

Effective Date: October 10, 2012

### **CRITERIA FOR PRIOR AUTHORIZATION**

Multiple Sclerosis Agents: Copaxone

**PROVIDER GROUP:** Pharmacy and Professional

**MANUAL GUIDELINES:** The following drug(s) require prior authorization:  
Copaxone® (glatiramer)

**CRITERIA:** (must meet all of the following)

- Diagnosis for multiple sclerosis (340.00).
- Age  $\geq$  18.
- Absence of concurrent therapy with another disease-modifying MS agent: an interferon, natalizumab, or fingolimod.
- Does not exceed the following quantity limits:
  - Copaxone (glatiramer) – Quantity limit: 1 kit (of 30 units) per 30 days

**Prior authorizations will be approved for 1 year.**