**Clinical Policy: Amantadine ER (Gocovri, Osmolex ER)**

Reference Number: CP.PMN.89
Effective Date: 10.10.17
Last Review Date: 02.20
Line of Business: Commercial, Medicaid

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

**Description**

Amantadine extended-release (Gocovri™, Osmolex ER™) is a weak uncompetitive antagonist of the N-methyl-D-aspartate (NMDA) receptor.

**FDA Approved Indication(s)**

Gocovri is indicated for the treatment of dyskinesia in patients with Parkinson’s disease receiving levodopa-based therapy, with or without concomitant dopaminergic medications.

Osmolex ER is indicated for the treatment of Parkinson's disease and for the treatment of drug-induced extrapyramidal reactions in adult patients.

**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 Gocovri and Osmolex ER are **medically necessary** when the following criteria are met:

**I. Initial Approval Criteria**

**A. Dyskinesia in Patients with Parkinson’s Disease** (must meet all):

1. Diagnosis of dyskinesia in patients with Parkinson’s disease;
2. Member is receiving levodopa-based therapy;
3. Meets one of the following (a or b):
   a. Failure of a 2-week trial of immediate-release amantadine unless contraindicated or clinically significant adverse effects are experienced;
   b. Medical justification supports inability to continue use of immediate-release amantadine (e.g., contraindications to excipients);
4. Dose does not exceed 274 mg per day for Gocovri or 322 mg per day for Osmolex ER.

**Approval duration:**

- **Medicaid** – 12 months
- **Commercial** – Length of Benefit

**B. Drug Induced Extrapyramidal Reactions** (must meet all):

1. Diagnosis of a drug induced extrapyramidal reaction;
2. Request is for Osmolex ER;
3. Meets one of the following (a or b):
Amantadine ER

a. Failure of a 2-week trial of immediate-release amantadine unless contraindicated or clinically significant adverse effects are experienced;
b. Medical justification supports inability to continue use of immediate-release amantadine (e.g., contraindications to excipients);
4. Dose does not exceed 274 mg per day.

Approval duration:
Medicaid – 12 months
Commercial – Length of Benefit

C. 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): CP.CPA.09 for commercial and CP.PMN.53 for Medicaid.

II. Continued Therapy
A. All Indications in Section I (must meet all):
1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy (e.g., reductions in OFF time, improvement in dyskinesia symptoms);
3. If request is for a dose increase, new dose does not exceed 274 mg per day for Gocovri or 322 mg per day for Osmolex ER.

Approval duration:
Medicaid – 12 months
Commercial – Length of Benefit

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): CP.CPA.09 for commercial 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 policy – CP.CPA.09 for commercial 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</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>amantadine immediate-release</td>
<td>Titrated up to 100 mg PO QID</td>
<td>400 mg/day</td>
</tr>
</tbody>
</table>

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings
- Contraindication(s): end-stage renal disease
- Boxed Warning(s): none reported

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amantadine ER (Gocovri)</td>
<td>Dyskinesia in Parkinson’s disease</td>
<td>137 mg PO QHS for 1 week. After 1 week, increase to 274 mg (two 137 mg capsules) PO QHS</td>
<td>274 mg/day</td>
</tr>
<tr>
<td>Amantadine ER (Osmolex ER)</td>
<td>Dyskinesia in Parkinson’s disease; drug induced extrapyramidal reaction</td>
<td>129 mg PO QAM, increase dose in weekly intervals</td>
<td>322 mg/day</td>
</tr>
</tbody>
</table>

VI. Product Availability

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amantadine ER (Gocovri)</td>
<td>Extended-release capsules: 68.5 mg and 137 mg</td>
</tr>
<tr>
<td>Amantadine ER (Osmolex ER)</td>
<td>Extended-release tablets: 129 mg, 193 mg, 258 mg</td>
</tr>
</tbody>
</table>

VII. References
CLINICAL POLICY
Amantadine ER

Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Description</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy created</td>
<td>10.10.17</td>
<td>01.18</td>
</tr>
<tr>
<td>Per SDC, added requirement for medical justification that supports inability to use immediate-release amantadine</td>
<td>04.12.18</td>
<td></td>
</tr>
<tr>
<td>Added Osmolex ER per SDC based on approved clinical guidance; added criteria set for drug induced extrapyramidal reaction.</td>
<td>09.18.18</td>
<td></td>
</tr>
<tr>
<td>1Q 2019 annual review; no significant changes; immediate-release amantadine two-week trial and medical justification requirements are edited to reflect either/or; references reviewed and updated.</td>
<td>11.13.18</td>
<td>02.19</td>
</tr>
<tr>
<td>1Q 2020 annual review: no significant changes; references reviewed and updated.</td>
<td>10.30.19</td>
<td>02.20</td>
</tr>
</tbody>
</table>

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.

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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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