



GEORGIA MEDICAID FEE-FOR-SERVICE ANTICONVULSANTS PA SUMMARY

Preferred	Non-Preferred
Carbamazepine IR, SR and ER generic Clobazam tablets generic Diastat (diazepam rectal gel generic) Diazepam rectal gel generic Divalproex generic Epidiolex (cannabidiol)* Ethosuximide generic Gabapentin generic Lacosamide tablets generic Lacosamide injection generic* Lamotrigine tablets and chewable dispersible tablets generic Levetiracetam tablets and oral solution generic Lyrica capsules and oral solution (pregabalin) Nayzilam (midazolam nasal spray)* Oxcarbazepine generic Peganone (ethotoin) Phenytoin generic Primidone generic Qudexy XR (topiramate ER) Topiramate IR sprinkle capsules, tablets generic Topiramate ER generic by Upsher-Smith (NDC 00832-####-##)* Valproic Acid syrup generic Vimpat oral solution (lacosamide) Zonisamide generic	Aptiom (eslicarbazepine) Banzel suspension and tablets (rufinamide) Briviact (brivaracetam) Clobazam oral suspension generic Diacomit (stiripentol) Elepsia XR (levetiracetam ER 1000 mg, 1500 mg tablets) Eprontia (topiramate oral solution) Equetro (carbamazepine ER) Felbamate generic Fintepla (fenfluramine) Fycompa oral suspension and tablets (perampanel) Gabitril (tiagabine) Lamictal Kits (lamotrigine IR, ODT and XR kits) Lamictal ODT (lamotrigine) Lamotrigine kits generic Lamotrigine ER and ODT generic Levetiracetam ER 500 mg, 750 mg tablets generic Lyrica CR (pregabalin extended-release) Oxtellar XR (oxcarbazepine ER) Sabril tablets and powder for solution (vigabatrin) Stavzor (valproic acid delayed release capsules) Sympazan (clobazam films) Tiagabine generic Trokendi XR (topiramate ER) Valproic Acid capsules generic Valtoco (diazepam nasal spray) Xcopri (cenobamate)

*Preferred agent that requires PA. IR=immediate-release; ER/XR=extended-release; ODT=orally disintegrating tablet

LENGTH OF AUTHORIZATION: Varies

NOTES:

- Epidiolex, Nayzilam, topiramate ER generic by Upsher-Smith generic and lacosamide injection generic are preferred but require prior authorization.
- 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 lamotrigine kits are approved, the PA will be issued for brand Lamictal Kits.

PA CRITERIA:

Aptiom

- ❖ Approvable for members 4 years and older with a seizure disorder (epilepsy) who have tried and failed at least three preferred anticonvulsants, one of which must be oxcarbazepine.



Banzel

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

Briviact

- ❖ Approvable for members 1 month and older with a seizure disorder (epilepsy) who have tried and failed at least three preferred anticonvulsants, one of which must be levetiracetam.
- ❖ 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 or in a long-term care facility.

Clobazam Oral Suspension Generic and Sympazan

- ❖ For members 2 years of age and older with seizures associated with Lennox-Gastaut Syndrome (LGS) who are unable to swallow clobazam tablets whole, cut in half or crushed and when used in combination with another anticonvulsant for LGS.
- ❖ For members 2 years of age and older with seizures associated with Dravet syndrome (DS) who are unable to swallow clobazam tablets whole, cut in half or crushed.
- ❖ In addition for Sympazan, prescriber must submit a written letter of medical necessity stating the reasons generic clobazam oral suspension is not appropriate for the member.

Diacomit

- ❖ Approvable for members 2 years of age and older with seizures associated with Dravet syndrome (DS) who have had an inadequate response to clobazam (Onfi, Sympazan) and valproic acid derivative (Depakene, Depakote) and when the medication is being used in combination with clobazam or valproic acid derivative.
- ❖ Must be prescribed by or in consultation with a neurologist.

Elepsia XR and 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.

Epidiolex

- ❖ Approvable for members 1 year of age and older with seizures associated with Lennox Gastaut Syndrome (LGS) or Dravet syndrome (DS) who have had an inadequate response to at least one of the following: clobazam (Onfi, Sympazan), clonazepam (Klonopin), levetiracetam (Keppra), topiramate (Qudexy XR, Topamax, Trokendi XR) or valproic acid derivative (Depakene, Depakote).
- ❖ Approvable for members 1 year of age and older with seizures associated with tuberous sclerosis complex (TSC) who have had an inadequate response to at least one other preferred anticonvulsant.
- ❖ Must be prescribed by or in consultation with a neurologist.



Eprontia

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred products, generic topiramate tablets and generic topiramate sprinkle capsules, are not appropriate for the member.

Equetro

- ❖ Approvable for members 12 years of age and older with a seizure disorder (epilepsy) who have tried and failed at least three preferred anticonvulsants, one of which must be generic carbamazepine extended-release.
- ❖ Approvable for members 12 years of age and older with pain associated with trigeminal neuralgia or with manic or mixed episodes associated with bipolar disorder who have tried and failed generic carbamazepine extended-release.

Felbamate Generic

- ❖ Approvable for members 2 years of age and older with a seizure disorder (epilepsy) who have tried and failed at least three preferred anticonvulsants.
- ❖ Member, parent, or guardian must provide signed acknowledgement that they are aware of the risks associated with therapy.

Fintepla

- ❖ Approvable for members 2 years of age and older with seizures associated with Dravet syndrome (DS) who have had an inadequate response to cannabidiol (Epidiolex) and at least two of the following: clobazam (Onfi, Sympazan), clonazepam (Klonopin), levetiracetam (Keppra), stiripentol (Diacomit), topiramate (Qudexy XR, Topamax, Trokendi XR) or valproic acid derivative (Depakene, Depakote).
- ❖ Approvable for members 2 years of age and older with seizures associated with Lennox-Gastaut Syndrome (LGS) who have had an inadequate response to at least two anticonvulsants used for LGS and when used in combination with another anticonvulsant for LGS.
- ❖ In addition, the medication must be prescribed by or in consultation with a neurologist.

Fycompa

- ❖ Approvable for members 4 years of age and older with a seizure disorder (epilepsy) who have tried and failed at least three preferred anticonvulsants.
- ❖ In addition 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.

Gabitril and Tiagabine Generic

- ❖ Approvable for members 12 years of age and older with a seizure disorder (epilepsy) who have tried and failed at least three preferred anticonvulsants and when used in combination with another anticonvulsant.

Lacosamide Injection Generic

- ❖ Approvable for members 4 years of age or older with a seizure disorder (epilepsy) who have received clinical benefit from lacosamide tablets or oral solution (Vimpat) and have temporary inability to swallow, tolerate or absorb the tablets or oral solution.
- ❖ Must be administered in member's home or in a long-term care facility.



Lamictal ODT and 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.

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 and 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 CR

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

Nayzilam

- ❖ Approvable for members 12 years of age and older with a seizure disorder (epilepsy) who are currently on a stable antiepileptic drug regimen, are experiencing increased bouts (clusters) of seizure activity different from the member's ordinary seizure activity and have experienced inadequate response, allergy, contraindication, drug-drug interaction or intolerable side effect with diazepam rectal gel (Diastat) or are not candidates for rectal administration of diazepam rectal gel (Diastat).

Oxtellar XR

- ❖ 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.

Sabril

- ❖ Approvable for members 1 month to 2 years of age with infantile spasms.
- ❖ Approvable for members 10 years of age and older with refractory complex partial seizures who have tried and failed at least three other anticonvulsants and when used in combination with another anticonvulsant.
- ❖ 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 and Valproic Acid Capsules Generic

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

Topiramate ER Generic and Trokendi XR

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

Valtoco

- ❖ Approvable for members 6 to 11 years of age with a seizure disorder (epilepsy) who are currently on a stable antiepileptic drug regimen, are experiencing increased bouts (clusters) of seizure activity different from the member's ordinary seizure activity and have experienced inadequate response with Diastat (diazepam rectal gel) or are not candidates for rectal administration.
- ❖ Approvable for members 12 years of age and older with a seizure disorder (epilepsy) who are currently on a stable antiepileptic drug regimen, are experiencing increased bouts (clusters) of seizure activity different from the member's ordinary seizure activity, have experienced inadequate response, allergy, contraindication, drug-drug interaction or intolerable side effect with Nayzilam (midazolam) and have experienced inadequate response with Diastat (diazepam rectal gel) or are not candidates for rectal administration.

Xcopri

- ❖ Approvable for members 18 years of age and older with a seizure disorder (epilepsy) who have tried and failed at least three preferred anticonvulsants.

QLL CRITERIA:

Lacosamide Tablets Generic

- ♦ An authorization to exceed the QLL may be approved when the member's dose is being titrated due to initiation of therapy or an increase in dosage requirements.

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **OptumRx 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 Pharmacy and click on [Other Documents](#), then select the most recent quarters QLL list.