Clinical Policy: Cenobamate (Xcopri)
Reference Number: CP.PMN.231
Effective Date: 03.01.20
Last Review Date: 02.21
Line of Business: Commercial, HIM, Medicaid

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

Description
Cenobamate (Xcopri®) is a voltage-gated sodium channel inhibitor and a positive allosteric modulator of the \( \gamma \)-aminobutyric acid (GABA\( _\lambda \)) ion channel.

FDA Approved Indication(s)
Xcopri is indicated for the treatment of partial-onset seizures 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 Xcopri 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. Prescribed by or in consultation with a neurologist;
      3. Age \( \geq \) 18 years;
      4. Failure of two preferred anticonvulsants indicated for partial seizures (see Appendix B for examples), unless clinically significant adverse effects are experienced or all are contraindicated;
      5. Dose does not exceed 400 mg (2 tablets) per day.

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

   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): CP.CPA.09 for commercial, HIM.PA.154 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 Xcopri for a covered indication 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 400 mg (2 tablets) per day.

Approval duration:
Medicaid/HIM – 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, 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.

IV. Appendices/General Information
Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
GABA<sub>A</sub>: γ-aminobutyric acid-subtype A

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 Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>carbamazepine (Carbatrol®, Epitol®, Equetro®, Tegretol®, Tegretol XR®)</td>
<td>Refer to prescribing information</td>
<td>Refer to prescribing information</td>
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<tr>
<td>felbamate (Felbatol®)</td>
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<tr>
<td>gabapentin (Neurontin®)</td>
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<td></td>
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<tr>
<td>lamotrigine (Lamictal®, Lamictal CD®, Lamictal ODT®, Lamictal XR®)</td>
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<tr>
<td>levetiracetam (Eilepsia XR®, Keppra®, Keppra XR®, Roweepra®, Spritam®)</td>
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<tr>
<td>oxcarbazepine (Oxtellar XR®, Trileptal®)</td>
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<td>phenobarbital (Luminal®)</td>
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<tr>
<td>phenytoin (Dilantin®, Phenytek®)</td>
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</table>
### CLINICAL POLICY

**Cenobamate**

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
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</thead>
<tbody>
<tr>
<td>pregabalin (Lyrica®, Lyrica® CR)</td>
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<td>tiagabine (Gabitril®)</td>
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<tr>
<td>topiramate (Qudexy XR®, Topamax®, Topamax Sprinkle®, Topiragen®, Trokendi XR®)</td>
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<tr>
<td>valproic acid, divalproex sodium (Depakene®, Depakote Sprinkle®, Depakote ER®, Depakote®)</td>
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<tr>
<td>zonisamide (Zonegran®)</td>
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*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):**
  - Hypersensitivity to cenobamate or any of the inactive ingredients in Xcopri
  - Familial short QT syndrome
- **Boxed warning(s):** none reported

### V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial-onset seizures</td>
<td><strong>Dose titration:</strong> 12.5 mg PO QD for two weeks, then 25 mg PO QD for two weeks, then 50 mg PO QD for two weeks, then 100 mg PO QD for two weeks, then 150 mg PO QD for two weeks</td>
<td>400 mg/day</td>
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<td><strong>Maintenance dose:</strong> 200 mg PO QD</td>
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<td>If needed based on clinical response and tolerability, dose may be increased above 200 mg by increments of 50 mg PO QD every two weeks to 400 mg PO QD.</td>
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</tbody>
</table>

### VI. Product Availability
- Tablets: 12.5 mg, 25 mg, 50 mg, 100 mg, 150 mg, 200 mg

### VII. References


<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
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<tbody>
<tr>
<td>Policy created</td>
<td>01.07.20</td>
<td>02.20</td>
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<tr>
<td>1Q 2021 annual review: no significant changes; references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.</td>
<td>10.22.20</td>
<td>02.21</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.

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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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