STANDARD COMMERCIAL DRUG FORMULARY
PRIOR AUTHORIZATION GUIDELINES

GLATIRAMER ACETATE

Generic	Brand	HICL	GCN	Exception/Other
GLATIRAMER ACETATE	COPAXONE, GLATOPA	12810		

This drug requires a written request for prior authorization.

GUIDELINES FOR USE

1. Does the patient have a diagnosis of a relapsing form of multiple sclerosis including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease **AND** meet the following criterion?
   - The patient is 18 years of age or older

   If yes, **approve for 12 months by GPID with the following quantity limits:**
   - **Glatiramer acetate 20mg/mL: #1mL per day.**
   - **Glatiramer acetate 40mg/mL: #12 syringes per 28 days.**

   If no, do not approve.
   DENIAL TEXT: The guideline named **GLATIRAMER ACETATE (Copaxone/Glatopa)** requires a diagnosis of a relapsing form of multiple sclerosis including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease. The following must also be met:
     - The patient is 18 years of age or older

RATIONALE
For further information, please refer to the prescribing information and/or drug monograph for Copaxone/Glatopa.

REFERENCES

- Copaxone [Prescribing Information]. Overland Park, KS: Teva; July 2019.
- Glatopa [Prescribing Information], Princeton, NJ: Sandoz Inc.; July 2019.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A | Created: 02/14
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