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### Antiepileptics

<table>
<thead>
<tr>
<th>Override(s)</th>
<th>Approval Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Authorization</td>
<td></td>
</tr>
<tr>
<td>Step Therapy</td>
<td></td>
</tr>
<tr>
<td>Quantity Limit</td>
<td>1 year</td>
</tr>
</tbody>
</table>

*Indiana Medicaid – See State Specific Mandate below

*Maryland Medicaid – See State Specific Mandate below

<table>
<thead>
<tr>
<th>Medications</th>
<th>Comment</th>
<th>Quantity Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carbamazepine</td>
<td>Preferred</td>
<td>May be subject to quantity limit</td>
</tr>
<tr>
<td>Epitol</td>
<td>Preferred</td>
<td></td>
</tr>
<tr>
<td>Ethosuximide</td>
<td>Preferred</td>
<td></td>
</tr>
<tr>
<td>Felbamate</td>
<td>Preferred</td>
<td></td>
</tr>
<tr>
<td>Lamotrigine Chewable</td>
<td>Preferred</td>
<td></td>
</tr>
<tr>
<td>Lamotrigine IR</td>
<td>Preferred</td>
<td></td>
</tr>
<tr>
<td>Lamotrigine ODT</td>
<td>Preferred</td>
<td></td>
</tr>
<tr>
<td>Lamotrigine XR</td>
<td>Preferred</td>
<td></td>
</tr>
<tr>
<td>Levetiracetam immediate release</td>
<td>Preferred</td>
<td></td>
</tr>
<tr>
<td>*note: generic for Keppra IR, not generic for Spritam.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Levetiracetam extended release</td>
<td>Preferred</td>
<td></td>
</tr>
<tr>
<td>Oxcarbazepine</td>
<td>Preferred</td>
<td></td>
</tr>
<tr>
<td>Phenytoin</td>
<td>Preferred</td>
<td></td>
</tr>
<tr>
<td>Primidone</td>
<td>Preferred</td>
<td></td>
</tr>
<tr>
<td>Roweepra (levetiracetam) immediate release</td>
<td>Preferred</td>
<td></td>
</tr>
<tr>
<td>*note: generic for Keppra IR, not generic for Spritam.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roweepra (levetiracetam) XR</td>
<td>Preferred</td>
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</tr>
<tr>
<td>*note: generic for Keppra XR, not generic for Spritam.</td>
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<td></td>
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<tr>
<td>Tiagabine</td>
<td>Preferred</td>
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<tr>
<td>Topiramate</td>
<td>Preferred</td>
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<tr>
<td>Topiramate Sprinkle Cap</td>
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</tr>
<tr>
<td>Valproic acid/Valproate</td>
<td>Preferred</td>
<td></td>
</tr>
</tbody>
</table>

*FHK- Florida Healthy Kids*
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**APPROVAL CRITERIA**

I. Requests for Gabitril (tigabine) may be approved if the following criteria are met:

   A. Individual is 12 years of age or older; **AND**
   B. Individual has a diagnosis of partial seizures; **AND**
   C. Individual is using as adjunctive therapy; **AND**
   D. Individual has had a trial (medication samples/coupons/discount cards are excluded from consideration as a trial) of and inadequate response or intolerance to one preferred product or has been receiving the requested non-preferred product for 90 days or more or the preferred agent is not FDA approved for the prescribed indication;

   **OR**

II. Requests for Keppra XR and levetiracetam extended-release may be approved if:

   A. The individual is 12 years of age or older, has a diagnosis of partial-onset seizures, and is using as adjunctive therapy; **AND**
   B. If a non-preferred product is requested, individual has had a trial (medication samples/coupons/discount cards are excluded from consideration as a trial) of and inadequate response or intolerance to one preferred product or has been receiving the non-preferred product for 90 days or more or the preferred agent is not FDA approved for the prescribed indication;

   **OR**

III. Requests for Lamictal IR, Lamictal ODT, and Lamictal CD may be approved if the following criteria are met:

<table>
<thead>
<tr>
<th>Market Applicability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Market</td>
</tr>
<tr>
<td>--------</td>
</tr>
<tr>
<td>Applicable</td>
</tr>
</tbody>
</table>

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Topamax Sprinkles (topiramate) – brand only | Non-Preferred
Topiramate ER – brand only | Non-Preferred
Vimpat (lacosamide) | Non-Preferred
Zarontin (ethosuximide) – brand only | Non-Preferred
Zonegran (zonisamide) – brand only | Non-Preferred

*Note: prior authorization of benefits ONLY applies to the non-preferred agents.*
A. The individual is 18 years of age or older and has a diagnosis of Bipolar disorder; OR

B. The individual is 2 years of age or older, has a diagnosis of Lennox-Gastaut syndrome, and is using as adjunct therapy; OR

C. The individual is 2 years of age or older, has a diagnosis of a seizure disorder, and is using as adjunct therapy; OR

D. Individual is 16 years of age or older, has a diagnosis of partial seizures, and is converting to monotherapy from one of the following single antiepileptic drugs or has been receiving the medication for 90 days or more:
   1. Carbamazepine; OR
   2. Phenytoin; OR
   3. Phenobarbital; OR
   4. Primidone; OR
   5. Valproic Acid; OR

E. Medication is being used to treat intractable infantile spasms (DrugPoints B, Ila);

AND

F. Individual has had a trial (medication samples/coupons/discount cards are excluded from consideration as a trial) of and inadequate response or intolerance to one preferred product or has been receiving the non-preferred product for 90 days or more or the preferred agent is not FDA approved for the prescribed indication;

OR

IV. Requests for brand Lamictal XR may be approved if the following criteria are met:

A. Individual is 13 years of age or older and has a diagnosis of partial seizures; OR

B. Individual is 13 years of age or older, has a diagnosis of primary generalized tonic-clonic (PGTC) seizures, and is using as adjunctive therapy;

AND

C. Individual has trial (medication samples/coupons/discount cards are excluded from consideration as a trial) of and inadequate response or intolerance to one preferred product or has been receiving Lamictal XR (brand) for 90 days or more or the preferred agent is not FDA approved for the prescribed;

Note: Lamotrigine agents have a black box warning for serious skin rashes. Serious, life-threatening rashes (including Stevens-Johnson syndrome) requiring hospitalization and discontinuation of treatment have occurred. The rate of serious rash is greater in pediatric individuals than in adults. The risk of rash may also be increased by co-administration with valproate (includes valproic acid and divalproex sodium), exceeding the recommended initial
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### Market Applicability

| Market | DC | FL & FHK | FL MMA | FL LTC | GA | KS | KY | MD | NJ | NV | NY | TN | TX | WA |
|--------|----|----------|--------|--------|----|----|----|----|----|----|----|----|----|----|----|
| Applicable | X | X | NA | NA | X | NA | X | NA | X | X | X | NA | NA | NA | NA |

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occur while taking Fycompa. Individuals should be closely monitored during titration periods and at higher doses. Fycompa should be reduced if symptoms occur and discontinued immediately if symptoms are severe or worsening.

**OR**

VII. Requests for Onfi (clobazam) may be approved if the following criteria are met:

A. Individual has a diagnosis of seizures associated with Lennox-Gastaut Syndrome (LGS) and is using as adjunctive therapy; **AND**

B. One of the following:
   1. Individual is between 2 and 64 years of age; **OR**
   2. Individual is 65 years of age or older and the physician has indicated the requested medication is not causing adverse effects; **OR**
   3. Individual has a contraindication or has a clinical reason not to use safer alternatives; **AND**

C. The individual has a trial (medication samples/coupons/discount cards are excluded from consideration as a trial) of an inadequate response or intolerance to one preferred product unless the individual has been on Onfi (clobazam) for greater than or equal to 90 days or the preferred agent is not FDA approved for the prescribed indication;

**OR**

VIII. Requests for Potiga (ezogabine) may be approved when the following criteria are met:

A. Individual is 18 years of age or older, using for the adjunctive treatment of partial-onset seizures, and benefits outweigh the risk of retinal abnormalities and potential decline in visual acuity;

**AND**

B. The individual has had a trial (medication samples/coupons/discount cards are excluded from consideration as a trial) of and inadequate response or intolerance to one preferred product unless the individual has been on Potiga (ezogabine) for greater than or equal to 90 days or the preferred agent is not FDA approved for the prescribed indication;

**OR**

IX. Requests for Sabril (vigabatrin) may be approved when the following criteria are met:

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A. Individual is between the ages of 1 month and 2 years, is using for infantile spasms, and benefits outweigh the risk of vision loss; OR
B. Individual is 10 years of age or older, using as adjunctive therapy for refractory complex partial seizures, and the benefits outweigh the risk of vision loss;

AND
C. The individual has had a trial (medication samples/coupons/discount cards are excluded from consideration as a trial) of and inadequate response or intolerance to one preferred product unless the individual has been on Sabril (vigabatrin) for greater than or equal to 90 days or the preferred agent is not FDA approved for the prescribed indication;

Note: Sabril (vigabatrin) has a black box warning for vision loss. Sabril causes permanent bilateral concentric visual field constriction. Because assessing vision loss is difficult in infants and children, the frequency and extent of vision loss is poorly characterized in these individuals. For this reason, the risk is primarily based on the adult experience. Because of the risk of permanent vision loss, Sabril is available only through a special restricted program under a risk evaluation and mitigation strategy (REMS) called the SHARE program. Further information is available at http://www.sabril.net or by calling 1-888-457-4273.

OR
X. Requests for Vimpat (lacosamide) oral solution or tablets may be approved if the following criteria are met:

A. Individual is 4 years of age or older, and has a diagnosis of partial-onset seizures; AND
B. The individual has had a trial (medication samples/coupons/discount cards are excluded from consideration as a trial) of and inadequate response or intolerance to one preferred product unless the individual has been on Vimpat (lacosamide) for greater than or equal to 90 days or the preferred agent is not FDA approved for the prescribed indication;

OR
XI. Requests for Vimpat (lacosamide) injection may be approved if the following criteria are met:

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Market Applicability

| Market | DC | FL & FHK | FL MMA | FL LTC | GA | KS | KY | MD | NJ | NV | NY | TN | TX | WA |
|--------|----|----------|--------|--------|----|----|----|----|----|----|----|----|----|----|----|
| Applicable | X | X | NA | NA | X | NA | X | NA | X | X | X | NA | NA | NA | NA |

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A. Individual is 17 years of age or older, and has a diagnosis of partial-onset seizures;

**AND**

B. The individual has had a trial (medication samples/coupons/discount cards are excluded from consideration as a trial) of and inadequate response or intolerance to one preferred product unless the individual has been on Vimpat (lacosamide) for greater than or equal to 90 days or the preferred agent is not FDA approved for the prescribed indication;

**OR**

XII. Requests for Trokendi XR, Qudexy XR may be approved if the following criteria are met:

A. Individual has a diagnosis of partial-onset seizures, primary generalized tonic-clonic seizures, or seizures associated with Lennox-Gastaut syndrome (LGS);

**OR**

B. Individual is 12 years of age or older and using for migraine headache prophylaxis;

**AND**

C. The individual has had a trial (medication samples/coupons/discount cards are excluded from consideration as a trial) of and inadequate response or intolerance to one preferred product unless the individual has been on the requested non-preferred product for greater than or equal to 90 days or the preferred agent is not FDA approved for the prescribed indication;

**OR**

XIII. Requests for Topamax (brand only), Topamax Sprinkles (brand only) and Topiramate ER (brand only) may be approved if the following criteria are met:

A. Individual has a diagnosis of partial-onset seizures, primary generalized tonic-clonic seizures, or seizures associated with Lennox-Gastaut syndrome (LGS); **OR**

B. Individual is 12 years of age or older and using for migraine headache prophylaxis;

**OR**

C. Individual is using for the management of alcohol dependence (AHFS);

**AND**

D. Individual has had a trial (medication samples/coupons/discount cards are excluded from consideration as a trial) of and inadequate response or intolerance to one preferred product unless the individual has been on the requested non-preferred
### Market Applicability

| Market | DC | FL & FHK | FL MMA | FL LTC | GA | KS | KY | MD | NJ | NV | NY | TN | TX | WA |
|--------|----|----------|--------|--------|----|----|----|----|----|----|----|----|----|----|----|
| Applicable | X | X | NA | NA | X | NA | X | NA | X | X | X | NA | NA | NA |

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product for greater than or equal to 90 days or the preferred agent is not FDA approved for the prescribed indication;

**OR**

XIV. Requests for Spritam (levitiracetam) may be approved when the following criteria are met:

A. Individual is 4 years of age and older;  **AND**
B. Individual weighs more than 20 kg;  **AND**
C. Individual is using to treat partial onset seizures;

**OR**

D. Individual is 12 years of age or older;  **AND**
E. Individual is using to treat juvenile myoclonic epilepsy;

**OR**

F. Individual is 6 years of age or older;  **AND**
G. Individual weighs more than 20 kg;  **AND**
H. Individual is using to treat primary generalized tonic-clonic seizures;  **AND**
I. Individual has idiopathic generalized epilepsy;

**AND**

J. Individual has had a trial (medication samples/coupons/discount cards are excluded from consideration as a trial) of and inadequate response or intolerance to one preferred product unless the individual has been on Spritam (levitiracetam) for greater than or equal to 90 days or the preferred agent is not FDA approved for the prescribed indication;

**OR**

XV. Requests for Aptiom (eslicarbazepine) may be approved if the following criteria are met:

A. Individual is 4 years of age or older;  **AND**
B. Individual is using to treat partial-onset seizures;  **AND**
C. Individual has had a trial (medication samples/coupons/discount cards are excluded from consideration as a trial) of and inadequate response or intolerance to one preferred product unless the individual has been on Aptiom (eslicarbazepine) for greater than or equal to 90 days or the preferred agent is not FDA approved for the prescribed indication;
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