SENTARA HEALTH PLANS

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Anticonvulsants

Drug Requested: (Select applicable drug below)

❑ **Aptiom®** (eslicarbazepine)	❑ **Banzel®** (rufinamide)	❑ **Briviact®** (brivaracetam)
❑ **Carbatrol®** (carbamazepine)	❑ **Depakote®** (valproic acid)	❑ **Depakote® ER** (valproic acid)
❑ **Depakote® Sprinkles** (valproic acid)	❑ **Dilantin®** (phenytoin)	❑ **Dilantin® Infatabs®** (phenytoin)
❑ **Equetro®** (carbamazepine)	❑ **Felbatol®** (felbamate)	❑ **Fycompa®** (perampanel)
❑ **Gabitril®** (tiagabine)	❑ **Keppra®** (levetiracetam)	❑ **Keppra® XR** (levetiracetam)
❑ **Lamictal®** (lamotrigine)	❑ **Lamictal® XR** (lamotrigine)	❑ **Mysoline®** (primidone)
❑ **Neurontin®** (gabapentin)	❑ **Onfi®** (clobazam)	❑ **Oxtellar XR®** (oxcarbazepine)
❑ **Phenytek®** (phenytoin)	❑ **Tegretol®** (carbamazepine)	❑ **Tegretol® XR** (carbamazepine)
❑ **Topamax®** (topiramate)	❑ **Topamax® Sprinkle** (topiramate)	❑ **Trileptal®** (oxcarbazepine)
❑ **Vimpat®** (lacosamide	❑ **Xcopri®** (cenobamate)	❑ **Zarontin®** (ethosuximide)
❑ **Zonegran®** (zonisamide)		

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

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DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

If requesting the following Anticonvulsants: Diacomit® (stiripentol), Lyrica®, Lyrica® CR (pregabalin), Epidiolex® (cannabidiol), Fintepla® (fenfluramine), Nayzilam® (midazolam nasal spray), Valtoco® (diazepam nasal spray), Sabril® (vigabatrin) or Ztalmy® (ganaxolone), please refer to https://www.sentarahealthplans.com/providers/pharmacy/drug-authorization-forms

Quantity Limits: If the requested quantity exceeds approved doses in FDA-package, labeling, nationally recognized compendia or peer-reviewed medical literature, submission of clinical trial data/literature that supports safety of the requested dose must be submitted.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

All the following criteria MUST be met:

- ❑ Medication is being prescribed by or in consultation with a neurologist or psychiatrist
- ❑ Prescriber agrees to assess the member for appropriate monitoring and safety precautions
- ❑ Provider **MUST** submit documentation of therapy failures, including insufficient response or intolerable side effects and efforts were made to minimize treatment failure (e.g., change time of dosing, divide dose out for more frequent but smaller doses)
- ❑ For approval of any brand name medication whose active ingredient is available as a generic product, please submit documentation of **ONE** of the following **(chart notes must be submitted)**:
  - ❑ Member has tried a generic formulation of the requested medication and experienced a life-threatening adverse reaction
  - ❑ Member has a documented history of persisting seizures after titration to the highest tolerated dose of generic product and lack of compliance as a reason for treatment failure has been ruled out
  - ❑ Member has experienced a recent hospitalization and was stabilized on the branded product while inpatient
  - ❑ Member has history of severe risk of harm to self or others
- ❑ Member must meet **ALL** drug specific clinical criteria for requested medication below

Disclaimer statement:

If the provider submits documentation of the required criteria, including a diagnosis of epilepsy and failure/intolerance to first line and or generic medications, the member will receive the medication at the brand copay cost. Please reference drug specific section of this PA form.

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❑ **Aptiom®** (eslicarbazepine)

- ❑ Member is 4 years of age or older and has a confirmed diagnosis of partial-onset seizures
- ❑ Member has had an insufficient response or intolerance to oxcarbazepine **AND at least TWO** additional of the following medications **(Please note all that have been tried and failed)**:

❑ carbamazepine/ER	❑ divalproex sodium ER/DR	❑ felbamate
❑ gabapentin	❑ lamotrigine/ER	❑ levetiracetam/ER
❑ oxcarbazepine	❑ phenobarbital	❑ phenytoin
❑ pregabalin	❑ primidone	❑ tiagabine
❑ topiramate /ER	❑ valproic acid/valproate	❑ zonisamide

❑ **Banzel®** (rufinamide)

- ❑ Member is 1 year of age or older and has a confirmed diagnosis of Lennox-Gastaut Syndrome
- ❑ For generic rufinamide member has had an insufficient response or intolerance to **at least TWO** of the following medications **(Please note all that have been tried and failed)**:

❑ clobazam	❑ clonazepam	❑ felbamate
❑ lamotrigine	❑ topiramate	

- ❑ For **brand Banzel**, member has had an insufficient response or intolerance to generic rufinamide **AND at least TWO** of the following medications **(Please note all that have been tried and failed)**:

❑ clobazam	❑ clonazepam	❑ felbamate
❑ lamotrigine	❑ topiramate	

❑ **Briviact®** (brivaracetam)

- ❑ Member is 1 month of age or older and has a confirmed diagnosis of partial-onset seizures
- ❑ Member has had an insufficient response or intolerance to levetiractam **AND at least TWO** of the following medications **(Please note all that have been tried and failed)**:

❑ carbamazepine/ER	❑ divalproex sodium ER/DR	❑ felbamate
❑ gabapentin	❑ lamotrigine/ER	❑ levetiracetam/ER
❑ oxcarbazepine	❑ phenobarbital	❑ phenytoin
❑ pregabalin	❑ primidone	❑ tiagabine
❑ topiramate /ER	❑ valproic acid/valproate	❑ zonisamide

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❑ Brand Carbatrol, Equetro, Tegretol, and Tegretol XR (carbamazepine)

- ❑ Member has a confirmed diagnosis of **ONE** of the following:
  - ❑ Bipolar disorder
  - ❑ Partial-onset or generalized onset seizures
  - ❑ Neuropathic pain
- ❑ Provider has submitted documentation that therapy with generic immediate-release and extended-release carbamazepine has been insufficient

❑ Brand Depakote, Depakote ER and Depakote Sprinkles (valproic acid and derivatives)

- ❑ Member has a confirmed diagnosis of **ONE** of the following:
  - ❑ Bipolar disorder
  - ❑ Partial-onset and generalized onset seizures (FDA-approved for monotherapy or adjunctive therapy of complex partial and absence seizures, and as adjunctive therapy for multiple seizure types; may be used off-label as monotherapy for other seizure types)
  - ❑ Migraine Prophylaxis
- ❑ Provider has submitted documentation that therapy with generic valproic acid or divalproex sodium has been insufficient

❑ Brand Dilantin, Dilantin Infatabs, and Phenytek (phenytoin)

- ❑ Member has a confirmed diagnosis of partial-onset or generalized onset seizures (FDA-approved for generalized tonic-clonic and complex partial seizures; may be used off-label for other seizure types)
- ❑ Provider has submitted documentation that therapy with generic phenytoin has been insufficient

❑ Brand Felbatol (felbamate)

- ❑ Member has a confirmed diagnosis of **ONE** of the following:
  - ❑ Partial seizures with and without generalization and is 14 years of age or older
  - ❑ Lennox-Gastaut Syndrome and is 2 years of age or older
- ❑ Member has epilepsy so severe that a substantial risk of aplastic anemia and/or liver failure is deemed a risk versus benefit conferred by its use. Felbatol (felbamate) is not indicated as a first line antiepileptic treatment. Member **MUST** have had an insufficient response or intolerance to **at least THREE** alternative treatments
- ❑ Provider must submit documentation that therapy with generic felbamate has been insufficient **AND** member must have insufficient response or intolerance to **at least THREE** of the following medications **(Please note all that have been tried and failed)**:

❑ carbamazepine/ER	❑ divalproex sodium ER/DR	❑ felbamate
❑ gabapentin	❑ lamotrigine/ER	❑ levetiracetam/ER
❑ oxcarbazepine	❑ phenobarbital	❑ phenytoin
❑ pregabalin	❑ primidone	❑ tiagabine
❑ topiramate /ER	❑ valproic acid/valproate	❑ zonisamide

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❑ **Fycompa** (perampanel)

- ❑ Member must meet **ONE** of the following age and diagnosis requirements:
  - ❑ Member is 4 years of age or older and has a confirmed diagnosis of partial-onset seizures with or without secondarily generalized seizures in patients with epilepsy
  - ❑ Member is 12 years of age or older and has a confirmed diagnosis of primary generalized tonic-clonic seizure
- ❑ Member has had an insufficient response or intolerance to **at least THREE** of the following medications (Please note all that have been tried and failed)**:**

❑ carbamazepine/ER	❑ divalproex sodium ER/DR	❑ felbamate
❑ gabapentin	❑ lamotrigine/ER	❑ levetiracetam/ER
❑ oxcarbazepine	❑ phenobarbital	❑ phenytoin
❑ pregabalin	❑ primidone	❑ tiagabine
❑ topiramate /ER	❑ valproic acid/valproate	❑ zonisamide

❑ **Brand Gabitril** (tiagabine)

- ❑ Member is 12 years of age or older and has a confirmed diagnosis of partial-onset seizures
- ❑ For **Brand Gabitril**, provider must submit documentation that therapy with generic tiagabine has been insufficient **AND** member must have insufficient response or intolerance to **at least TWO** of the following medications **(Please note all that have been tried and failed)**:

❑ carbamazepine/ER	❑ divalproex sodium ER/DR	❑ felbamate
❑ gabapentin	❑ lamotrigine/ER	❑ levetiracetam/ER
❑ oxcarbazepine	❑ phenobarbital	❑ phenytoin
❑ pregabalin	❑ primidone	❑ tiagabine
❑ topiramate /ER	❑ valproic acid/valproate	❑ zonisamide

❑ **Brand Keppra** (levetiracetam)

- ❑ Member must meet **ONE** of the following age and diagnosis requirements:
  - ❑ Member is one month of age or older and has a confirmed diagnosis of epilepsy with partial onset seizures
  - ❑ Member is 12 years of age or older and has a confirmed diagnosis of myoclonic seizures with juvenile myoclonic epilepsy
  - ❑ Member is 6 years of age or older and has a confirmed diagnosis of primary generalized tonic-clonic seizures with idiopathic generalized epilepsy
- ❑ Provider has submitted documentation that therapy with generic immediate-release levetiracetam has been insufficient.

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❑ **Brand Keppra XR** (levetiracetam)

- ❑ Member is 12 years of age or older and has a confirmed diagnosis of partial onset seizures
- ❑ Provider has submitted documentation that therapy with generic extended-release levetiracetam has been insufficient

❑ **Brand Lamictal** (lamotrigine)

- ❑ Member has a confirmed diagnosis of **ONE** of the following:
  - ❑ Epilepsy—adjunctive therapy in members 2 years of age or older
  - ❑ partial-onset seizures
  - ❑ primary generalized tonic-clonic seizures
  - ❑ generalized seizures of Lennox-Gastaut syndrome
  - ❑ Epilepsy—monotherapy in patients aged 16 years and older: Conversion to monotherapy in patients with partial-onset seizures who are receiving treatment with carbamazepine, phenytoin, phenobarbital, primidone, or valproate as the single AED
  - ❑ Bipolar disorder: Maintenance treatment of bipolar I disorder to delay the time to occurrence of mood episodes in patients treated for acute mood episodes with standard therapy. Limitations of Use: Treatment of acute manic or mixed episodes is not recommended. Effectiveness of Lamictal in the acute treatment of mood episodes has not been established
- ❑ Provider has submitted documentation that therapy with generic immediate-release lamotrigine has been insufficient

❑ **Brand Lamictal XR** (lamotrigine)

- ❑ Medication will be used for **ONE** of the following indications:
  - ❑ Adjunctive therapy for primary generalized tonic-clonic seizures and partial-onset seizures with or without secondary generalization in members 13 years of age or older
  - ❑ Conversion to monotherapy in member 13 years of age or older with partial-onset seizures who are receiving treatment with a single AED. Limitation of use: Safety and effectiveness in members younger than 13 years have not been established
- ❑ Provider has submitted documentation that therapy with generic extended-release lamotrigine has been insufficient

❑ **Brand Mysoline** (primidone)

- ❑ Member has a confirmed diagnosis of **ONE** of the following:
  - ❑ Partial-onset seizures
  - ❑ Primary generalized tonic-clonic seizures
- ❑ Provider has submitted documentation that therapy with primidone has been insufficient

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❑ **Neurontin** (gabapentin)

- ❑ Medication will be used for **ONE** of the following indications:
  - ❑ Member is 3 years of age or older and has a confirmed diagnosis of partial onset seizures, with and without secondary generalization
  - ❑ Member has a confirmed diagnosis of Post neuralgia
- ❑ Provider has submitted documentation that therapy with generic gabapentin has been insufficient

❑ **Onfi** (clobazam)

- ❑ Provider is requesting **ONE** of the following clobazam products:
  - ❑ Brand Onfi tablets
  - ❑ Brand Onfi suspension
  - ❑ Generic clobazam suspension
- ❑ Medication will be used for **ONE** of the following indications:
  - ❑ Member is 2 years of age or older and has a confirmed diagnosis of Lennox-Gastaut Syndrome
  - ❑ Member has a confirmed diagnosis of intractable/refractory/treatment-resistant seizures
- ❑ Member has had an insufficient response or intolerance to generic clobazam tablets **AND at least TWO** additional antiepileptic medications **(Documentation that therapy has been insufficient must be submitted)**

❑ **Oxtellar XR and Trileptal** (oxcarbazepine)

- ❑ Member must select **ONE** of the following medications and indications for use:
  - ❑ For Trileptal requests: Member is 2 years of age or older and has a confirmed diagnosis of partial-onset seizures
  - ❑ Oxtellar XR: Member is 6 years of age or older and has a confirmed diagnosis of partial-onset seizures
- ❑ Provider has submitted documentation that therapy with generic immediate-release oxcarbazepine has been insufficient

❑ **Topamax and Topamax Sprinkles** (topiramate)

- ❑ Medication will be used for **ONE** of the following indications:
  - ❑ Epilepsy: initial monotherapy in member's 2 years of age or older with partial onset or primary generalized tonic-clonic seizures
  - ❑ Adjunctive therapy for adults and pediatric member's (2 to 16 years of age) with partial onset seizures or primary generalized tonic-clonic seizures
  - ❑ Seizures associated with Lennox-Gastaut syndrome in members 2 years of age or older
  - ❑ Prophylaxis of migraines in members 12 years of age or older
- ❑ Provider has submitted documentation that therapy with generic immediate-release topiramate has been insufficient

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❑ **Xcopri** (cenobamate)

- ❑ Member is 18 years of age or older and has a confirmed diagnosis of partial-onset seizures
- ❑ Member has had an insufficient response or intolerance to **at least THREE** of the following medications **(Please note all that have been tried and failed):**

❑ carbamazepine/ER	❑ divalproex sodium ER/DR	❑ felbamate
❑ gabapentin	❑ lamotrigine/ER	❑ levetiracetam/ER
❑ oxcarbazepine	❑ phenobarbital	❑ phenytoin
❑ pregabalin	❑ primidone	❑ tiagabine
❑ topiramate /ER	❑ valproic acid/valproate	❑ zonisamide

❑ **Vimpat** (lacosamide)

- ❑ Member has a confirmed diagnosis of **ONE** of the following:
  - ❑ Primary generalized tonic-clonic seizures and member is 4 years of age or older
  - ❑ Partial-onset seizures and member is 1 month of age or older
- ❑ For generic lacosamide, member has had an insufficient response or intolerance to **at least THREE** of the following medications **(Please note all that have been tried and failed)**:

❑ carbamazepine/ER	❑ divalproex sodium ER/DR	❑ felbamate
❑ gabapentin	❑ lamotrigine/ER	❑ levetiracetam/ER
❑ oxcarbazepine	❑ phenobarbital	❑ phenytoin
❑ pregabalin	❑ primidone	❑ tiagabine
❑ topiramate /ER	❑ valproic acid/valproate	❑ zonisamide

- ❑ For **brand Vimpat**, member has had an insufficient response or intolerance to generic lacosamide **AND at least THREE** of the following medications **(Please note all that have been tried and failed)**:

❑ carbamazepine/ER	❑ divalproex sodium ER/DR	❑ felbamate
❑ gabapentin	❑ lamotrigine/ER	❑ levetiracetam/ER
❑ oxcarbazepine	❑ phenobarbital	❑ phenytoin
❑ pregabalin	❑ primidone	❑ tiagabine
❑ topiramate /ER	❑ valproic acid/valproate	❑ zonisamide

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- ❑ **Zarontin** (ethosuximide)
  - ❑ Member has a confirmed diagnosis of absence (petit mal) seizures
  - ❑ Provider has submitted documentation that therapy with generic ethosuximide has been insufficient

- ❑ **Zonegran** (zonisamide)
  - ❑ Member has a confirmed diagnosis of partial-onset seizures
  - ❑ Provider has submitted documentation that therapy with generic zonisamide has been insufficient

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****