Clinical Policy: Lacosamide (Vimpat)
Reference Number: CP.PMN.155
Effective Date: 12.01.14
Last Review Date: 08.20
Line of Business: HIM, Medicaid

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Lacosamide (Vimpat®) is an anticonvulsant.

FDA Approved Indication(s)
Vimpat is indicated for the treatment of partial-onset seizures in patients 4 years of age and older.

As the safety of Vimpat injection in pediatric patients has not been established, Vimpat injection is indicated for the treatment of partial-onset seizures only in adult patients (17 years of age and older).

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 Vimpat is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Partial-Onset Seizures (must meet all):
      1. Diagnosis of partial-onset seizures;
      2. Age ≥ 4 years;
      3. Failure of two preferred alternatives (see Appendix B for examples) unless clinically significant adverse effects are experienced or all are contraindicated;
      4. Dose does not exceed any of the following (a or b):
         a. Age ≥ 17 years or weight ≥ 50 kg: 400 mg per day;
         b. Age 4 to < 17 years (i or ii):
            i. Weight 30 kg to < 50 kg: 8 mg/kg per day;
            ii. Weight 11 kg to < 30 kg: 12 mg/kg per day.
   Approval duration: 12 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. Partial-Onset Seizures (must meet all):
   1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Vimpat for partial-onset seizures and has received this medication for at least 30 days;
   2. Member is responding positively to therapy;
   3. If request is for a dose increase, new dose does not exceed any of the following (a or b):
      a. Age ≥ 17 years or weight ≥ 50 kg: 400 mg per day;
      b. Age 4 to < 17 years (i or ii):
         i. Weight 30 kg to < 50 kg: 8 mg/kg per day;
         ii. Weight 11 kg to < 30 kg: 12 mg/kg per day.

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 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): 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.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration

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.

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Examples</th>
<th>Dose Limit/ Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticonvulsants for partial seizures</td>
<td>carbamazepine (Tegretol®), felbamate (Felbatol®), gabapentin (Neurontin®), lamotrigine (Lamictal®), levetiracetam (Keppra®), oxcarbazepine (Trileptal®), phenytoin (Dilantin®), tiagabine (Gabitril®), topiramate (Topamax®), valproic acid (Depakene®), divalproex sodium (Depakote®), zonisamide (Zonegran®)</td>
<td>Varies according to the agent used</td>
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Appendix C: Contraindications / Boxed Warnings

- Contraindication(s): none reported
- Boxed warning(s): none reported

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
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</table>
| Partial-onset seizures          | Adults (17 years and older): Initial dosage for monotherapy is 100 mg BID; Initial dosage for adjunctive therapy is 50 mg BID.  
                                   | Pediatric Patients 4 Years to less than 17 years: The recommended dosage is based on body weight and is administered PO BID. | Adults (17 years and older): 400 mg per day  
                                   | pediatric Patients 4 Years to less than 17 years:  
                                   | 11 kg to < 30 kg: 12 mg/kg/day  
                                   | 30 kg to < 50 kg: 8 mg/kg/day  
                                   | ≥ 50 kg: 400 mg/day |

VI. Product Availability

- Tablets: 50 mg, 100 mg, 150 mg, 200 mg
- Oral solution: 10 mg/mL
- Single-dose vial for intravenous use: 200 mg/20 mL

VII. References


Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Change Description</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
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<tbody>
<tr>
<td>Changed guideline to new format.</td>
<td>08.16</td>
<td>08.16</td>
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<tr>
<td>Converted to new template</td>
<td>04.17</td>
<td>08.17</td>
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<tr>
<td>Added max dose.</td>
<td></td>
<td></td>
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<tr>
<td>Updated references.</td>
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Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Description</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
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<tbody>
<tr>
<td>Dosing updated per FDA expanded indication for pediatric patients. Age requirement added per safety guidance endorsed by Centene Medical Affairs.</td>
<td>11.15.17</td>
<td></td>
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<tr>
<td>3Q 2018 annual review: new policy for Medicaid line of business; modified number of preferred trials from 3 to 2; references reviewed and updated.</td>
<td>04.04.18</td>
<td>08.18</td>
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<tr>
<td>3Q 2019 annual review: no significant changes; references reviewed and updated.</td>
<td>05.05.19</td>
<td>08.19</td>
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<tr>
<td>3Q 2020 annual review: no significant changes; references reviewed and updated.</td>
<td>05.04.20</td>
<td>08.20</td>
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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.

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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.

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