Clinical Policy: Apomorphine (Apokyn)
Reference Number: CP.CPA.225
Effective Date: 11.16.16
Last Review Date: 11.18
Line of Business: Commercial

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

Description
Apomorphine (Apokyn®) is a non-ergoline dopamine agonist.

FDA Approved Indication(s)
Apokyn is indicated for acute, intermittent treatment of hypomobility, “off” episodes (“end-of-dose wearing off” and unpredictable “on/off” episodes) associated with advanced Parkinson’s disease.

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 Apokyn is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Parkinson’s Disease (must meet all):
      1. Diagnosis of Parkinson’s disease;
      2. Patient is experiencing hypomobility episodes at the end of the dosing interval or is experiencing unpredictable hypomobility (“on/off”) episodes;
      3. Dose does not exceed 0.6 mL per injection with a maximum of 5 injections per day (2 mL per day).
      Approval duration: 6 months or to the member’s renewal date, whichever is longer

   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.

II. Continued Therapy
   A. Parkinson’s Disease (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;
      3. If request is for a dose increase, new dose does not exceed 0.6 mL per injection with a maximum of 5 injections per day (2 mL per day).
Approval duration: 6 months or to the member’s renewal date, whichever is longer

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 6 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.

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 or evidence of coverage documents.

IV. Appendices/General Information
   Appendix A: Abbreviation/Acronym Key
   Not applicable

   Appendix B: Therapeutic Alternatives
   Not applicable

   Appendix C: Contraindications/Boxed Warnings
   • Contraindication(s):
     o Concomitant use of Apokyn with 5HT₃ antagonists, including antiemetics (e.g., ondansetron, granisetron, dolasetron, palonosetron) and alosetron.
   • Boxed warning(s): None reported

   Appendix D: General Information
   • Based on reports of profound hypotension and loss of consciousness when apomorphine was given to patients receiving ondansetron, the concomitant use of apomorphine with drugs of the 5-HT₃ antagonist class is contraindicated. These drugs should not be used to prevent or treat apomorphine-induced nausea and vomiting.
   • Apomorphine induces nausea and vomiting. Patients should be pretreated with trimethobenzamide 300 mg orally three times a day for three days prior to beginning apomorphine therapy. The manufacturer recommends continuing trimethobenzamide for the first two months of apomorphine therapy. However, the length of concomitant therapy in trials varied.

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
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<tbody>
<tr>
<td>Parkinson’s disease</td>
<td>0.2 mL SC initial test dose. If patient tolerates and responds, starting dose should be 0.2 mL used on an as needed basis to treat “off” episodes. If needed, may increase dose by 0.1 mL (1 mg) increments every few days.</td>
<td>0.6 mL per dose, max of 2 mL per day</td>
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</table>
VI. Product Availability
Multi-dose glass cartridge solution for injection: 30 mg/3mL (10 mg/mL) with a multiple-dose pen injector

VII. References

<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Converted to new template. Minor changes to verbiage and grammar. References updated.</td>
<td>06.28.17</td>
<td>11.17</td>
</tr>
<tr>
<td>4Q 2018 annual review: no significant changes; references reviewed and updated.</td>
<td>07.30.18</td>
<td>11.18</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.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to
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