Original Effective Date: 10/01/2019
Current Effective Date: 04/2023
Last P&T Approval/Version: 04/26/2023
Next Review Due By: 04/2024
Policy Number: C21453-A

Anticonvulsants – IL Medicaid Only

PRODUCTS AFFECTED

Aptiom (Eslicarbazepine Acetate Tab); Banzel (Rufinamide Susp); Banzel (Rufinamide Tab); Briviact (Brivaracetam Oral Soln); Briviact (Brivaracetam Tab); carBAMazepine (Carbamazepine Cap ER 12HR); Carbatrol (Carbamazepine Cap ER 12HR); Celontin (Methsuximide Cap); cloBAZam (Clobazam Suspension); cloBAZam (Clobazam Tab); clonazePAM (Clonazepam Orally Disintegrating); Depakote (Divalproex Sodium Tab ER 24 HR); Depakote (Divalproex Sodium Cap Delayed Release Sprinkle); Depakote (Divalproex Sodium Tab Delayed Release); Diacomit (Stiripentol Cap); Diacomit (Stiripentol Packet); Dilantin (Phenytoin Sodium Extended); Dilantin (Phenytoin Chew Tab); Dilantin (Phenytoin Susp); Elepsia XR (Levetiracetam Tab ER 24HR); Epidiolex (Cannabidiol Soln); Eprontia (Topiramate Oral Soln); Felbamate (Felbamate Susp); Felbamate (Felbamate Tab); Felbatol (Felbamate Susp); Felbatol (Felbamate Tab); Fintepla (Fenfluramine HCl Oral); Fycompa (Perampanel Susp); Fycompa (Perampanel Tab); Gabitril (Tiagabine HCl Tab); Keppra (Levetiracetam Oral Soln); Keppra (Levetiracetam Tab); Keppra (Levetiracetam Tab ER 24HR); KlonoPIN (Clonazepam Tab); Lacosamide (Lacosamide Tab); LaMICtal (Lamotrigine Tab Chewable Dispersible); LaMICtal (Lamotrigine Tab Disint); LaMICtal (Lamotrigine Orally Disintegrating); LaMICtal (Lamotrigine Tab); LaMICtal XR (Lamotrigine Tab ER 24HR); lamoTRIgine (Lamotrigine Tab ER 24HR); lamoTRIgine (Lamotrigine Tab Disint); lamoTRIgine (Lamotrigine Tab); lamoTRIgine (Lamotrigine Orally Disintegrating); Mysoline (Primidone Tab); Nayzilam (Midazolam Nasal Spray); Neurontin (Gabapentin Cap); Neurontin (Gabapentin Oral Soln); Neurontin (Gabapentin Tab); Onfi (Clobazam Suspension); Onfi (Clobazam Tab); Oxtellar XR (Oxcarbazepine Tab ER 24HR); Phenytek (Phenytoin Sodium Extended); Qudexy (Topiramate Cap ER 24HR Sprinkle); Rufinamide (Rufinamide Susp); Rufinamide (Rufinamide Tab); Sabril (Vigabatrin Powd Pack); Sabril (Vigabatrin Tab); Spritam (Levetiracetam Tab Disintegrating Soluble); Subvenite (Lamotrigine Tab); Sympazan (Clobazam Oral Film); TEGretol (Carbamazepine Susp); TEGretol (Carbamazepine Tab); TEGretol-XR (Carbamazepine Tab ER 12HR); tiaGABine (Tiagabine HCl Tab); Topamax (Topiramate Sprinkle Cap); Topamax (Topiramate Tab); Topiramate ER (Topiramate Cap ER 24HR Sprinkle); Trileptal (Oxcarbazepine Susp); Trileptal (Oxcarbazepine Tab); Trokendi XR (Topiramate Cap ER 24HR); Valtoco (Diazepam Nasal Spray); Vigabatrin (Vigabatrin Powd Pack); Vigabatrin (Vigabatrin Tab); Vigadrone (Vigabatrin Powd Pack); Vimpat (Lacosamide Oral Solution); Vimpat (Lacosamide Tab); Zarontin (Ethosuximide Cap); Zarontin (Ethosuximide Soln); Zonisade (Zonisamide Susp)

COVERAGE POLICY

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.
This Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide Molina Healthcare complete medical rationale when requesting any exceptions to these guidelines

Documentation Requirements:

Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive

DIAGNOSIS:
Epilepsy or Seizure disorder

REQUIRED MEDICAL INFORMATION:
This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. If a drug within this policy receives an updated FDA label within the last 180 days, medical necessity for the member will be reviewed using the updated FDA label information along with state and federal requirements, benefit being administered and formulary preferencing. Coverage will be determined on a case-by case basis until the criteria can be updated through Molina Healthcare, Inc. clinical governance. Additional information may be required on a case-by-case basis to allow for adequate review

A. Epilepsy or Seizure disorder
    1. Documentation that member has a diagnosis of epilepsy or seizure disorder.
B. ALL OTHER INDICATIONS
    1. Review per IL Medicaid Medical Necessity Review.

CONTINUATION OF THERAPY:
A. Epilepsy or Seizure disorder
    1. Documentation that member has a diagnosis of epilepsy or seizure disorder.
B. ALL OTHER INDICATIONS
    1. Review per IL Medicaid Medical Necessity Review.

DURATION OF APPROVAL:
12 months

PRESCRIBER REQUIREMENTS:
None

AGE RESTRICTIONS:
N/A

QUANTITY:
Quantity limit per Illinois Medical Preferred drug listing.

PLACE OF ADMINISTRATION:
The recommendation is that oral medications in this policy will be for pharmacy benefit coverage and patient self-administered.

The recommendation is that intranasal medications in this policy will be for pharmacy benefit coverage and patient self-administered.

DRUG INFORMATION

ROUTE OF ADMINISTRATION:

DRUG CLASS:
Anticonvulsants

FDA-APPROVED USES:

COMPENDIAL APPROVED OFF-LABELED USES:
None

APPENDIX

APPENDIX:

G40	Epilepsy and recurrent seizures

BACKGROUND AND OTHER CONSIDERATIONS

BACKGROUND:

CONTRAINDICATIONS/EXCLUSIONS/DISCONTINUATION:
All other uses of agents listed in this policy are considered experimental/investigational and therefore, will follow Molina's Off- Label policy.

OTHER SPECIAL CONSIDERATIONS:

CODING/BILLING INFORMATION

Note: 1) This list of codes may not be all-inclusive. 2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement

HCPCS CODE	DESCRIPTION
NA	

AVAILABLE DOSAGE FORMS:

Aptiom TABS 200MG
Aptiom TABS 400MG
Aptiom TABS 600MG
Aptiom TABS 800MG
Banzel SUSP 40MG/ML
Banzel TABS 200MG
Banzel TABS 400MG
Briviact SOLN 10MG/ML
Briviact TABS 100MG
Briviact TABS 10MG
Briviact TABS 25MG
Briviact TABS 50MG
Briviact TABS 75MG
carBAMazepine ER CP12 100MG
carBAMazepine ER CP12 200MG
carBAMazepine ER CP12 300MG
Carbatrol CP12 100MG
Carbatrol CP12 200MG
Carbatrol CP12 300MG
Celontin CAPS 300MG
cloBAZam SUSP 2.5MG/ML
cloBAZam TABS 10MG
cloBAZam TABS 20MG
clonazePAM TBDP 0.125MG
clonazePAM TBDP 0.25MG
clonazePAM TBDP 0.5MG
clonazePAM TBDP 1MG
clonazePAM TBDP 2MG
Depakote ER TB24 250MG
Depakote ER TB24 500MG
Depakote Sprinkles CSDR 125MG
Depakote TBEC 125MG
Depakote TBEC 250MG
Depakote TBEC 500MG
Diacomit CAPS 250MG

Diacomit CAPS 500MG
Diacomit PACK 250MG
Diacomit PACK 500MG
Dilantin CAPS 100MG
Dilantin CAPS 30MG
Dilantin Infatabs CHEW 50MG
Dilantin SUSP 125MG/5ML
Elepsia XR TB24 1000MG
Elepsia XR TB24 1500MG
Epidiolex SOLN 100MG/ML
Eprontia SOLN 25MG/ML
Felbamate SUSP 600MG/5ML
Felbamate TABS 400MG
Felbamate TABS 600MG
Felbatol SUSP 600MG/5ML
Felbatol TABS 400MG
Felbatol TABS 600MG
Fintepla SOLN 2.2MG/ML
Fycompa SUSP 0.5MG/ML
Fycompa TABS 10MG
Fycompa TABS 12MG
Fycompa TABS 2MG
Fycompa TABS 4MG
Fycompa TABS 6MG
Fycompa TABS 8MG
Gabitril TABS 12MG
Gabitril TABS 16MG
Gabitril TABS 2MG
Gabitril TABS 4MG
Keppra SOLN 100MG/ML
Keppra TABS 1000MG
Keppra TABS 250MG
Keppra TABS 500MG
Keppra TABS 750MG
Keppra XR TB24 500MG
Keppra XR TB24 750MG
KlonoPIN TABS 0.5MG
KlonoPIN TABS 1MG
KlonoPIN TABS 2MG
Lacosamide TABS 100MG
Lacosamide TABS 150MG
Lacosamide TABS 200MG
Lacosamide TABS 50MG
LaMICtal CHEW 25MG
LaMICtal CHEW 5MG
LaMICtal ODT KIT 21 x 25 MG &7 x 50 MG
LaMICtal ODT KIT 25 & 50 & 100MG
LaMICtal ODT KIT 42 x 50 MG &14x100 MG
LaMICtal ODT TBDP 100MG
LaMICtal ODT TBDP 200MG
LaMICtal ODT TBDP 25MG
LaMICtal ODT TBDP 50MG
LaMICtal Starter KIT 35 x 25MG
LaMICtal Starter KIT 42 x 25 MG &7 x 100 MG
LaMICtal Starter KIT 84 x 25 MG &14x100 MG
LaMICtal TABS 100MG
LaMICtal TABS 150MG
LaMICtal TABS 200MG
LaMICtal TABS 25MG
LaMICtal XR KIT 21 x 25 MG &7 x 50 MG
LaMICtal XR KIT 25 & 50 & 100MG
LaMICtal XR KIT 50 & 100 & 200MG
LaMICtal XR TB24 100MG
LaMICtal XR TB24 200MG
LaMICtal XR TB24 250MG
LaMICtal XR TB24 25MG
LaMICtal XR TB24 300MG
LaMICtal XR TB24 50MG
lamoTRIgine ER TB24 100MG
lamoTRIgine ER TB24 200MG
lamoTRIgine ER TB24 250MG
lamoTRIgine ER TB24 25MG
lamoTRIgine ER TB24 300MG
lamoTRIgine ER TB24 50MG
lamoTRIgine KIT 21 x 25 MG &7 x 50 MG
lamoTRIgine KIT 25 & 50 & 100MG
lamoTRIgine KIT 42 x 50 MG &14x100 MG
lamoTRIgine Starter Kit-Blue KIT 35 x 25MG
lamoTRIgine Starter Kit-Green KIT 84 x 25 MG &14x100 MG
lamoTRIgine Starter Kit-Orange KIT 42 x 25 MG &7 x 100 MG
lamoTRIgine TBDP 100MG
lamoTRIgine TBDP 200MG
lamoTRIgine TBDP 25MG
lamoTRIgine TBDP 50MG
Mysoline TABS 250MG
Mysoline TABS 50MG
Nayzilam SOLN 5MG/0.1ML
Neurontin CAPS 100MG
Neurontin CAPS 300MG
Neurontin CAPS 400MG
Neurontin SOLN 250MG/5ML
Neurontin TABS 600MG
Neurontin TABS 800MG
Onfi SUSP 2.5MG/ML
Onfi TABS 10MG
Onfi TABS 20MG
Oxtellar XR TB24 150MG
Oxtellar XR TB24 300MG
Oxtellar XR TB24 600MG
Phenytek CAPS 200MG
Phenytek CAPS 300MG
Qudexy XR CS24 100MG
Qudexy XR CS24 150MG
Qudexy XR CS24 200MG
Qudexy XR CS24 25MG
Qudexy XR CS24 50MG
Rufinamide SUSP 40MG/ML
Rufinamide TABS 200MG
Rufinamide TABS 400MG
Sabril PACK 500MG
Sabril TABS 500MG
Spritam TB3D 1000MG
Spritam TB3D 250MG
Spritam TB3D 500MG
Spritam TB3D 750MG
Subvenite Starter Kit-Blue KIT 35 x 25MG
Subvenite Starter Kit-Green KIT 84 x 25 MG &14x100 MG
Subvenite Starter Kit-Orange KIT 42 x 25 MG &7 x 100 MG
Sympazan FILM 10MG
Sympazan FILM 20MG
Sympazan FILM 5MG
TEGretol SUSP 100MG/5ML
TEGretol TABS 200MG
TEGretol-XR TB12 100MG
TEGretol-XR TB12 200MG
TEGretol-XR TB12 400MG
tiaGABine HCl TABS 12MG
tiaGABine HCl TABS 16MG
tiaGABine HCl TABS 2MG
tiaGABine HCl TABS 4MG
Topamax Sprinkle CPSP 15MG
Topamax Sprinkle CPSP 25MG
Topamax TABS 100MG
Topamax TABS 200MG
Topamax TABS 25MG
Topamax TABS 50MG
Topiramate ER CS24 100MG
Topiramate ER CS24 150MG
Topiramate ER CS24 200MG
Topiramate ER CS24 25MG
Topiramate ER CS24 50MG
Trileptal SUSP 300MG/5ML
Trileptal TABS 150MG
Trileptal TABS 300MG
Trileptal TABS 600MG

Trokendi XR CP24 100MG
Trokendi XR CP24 200MG
Trokendi XR CP24 25MG
Trokendi XR CP24 50MG
Valtoco 10 MG Dose LIQD 10MG/0.1ML
Valtoco 15 MG Dose LQPK 7.5MG/0.1ML
Valtoco 20 MG Dose LQPK 10MG/0.1ML
Valtoco 5 MG Dose LIQD 5MG/0.1ML
Vigabatrin PACK 500MG
Vigabatrin TABS 500MG
Vigadrone PACK 500MG
Vimpat SOLN 10MG/ML
Vimpat TABS 100MG
Vimpat TABS 150MG
Vimpat TABS 200MG
Vimpat TABS 50MG
Zarontin CAPS 250MG
Zarontin SOLN 250MG/5ML
Zonisade SUSP 100MG/5ML

REFERENCES

1. Illinois Medicaid Preferred Drug List, Effective April 1, 2023
2. https://ilga.gov/legislation/publicacts/101/PDF/101-0209.pdf

SUMMARY OF REVIEW/REVISIONS	DATE
ANNUAL REVIEW COMPLETED- No coverage criteria changes with this annual review.	Q2/2022
Updated reference to Medical Necessity and deleted Global Clinical Exception Policy	7/2022
ANNUAL REVIEW COMPLETED – Updated medications. Minor criteria revisions	Q2/2023