STEP THERAPY POLICY

POLICY: Antiseizure Medications – Lacosamide Step Therapy Policy
- Motpoly XR (lacosamide extended-release capsules – Aucta)
- Vimpat® (lacosamide tablets and oral solution – UCB, generic)

REVIEW DATE: 03/01/2023; selected revision 11/01/2023

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Lacosamide (Vimpat, generic) is indicated for the following:[1]
- **Treatment of partial-onset seizures** in patients ≥ 1 month of age.
- **Adjunctive therapy in the treatment of primary generalized tonic-clonic seizures** in patients ≥ 4 years of age.

Motpoly XR is indicated for the treatment of partial-onset seizures in adults and in pediatric patients weighing ≥ 50 kg.[2]

POLICY STATEMENT

This program has been developed to encourage the use of a Step 1 Product prior to the use of a Step 2 Product. If the Step Therapy rule is not met for a Step 2 Product at the point of service, coverage will be determined by the Step Therapy criteria below. All approvals are provided for 1 year in duration.

Antiseizure Medications – Lacosamide product(s) is(are) covered as medically necessary when the following step therapy criteria is(are) met. Any other exception is considered not medically necessary.

Step 1: generic lacosamide tablets, generic lacosamide oral solution

Step 2: Motpoly XR, Vimpat tablets, Vimpat oral solution

CRITERIA

1. If the patient has tried one Step 1 Product, approve a Step 2 Product.

REFERENCES

1. Vimpat® tablets and oral solution [prescribing information]. Smyrna, GA: UCB; September 2022.
2. Motpoly XR extended-release capsules [prescribing information]. Piscataway, NJ: Aucta; May 2023.

HISTORY

Type of Revision	Summary of Changes	Review Date
New Policy	--	03/16/2022
Selected Revision	**Vimpat oral solution:** Vimpat oral solution and generic lacosamide oral solution were removed from the policy because the generic oral solution did not received FDA approval as had been anticipated.	04/22/2022
Selected Revision	**Vimpat oral solution:** Vimpat oral solution (Step 2 product) and generic lacosamide oral solution (Step 1 product) have been added back into the policy because the generic oral solution was approved and launched.	6/15/2022
Annual Revision	**Policy Name Change:** Changed from Antiepileptics – Lacosamide Step Therapy to Antiseizure Medications – Lacosamide Step Therapy Policy. No criteria changes.	03/01/2023
Selected Revision	**Motpoly XR:** Added to Step 2.	11/01/2023