GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA MEDICAID FEE-FOR-SERVICE
ANTICONVULSANTS PA SUMMARY

Preferred	Non-Preferred
Carbamazepine IR, SR and ER generic Clobazam tablets generic Diacomit (stiripentol)* Diazepam rectal gel generic^ Divalproex generic Epidiolex (cannabidiol)* Ethosuximide generic Gabapentin generic Lamotrigine tablets and chewable dispersible tablets generic Levetiracetam tablets and oral solution generic Lyrica capsules and oral solution (pregabalin) Oxcarbazepine generic Peganone (ethotoin) Phenytoin generic Primidone generic Topiramate IR sprinkle capsules, tablets generic Topiramate ER generic* Valproic Acid syrup generic Vimpat oral solution, tablets (lacosamide) Vimpat injection (lacosamide)* Zonisamide generic	Aptiom (eslicarbazepine) Banzel suspension and tablets (rufinamide) Briviact (brivaracetam) Clobazam oral suspension generic 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 tablets generic Lyrica CR (pregabalin extended-release) Nayzilam (midazolam nasal spray) Oxtellar XR (oxcarbazepine SR) Qudexy XR (topiramate ER) Sabril tablets and powder for solution (vigabatrin) Stavzor (valproic acid delayed release capsules) Sympazan (clobazam films) Tiagabine generic Trokendi XR (topiramate SR) Valproic Acid capsules generic Valtoco (diazepam nasal spray) Xcopri (cenobamate)

*Preferred agents that require PA. ^Preferred but requires PA for members ≥21 years old. IR=immediate-release; ER=extended-release; ODT=orally disintegrating tablet; SR=sustained release

LENGTH OF AUTHORIZATION: Varies

NOTES:

- Diacomit, Epidiolex, topiramate ER generic and Vimpat injection are preferred but require prior authorization.
- Diazepam rectal gel generic requires PA for members 21 years of age and older.
- 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 4 years 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) or valproic acid derivative (Depakene, Depakote).

Diastat and Diazepam Rectal Gel Generic

- ❖ Approvable for members 21 years of age and older (prior authorization not required for members younger than 21 years of age) with a seizure disorder (epilepsy) who are currently on a stable antiepileptic drug regimen and are experiencing increased bouts (clusters) of seizure activity different from the member's ordinary seizure activity.

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.
- ❖ In addition, the medication must be prescribed by or in consultation with a neurologist.

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).
- ❖ 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.

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.

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.

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.

Qudexy XR and Trokendi XR

- Prescriber must submit a written letter of medical necessity stating the reasons the preferred products, generic topiramate immediate-release and generic topiramate extended-release, are 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

- ❖ 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.

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 diazepam rectal gel (Diastat) or are not candidates for rectal administration of diazepam rectal gel (Diastat).
- ❖ 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 midazolam (Nayzilam) and have experienced inadequate response with diazepam rectal gel (Diastat) or are not candidates for rectal administration of diazepam rectal gel (Diastat).

Vimpat Injection

- ❖ Approvable for members 4 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 or in a long-term care facility.

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.

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.