whichever is longer”, consistent with standard approach for injectable agents; references reviewed and updated. | 01.27.20 | 05.20 |
| Added requirements for documentation of baseline relapses/EDSS and objective measures of positive response upon re-authorization; modified Medicaid/HIM continued approval duration to 6 months for the first re-authorization and 12 months for second/subsequent re-authorizations; references reviewed and updated. | 05.27.20 | 08.20 |
| Per December SDC and prior clinical guidance, removed HIM LOB from policy (HIM.PA.SP68 created). | 12.15.20 | |
| 2Q 2021 annual review: no significant changes; references reviewed and updated. | 02.08.21 | 05.21 |
| 2Q 2022 annual review: no significant changes; references reviewed and updated. | 02.07.22 | 05.22 |
| Template changes applied to other diagnoses/indications and continued therapy section. | 10.11.22 | |
| 2Q 2023 annual review: no significant changes; added generic redirection to continued therapy section; to be inclusive of members continuing therapy from a different benefit, revised Medicaid continued approval duration to reference the duration of total treatment received rather than the number of re-authorizations; references reviewed and updated. | 01.30.23 | 05.23 |
| Per August SDC, added HIM line of business (HIM.PA.SP68 retired). | 08.22.23 | 11.23 |
| 2Q 2024 annual review: no significant changes; revised policy/criteria section to also include generic glatiramer; references reviewed and updated. | 01.25.24 | 05.24 |

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.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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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.

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