Clinical Policy: Topiramate Extended-Release (Qudexy XR, Trokendi XR)

Reference Number: CP.CPA.207
Effective Date: 11.16.16
Last Review Date: 11.19
Line of Business: Commercial

Revision Log

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

Description

Topiramate extended-release (Qudexy® XR, Trokendi XR®) is a sulfamate-substituted monosaccharide.

FDA Approved Indication(s)

Qudexy XR is indicated:

- As initial monotherapy in patients 2 years of age and older with partial onset or primary generalized tonic-clonic seizures and adjunctive therapy in patients 2 years of age and older with partial onset or primary generalized tonic-clonic seizures
- As adjunctive therapy in patients 2 years of age and older with seizures associated with Lennox-Gastaut syndrome (LGS)
- For the prophylaxis of migraine headache in patients 12 years of age and older

Trokendi XR is indicated:

- In patients 6 years of age and older as initial monotherapy for partial onset or primary generalized tonic-clonic seizures
- As adjunctive therapy in patients 6 years of age and older with partial onset or primary generalized tonic-clonic seizures, and seizures associated with LGS
- For patients 12 years and older for the prophylaxis of migraine headache

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 Qudexy XR and Trokendi XR are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Partial Onset Seizures, Primary Generalized Tonic-Clonic Seizures, or Lennox-Gastaut Syndrome (must meet all)**:**

1. Diagnosis of partial onset seizures, primary generalized tonic-clonic seizures, or LGS;
2. One of the following (a or b):
   a. For Qudexy XR: Age ≥ 2 years;
   b. For Trokendi XR: Age ≥ 6 years;
3. Failure of immediate-release topiramate at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
4. Dose does not exceed:

a. Monotherapy for adults and pediatric members ≥ 10 years old: 400 mg per day;
b. Monotherapy for members 2 years to < 10 years of age:
    i. Weight 11 kg or less: 250 mg per day;
    ii. Weight between 12 to 22 kg: 300 mg per day;
    iii. Weight between 23 to 38 kg: 350 mg per day;
    iv. Weight greater than 38 kg: 400 mg per day;
c. Adjunctive therapy for members ≥ 17 years of age: 400 mg per day;
d. Adjunctive therapy for members ≤ 16 years of age: 9 mg per kg per day.

Approval duration: Length of Benefit

B. Migraine Prophylaxis (must meet all)**:**
1. Prescribed for prophylaxis of migraine headache;
2. Age ≥ 12 years;
3. Failure of immediate-release topiramate at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
4. Dose does not exceed 100 mg per day.

Approval duration: 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.

II. Continued Therapy

A. Partial Onset Seizures, Primary Generalized Tonic-Clonic Seizures, or Lennox-Gastaut Syndrome (must meet all)**:**
1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Qudexy XR or Trokendi XR for partial seizures, primary generalized tonic-clonic seizures, or LGS 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:
    a. Monotherapy for adults and pediatric members ≥10 years old: 400 mg per day;
    b. Monotherapy for members 2 years to < 10 years of age:
        i. Weight 11 kg or less: 250 mg per day;
        ii. Weight between 12 to 22 kg: 300 mg per day;
        iii. Weight between 23 to 38 kg: 350 mg per day;
        iv. Weight greater than 38 kg: 400 mg per day;
    c. Adjunctive therapy for members ≥ 17 years of age: 400 mg per day;
    d. Adjunctive therapy for members ≤ 16 years of age: 9 mg per kg per day.

Approval duration: Length of Benefit

B. Migraine Prophylaxis (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 100 mg per day.
Approval duration: Length of Benefit

C. 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.

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 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
LGS: Lennox-Gastaut syndrome

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.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
topiramate, immediate-release (Topamax®)	Initial dose, titration, and recommended maintenance dose varies by indication and age group	100 to 400 mg/day based on age and indication

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):
  - Qudexy XR: none reported
  - Trokendi XR: patients with recent alcohol use (i.e., within 6 hours prior to and 6 hours after Trokendi XR use)
- Boxed warning(s): none reported

Appendix D: General Information
- Qudexy XR and Trokendi XR taken once a day provides steady state plasma levels comparable to immediate release topiramate taken every 12 hours, when administered at the same total 200 mg daily dose.

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Topiramate extended release (Qudexy XR)	Monotherapy: Partial onset or primary generalized tonic-clonic seizures	Adults and pediatric patients 10 years and older: Initial: 50 mg PO QD; Increase dose weekly by increments of 50 mg for the first 4 weeks then 100 mg for weeks 5 to 6 Recommended dose: 400 mg QD Pediatric patients 2 years to 9 years: Initial: 25 mg PO QD at nighttime for the first week; Titrate the dosage by 25 mg to 50 mg PO QD each subsequent week over 5 to 7 weeks. Recommended dose: based on weight	400 mg/day (varies by weight for pediatric patients)
Topiramate extended release (Qudexy XR)	Adjunctive therapy	Adults (≥ 17 years) with partial onset seizures or LGS: Initial: 25 mg to 50 mg PO QD; Increase dose weekly by increments of 25 mg to 50 mg to achieve an effective dose Recommended dose: 200 mg to 400 mg PO QD Adults (≥ 17 years) with primary generalized tonic-clonic seizures: Initial: 25 mg to 50 mg PO QD; Increase dose weekly to an effective dose by increments of 25 mg to 50 mg Recommended dose: 400 mg PO QD Pediatric patients 2 to 16 years with partial onset seizures, primary generalized tonic-clonic seizures or LGS: Initial: 25 mg PO QD at nighttime for the first week; Increase dosage at 1 or 2 week intervals by increments of 1 mg/kg to 3 mg/kg; dose titration should be guided by clinical outcome	Adults: 400 mg/day Pediatric patients 2 to 16 years old: 9 mg/kg/day

Drug Name	Indication	Dosing Regimen	Maximum Dose
		Recommended dose: 5 mg/kg to 9 mg/kg QD	
Topiramate extended release (Qudexy XR)	Migraine prophylaxis	25 to 100 mg PO QD	100 mg/day
Topiramate extended release (Trokendi XR)	Monotherapy: Partial onset or primary generalized tonic-clonic seizures	Adults and pediatric patients 10 years and older: Initial: 50 mg PO QD; Increase dose weekly by increments of 50 mg for the first 4 weeks then 100 mg for weeks 5 to 6 Recommended dose: 400 mg QD Pediatric patients 6 years to 9 years of age: Dosing is based on weight; 150 mg to 400 mg PO QD	400 mg/day (varies by weight for pediatric patients)
Topiramate extended release (Trokendi XR)	Adjunctive therapy	Adults (≥ 17 years) with partial onset seizures or LGS: 200 mg to 400 mg PO QD Adults (≥17 years) with primary generalized tonic-clonic seizures: 400 mg PO QD Pediatric patients 6 to 16 years of age with partial onset seizures, primary generalized tonic-clonic seizures, or seizures associated with LGS: 5 mg/kg to 9 mg/kg PO QD	Adults: 400 mg/day Pediatric patients 6 to 16 years old: 9 mg/kg/day (the total daily dose should not exceed 400 mg/day)
Topiramate extended release (Trokendi XR)	Migraine prophylaxis	25 to 100 mg PO QD	100 mg/day

VI. Product Availability

Drug Name	Availability
Topiramate extended release (Qudexy XR)	Capsule: 25 mg, 50 mg, 100 mg, 150 mg, 200 mg
Topiramate extended release (Trokendi XR)	Capsule: 25 mg, 50 mg, 100 mg, 200 mg

VII. References

1. Trokendi XR Prescribing Information. Winchester, KY: Catalent Pharma Solutions; February 2019. Available at: https://www.trokendixr.com/. Accessed August 8, 2019.
2. Qudexy XR Prescribing Information. Maple Grove, MN: Upsher-Smith Laboratories, Inc.; February 2019. Available at: https://qudexyxr.com/. Accessed August 8, 2019.
3. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2018. Available at: http://www.clinicalpharmacology-ip.com/.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Converted to new template. Minor changes to verbiage and grammar. References updated.	07.18.17	11.17
4Q 2018 annual review: no significant changes; updated continued therapy language to include continuity of care for partial seizures, primary generalized tonic-clonic seizures, or LGS; references reviewed and updated.	07.10.18	11.18
4Q 2019 annual review: no significant changes; references reviewed and updated.	08.08.19	11.19

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 applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan

retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.