



**GEORGIA MEDICAID FEE-FOR-SERVICE
ANTICONVULSANTS PA SUMMARY**

Preferred	Non-Preferred
Banzel tablets (rufinamide)*	Aptiom (eslicarbazepine)
Carbamazepine IR and ER generic	Banzel suspension (rufinamide)
Carbatrol capsules (carbamazepine SR capsules)	Briviact (brivaracetam)
Celontin (methsuximide)	Carbamazepine SR capsules generic
Depakote Sprinkles (divalproex sprinkles)	Diazepam rectal gel generic
Diastat (diazepam rectal gel)*	Divalproex sprinkles generic
Divalproex DR and ER generic	Felbamate generic
Gabapentin capsules and solution generic	Felbatol (felbamate)
Lamotrigine tablets and chewable dispersible tablets generic	Fycompa oral suspension and tablets (perampanel)
Levetiracetam tablets and oral solution generic	Gabapentin tablets generic
Lyrica capsules (pregabalin)	Gabitril (tiagabine)
Oxcarbazepine generic	Lamictal Kits (lamotrigine IR, ODT and XR kits)
Oxtellar XR (oxcarbazepine SR)*	Lamictal ODT (lamotrigine)
Peganone (ethotoin)Phenytoin generic	Lamotrigine kits generic
Primidone generic	Lamotrigine ER and ODT generic
Qudexy XR (topiramate ER)*	Levetiracetam ER tablets generic
Topiramate IR sprinkle capsules, tablets generic	Lyrica oral solution (pregabalin)
Topiramate ER generic*	Onfi oral suspension and tablets (clobazam)
Valproic Acid syrup generic	Potiga (ezogabine)
Vimpat oral solution, tablets (lacosamide)	Sabril tablets and powder for solution (vigabatrin)
Vimpat injectable (lacosamide)*	Stavzor (valproic acid delayed release capsules)
Zonisamide generic	Tiagabine generic
	Trokendi XR (topiramate SR)
	Valproic Acid capsules generic

*Preferred agents that require prior authorization

LENGTH OF AUTHORIZATION: Varies

NOTES:

- ❖ Criteria for Horizant and Gralise are listed in the Gabapentin Products PA Summary.
- ❖ Brand Diastat only requires PA for members age 21 and over; generic diazepam rectal gel requires PA for members of all ages.
- ❖ If generic diazepam rectal gel is approved, the PA will be issued for brand Diastat rectal gel. If generic tiagabine is approved, the PA will be issued for brand Gabitril. If generic lamotrigine ODT is approved, the PA will be issued for brand Lamictal ODT. If generic felbamate is approved, the PA will be issued for brand Felbatol. If generic lamotrigine kits is approved, the PA will be issued for brand Lamictal Kits.



PA CRITERIA:

Aptiom

- ❖ Approvable for members 18 years and older with a seizure disorder (epilepsy) who have tried and failed at least two preferred anticonvulsants, one of which must be oxcarbazepine.

Banzel

- ❖ Approvable for members 1 years of age and older with seizures associated with Lennox-Gastaut Syndrome (LGS) when used in combination with another anticonvulsant for LGS and member must have experienced an insufficient response to at least two medications used for LGS.
- ❖ For suspension, member must be unable to swallow solid dosage forms or must require a dose that cannot be delivered by the tablets.

Briviact

- ❖ Approvable for members 16 years and older with a seizure disorder (epilepsy) who have tried and failed at least two preferred anticonvulsants, one of which must be levetiracetam, and when used in combination with another anticonvulsants.
- ❖ In addition, for the injection, approvable for members who have received clinical benefit from Briviact tablets or oral solution and have temporary inability to swallow, tolerate or absorb the tablets or oral solution. Briviact injection must be administered in member's home by home health or in a long-term care facility.

Carbamazepine SR Generic

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, brand Carbatrol, is not appropriate for the member.

Diastat, Diazepam Rectal Gel Generic

- ❖ Approvable for members with a seizure disorder (epilepsy) who are currently on a stable antiepileptic drug regimen
- ❖ Must be used for increased bouts (clusters) of seizure activity different from the member's ordinary seizure activity

AND

- ❖ For generic diazepam rectal gel, prescriber must submit a written letter of medical necessity stating the reasons the preferred product, brand Diastat, is not appropriate for the member.

Divalproex Sprinkles Generic

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, brand Depakote Sprinkles, is not appropriate for the member.

Felbatol, Felbamate Generic

- ❖ Approvable for members 2 years of age and older with a seizure disorder (epilepsy) who have tried and failed at least two other anticonvulsants
- ❖ Member, parent or guardian must provide signed acknowledgement that they are aware of the risks associated with therapy
- ❖ Member must be periodically monitored for blood dyscrasias and hepatic function



AND

- ❖ For generic felbamate, prescriber must submit a written letter of medical necessity stating the reasons the preferred product, brand Felbatol, is not appropriate for the member.

Gabapentin Tablets Generic

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, gabapentin capsules, is not appropriate for the member.

Fycompa, Gabitril, Tiagabine Generic

- ❖ Approvable as an adjunct anticonvulsant for members 12 years of age and older with a seizure disorder (epilepsy) who have tried and failed at least two preferred anticonvulsants

AND

- ❖ For generic tiagabine, prescriber must submit a letter of medical necessity stating the reasons brand Gabitril is not appropriate for the member

AND

- ❖ For Fycompa oral suspension, member must be unable to swallow solid dosage forms or require a dose that cannot be delivered by administering the tablets.

Levetiracetam ER Generic

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, generic immediate-release levetiracetam tablets or solution, is not appropriate for the member.

Lamictal ODT, Lamotrigine ODT Generic

- ❖ Approvable for members with bipolar disorder who are unable to swallow solid dosage forms
- ❖ Approvable for members with a seizure disorder (epilepsy) who are unable to swallow solid dosage forms and who have tried and failed at least two preferred anticonvulsants

OR

- ❖ For members that are able to swallow solid dosage forms, prescriber must submit a written letter of medical necessity stating the reasons the preferred product, lamotrigine tablets or chewable dispersible tablets, is not appropriate for the member.

AND

- ❖ For generic lamotrigine ODT, prescriber must submit a letter of medical necessity stating the reasons brand Lamictal ODT is not appropriate for the member.

Lamotrigine ER Generic

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, lamotrigine tablets or chewable dispersible tablets, is not appropriate for the member.

Lamictal Kits, Lamotrigine Kits Generic

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the non-kit formulation is not appropriate for the member.



Lyrica oral solution

- ❖ Approvable for members less than 18 years of age with neuropathic pain due to chemotherapy.
- ❖ Approvable for members 18 years of age or older who are unable to swallow capsules.

Onfi

- ❖ Approvable as an adjunct anticonvulsant for members 2 years of age and older with seizures associated with Lennox-Gastaut Syndrome (LGS) who have had an insufficient response to clonazepam and at least one other anticonvulsant used for LGS.

AND

- ❖ For the oral suspension, member must be unable to swallow solid dosage forms or must require a dose that cannot be delivered by administering the tablets whole or cut in half.

Oxtellar XR

- ❖ Approvable for members with claims history trial of an oxcarbazepine immediate-release product

OR

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, generic oxcarbazepine immediate-release tablets, is not appropriate for the member.

Potiga

- ❖ Approvable as an adjunct anticonvulsant for members 18 years of age or older with a seizure disorder (epilepsy) who have tried and failed at least two other anticonvulsants
- ❖ Prescriber and member must be aware of the risks of eye abnormalities characterized by pigment changes in the retina and the need for periodic eye exams
- ❖ Member must see an ophthalmologist for a baseline visual assessment.

Sabril

- ❖ Approvable for members 1 month to 2 years of age with infantile spasms
- ❖ Approvable as an adjunct anticonvulsant for members 10 years of age and older with refractory complex partial seizures who have tried and failed at least three other anticonvulsant medications.
- ❖ Prescriber and member must be enrolled in the Sabril SHARE program.
- ❖ Prescriber and member must be aware of the risks of permanent vision loss/reduced visual acuity and the need for visual monitoring during therapy and for up to 6 months after therapy discontinuation.
- ❖ Member must see an ophthalmologist for a baseline visual assessment.

Stavzor, Valproic Acid Capsules Generic

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred products, divalproex DR, Depakote sprinkles, divalproex ER, or valproic acid syrup, are not appropriate for the member.

Qudexy XR, Topiramate ER generic

- ❖ Approvable for members with claims history trial of a topiramate immediate-release product



OR

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, topiramate immediate-release generic, is not appropriate for the member

Trokendi XR

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred products, generic topiramate immediate-release, Qudexy XR AND generic topiramate extended-release, are not appropriate for the member.

Vimpat Injection

- ❖ Approvable for members 17 years of age or older with a seizure disorder (epilepsy) who have received clinical benefit from Vimpat tablets and have temporary inability to swallow, tolerate or absorb the tablets or oral solution. Vimpat injection must be administered in member's home by home health or in a long-term care facility.

EXCEPTIONS:

- ❖ Exceptions to these conditions of coverage are considered through the prior authorization process.
- ❖ The Prior Authorization process may be initiated by calling **Optum Rx at 1-866-525-5827**.

PREFERRED DRUG LIST:

- ❖ For online access to the Preferred Drug List (PDL), please go to <http://dch.georgia.gov/preferred-drug-lists>.

PA AND APPEAL PROCESS:

- ❖ For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- ❖ For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.