Clinical Pharmacy Program Guideline for Anticonvulsants

<table>
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<tr>
<th>Program</th>
<th>Prior Authorization - Anticonvulsants</th>
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<tr>
<td>Medication/Therapeutic Class</td>
<td>Aptiom (eslicarbazepine), Briviact (brivaracetam), Fycompa (perampanel), Vimpat (lacosamide), Gabitril (tiagabine), Potiga (ezogabine), Banzel (rufinamide), Onfi (clobazam)</td>
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<tr>
<td>Pharmacy &amp; Therapeutics Approval Date</td>
<td>6/2016, 9/2016</td>
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<td>Effective Date</td>
<td>8/1/2016</td>
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1. **Background:**
   This program requires a member to try at least two antiepileptic medications prior to receiving coverage for Aptiom, Briviact, Fycompa or Vimpat.

2. **Coverage Criteria - Aptiom, Briviact, Fycompa, Vimpat, Gabitril, Potiga, Banzel, Onfi**

   **A. Aptiom, Briviact, Fycompa or Vimpat** will be approved based on one of the following:

   1. **All** of the following:
      a. One of the following:
         (1) For **Aptiom, Briviact** or **Vimpat**: diagnosis of partial-onset seizures
         (2) For **Fycompa**: diagnosis of partial-onset or primary generalized tonic-clonic seizures

         -AND-

      b. History of greater than or equal to 8 week trial of at least two of the following (any release formulation qualifies):

         (1) Carbamazepine
         (2) Divalproex
         (3) Gabapentin
         (4) Lamotrigine
         (5) Levetiracetam
         (6) Oxcarbazepine
         (7) Phenytoin
         (8) Pregabalin
         (9) Topiramate
         (10) Valproic acid
         (11) Zonisamide
c. **One** of the following:

   (1) **Both** of the following:
      (a) Documented history of persisting seizures after titration to the highest tolerated dose with each medication trial
      (b) Lack of compliance as a reason for treatment failure has been ruled out

   -OR-

   (2) **Both** of the following:
      (a) Documentation of failure due to intolerable side effects.
      (b) Reasonable efforts were made to minimize the side effect (e.g. change timing of dosing, divide dose out for more frequent but smaller doses, etc.)

   -OR-

2. For continuation of prior therapy for a seizure disorder

**Authorization will be issued for 12 months.**

**B. Onfi or Banzel** will be approved based on **one** of the following:

1. **All** of the following:
   a. Diagnosis of seizures associated with Lennox-Gastaut syndrome (LGS)

   -AND-

   b. Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment.)

   -AND-

   c. Not used as primary treatment
d. If the request is for the suspension, the patient must be unable to swallow the oral solid preferred alternatives

Authorization will be issued for 12 months.

C. **Potiga** or **Gabitril** will be approved based on **one** of the following:

1. **All** of the following:
   a. Diagnosis of partial-onset seizures
      -AND-
   b. Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment.)
      -AND-
   c. Not used as primary treatment
      -AND-
   d. History of failure, contraindication, or intolerance to two preferred anticonvulsants [eg, Lamictal (lamotrigine), Depakene (valproic acid), Dilantin (phenytoin)]

   Authorization will be issued for 12 months.

4. **References:**

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<tr>
<td>6/2016</td>
<td>C&amp;S – new program</td>
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<tr>
<td>8/2016</td>
<td>Removed Felbatol criteria (Section D) and Multi-Source Brand Anticonvulsants and Modified Release Products Section. Added criteria for Onfi and Banzel suspensions.</td>
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