

**Clinical Policy: Anticonvulsant Agents**

Reference Number: OH.PHAR.PPA.35

Effective date: 01.20

Last review date: 10.20

Line of Business:Medicaid

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

**ANTICONVULSANTS: CARBAMAZEPINE DERIVATIVES**

<b>NO PA REQUIRED "PREFERRED"</b>	<b>PA REQUIRED "NON-PREFERRED"</b>
CARBAMAZEPINE IR tablet, chewable, oral suspension (generic of Tegretol®) CARBAMAZEPINE 12-hour ER capsule, tablet (generic of Carbatrol®, Tegretol XR®) OXCARBAZEPINE tablet, suspension (generic of Trileptal®)	OXTELLAR® XR (oxcarbazepine)

**ANTICONVULSANTS: FIRST GENERATION**

<b>NO PA REQUIRED "PREFERRED"</b>	<b>PA REQUIRED "NON-PREFERRED"</b>
CLOBAZEM tablet (generic for Onfi®) CLONAZEPAM tablet (generic of Klonopin®) DIAZEPAM rectal gel (generic of Diastat®) DIVALPROEX (generic of Depakote®) DIVALPROEX ER (generic of Depakote® ER) MIDAZOLAM (brand name NAYZILAM) ETHOSUXAMIDE (generic of Zarontin®) PHENOBARBITAL PHENYTOIN (generic of Dilantin®) PRIMIDONE (generic of Mysoline®)  VALPROIC ACID (generic of Depakene®)	CELONTIN® (methsuximide)  CLONAZEPAM ODT (generic of Klonopin® wafer)  PEGANONE® (ethotoin) STAVZOR® (valproic acid delayed-release) SYMPAZANTM (clobazam film)

**ANTICONVULSANTS: SECOND GENERATION**

<b>NO PA REQUIRED "PREFERRED"</b>	<b>STEP THERAPY REQUIRED "PREFERRED"</b>	<b>PA REQUIRED "NON-PREFERRED"</b>
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GABAPENTIN (generic of Neurontin®)  LAMOTRIGINE IR tablet, chewable tablet (generic of	FYCOMPA® (perampanel)	BANZEL® (rufinamide) BRIVIACT® (brivaracetam) FELBAMATE (generic of Felbatol®) LAMICTAL® ODT (lamotrigine)
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Lamictal®)		LAMOTRIGINE ER tablet (generic of Lamictal® XR)
LEVETIRACETAM IR tablet, solution (generic of Keppra®)		LEVETIRACETAM ER tablet (generic of Keppra® XR)
PREGABALIN (generic for Lyrica®)		QUDEXY XR® (topiramate ER)
SABRIL® powder (no PA for age < 2)		SABRIL® powder (PA required for age > 2)
TOPIRAMATE tablet (generic of Topamax®)		SABRIL® tablet (vigabatrin)
ZONISAMIDE (generic of Zonegran®)		SPRITAM® (levetiracetam tablet for suspension)
		SUBVENITE (lamotrigine)
		TIAGABINE (generic of Gabitril®)
		TOPIRAMATE ER
		TOPIRAMATE sprinkle cap (generic of Topamax® sprinkle cap)
		TROKENDI XR® (topiramate)

#### ANTICONVULSANTS: THIRD GENERATION

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
Alternative Anticonvulsant	VIMPAT® (lacosamide)	APTiom® (eslicarbazepine acetate)

#### ANTICONVULSANTS: CANNABINOID

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
EPIDIOLEX® (cannabidiol)†	

†Excluded from Grandfathering. Re-authorization requires documented reduction in average number of seizure days per month (measured monthly or quarterly).

#### ANTICONVULSANTS: STIRIPENTOL

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
DIACOMIT® (stiripentol)	

†Excluded from Grandfathering. Re-authorization requires documented reduction in average number of seizure days per month (measured monthly or quarterly).

#### ANTICONVULSANTS: RESCUE

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
DIAZEPAM rectal gel (generic of Diastat®) NAYZILAM® (midazolam) VALTOCO® (diazepam)	

### **FDA Approved Indication(s)**

- Refer to Clinical Pharmacology or other appropriate clinical resource for FDA approved indications

### **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 the medications listed in the above tables are **medically necessary** when the following criteria are met:

### **I. Initial Approval Criteria**

#### **A. Seizures (must meet all):**

1. Failure to no less than two preferred products for a 30 day trial of each unless one of the following:
    - a. Allergy to two preferred medications
    - b. Contraindication to or drug interaction with two preferred medications
    - c. History of unacceptable/toxic side effects to two preferred medications
  2. Prescriptions submitted with the prescriber NPI of a physician who has registered a neurology specialty with Ohio Medicaid, for products that are used only for seizures, require a trial of one preferred product for 30 days unless one of the following:
    - a. Allergy to one preferred medication
    - b. Contraindication to or drug interaction with one preferred medication
    - c. History of unacceptable/toxic side effects to one preferred medication
- \* This provision applies only to the standard tablet/capsule dosage form, and does not apply to brand products with available generic alternatives.**
3. The requested medication's corresponding generic (if covered by the state) has been attempted and failed or is contraindicated.

**Approval duration: 12 months**

#### **B. Lennox-Gastaut syndrome**

1. If medication is Epidiolex (must meet all):
  - a. Diagnosis of Lennox-Gastaut syndrome;
  - b. Age  $\geq$  2 years
  - c. Member has trialed and failed (inadequate seizure control or intolerance) 3 prior anticonvulsant therapies for 30 days each unless history of

- unacceptable/toxic side effects, contraindication or allergy to preferred medications;
- d. Prescriber has obtained serum transaminases (ALT and AST) and total bilirubin levels prior to starting therapy
- e. Prescriber must submit documented average number of seizure days per month (measured monthly or quarterly)
- f. Dose does not exceed 20 mg/kg/day (titration based on response/tolerability)

**Approval duration:****Initial: 180 days****Subsequent: 12 months****C. Dravet syndrome**

1. If medication is Diacomit (must meet all):
  - a. Diagnosis of Dravet syndrome;
  - b. Medication is prescribed by a neurologist or in consultation with a neurologist;
  - c. Prescriber must include management plans for patients with neutrophil counts <1500 cells/mm<sup>3</sup> or platelet count less than 150,000/ $\mu$ L;
  - d. Member must be concurrently managed with clobazam;
  - e. Dose does not exceed 50 mg/kg/day or 3000mg/day.
  - f. Prescriber must submit documented average number of seizure days per month (measured monthly or quarterly)
  - g. Members with phenylketonuria (PKU) will not be authorized for suspension dosage form without evidence of total daily amount of phenylalanine.
2. If medication is Epidiolex:
  - a. Age  $\geq$  2 years
  - b. Prescriber has obtained serum transaminases (ALT and AST) and total bilirubin levels prior to starting therapy
  - c. Prescriber must submit documented average number of seizure days per month (measured monthly or quarterly)
  - d. Dose does not exceed 20 mg/kg/day (titration based on response/tolerability)

**Approval duration:****Initial: 180 days****Subsequent: 12 months****D. Tuberous Sclerosis Complex**

1. If medication is Epidiolex (must meet all):
  - a. Diagnosis of Tuberous Sclerosis Complex;
  - b. Age  $\geq$  2 years
  - c. Member has trialed and failed (inadequate seizure control or intolerance) 3 prior anticonvulsant therapies for 30 days each unless history of unacceptable/toxic side effects, contraindication or allergy to preferred medications;
  - d. Prescriber has obtained serum transaminases (ALT and AST) and total bilirubin levels prior to starting therapy

- e. Prescriber must submit documented average number of seizure days per month (measured monthly or quarterly)
- f. Dose does not exceed 25 mg/kg/day (titration based on response/tolerability)

**Approval duration:**

**Initial: 180 days**

**Subsequent: 12 months**

**II. 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.PMN.53 for Medicaid or evidence of coverage documents.

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**III. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

FDA: Food and Drug Administration

*Appendix B: Therapeutic Alternatives*

- Dosing varies by drug product. See FDA approved dosing and administration.

*Appendix C: Contraindications / Boxed Warnings*

- Refer to Clinical Pharmacology or other appropriate clinical resource for contraindications or black box warnings

**IV. Dosage and Administration**

- A. Varies by drug product. See FDA approved dosing and administration.

**V. Product Availability**

- A. Varies by drug product. Refer to Clinical Pharmacology or other appropriate clinical resource for product availability

**VI. References**

Refer to package insert

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	11.2019	
Added Nayzilam (midazolam) as a preferred first generation anticonvulsant	03.20	
Added Valtoco (diazepam) to list of preferred first generation anticonvulsants	07.20	
Added Clobazem (generic for Onfi) to list of preferred first generation anticonvulsants; added new category: Anticonvulsants – Rescue (diazepam rectal gel, Nayzilam, Valtoco) – preferreds; Added diagnosis of Tuberous Sclerosis Complex for Epidiolex (see criteria point I.D.); removed requirement to try and fail three prior anticonvulsant therapies for 30 days each for Dravet Syndrome.	10.20	

**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.

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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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