Prior Authorization Review Panel

CHC-MCO Policy Submission

A separate copy of this form must accompany each policy submitted for review.
Policies submitted without this form will not be considered for review.

Plan: PA Health & Wellness	**Submission Date: N/A**
Policy Number: PHW.PDL.056	**Effective Date: 01/01/2020** **Revision Date: 10/2021**
Policy Name: Anticonvulsants	

Type of Submission – Check all that apply:

- ☐ **New Policy**
- ✓ **Revised Policy***
- ☐ **Annual Review - No Revisions**
- ✓ **Statewide PDL -** *Select this box when submitting policies for Statewide PDL implementation and when submitting policies for drug classes included on the Statewide PDL.*

***All revisions to the policy must be highlighted using track changes throughout the document.**

Please provide any changes or clarifying information for the policy below:

Q1 2022: policy revised according to DHS revisions effective 01/03/2022.

Name of Authorized Individual (Please type or print): **Venkateswara R. Davuluri, MD**	**Signature of Authorized Individual:**

Clinical Policy: Anticonvulsants

Reference Number: PHW.PDL.056
Effective Date: 01/01/2020
Last Review Date: 10/2021

Revision Log

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with PA Health and Wellness® that Anticonvulsants are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Anticonvulsants

A. Prescriptions That Require Prior Authorization

Prescriptions for Anticonvulsants that meet any of the following conditions must be prior authorized:

1. A non-preferred Anticonvulsant. See the Preferred Drug List (PDL) for the list of preferred Anticonvulsants at: https://papdl.com/preferred-drug-list.

2. An Anticonvulsant with a prescribed quantity that exceeds the quantity limit.

3. A prescription for a gabapentinoid (e.g., gabapentin, pregabalin) when there is a record of a recent paid claim for another gabapentinoid (therapeutic duplication).

4. A prescription for clonazepam when prescribed for a beneficiary under 21 years of age.

5. A prescription for clonazepam when there is a record of a recent paid claim for another benzodiazepine (excluding clobazam and benzodiazepines indicated for the acute treatment of increased seizure activity [e.g., rectal and nasal formulations]) (therapeutic duplication).

6. A prescription for a clonazepam when there is a record of 2 or more paid claims for any benzodiazepine (excluding clobazam and benzodiazepines indicated for the acute treatment of increased seizure activity [e.g., rectal and nasal formulations]) within the past 30 days.

7. A prescription for clonazepam when a beneficiary has a concurrent prescription for a buprenorphine agent indicated for the treatment of opioid use disorder.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Anticonvulsant, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. For a non-preferred Anticonvulsant, **one** of the following:

    a. Has a current history (within the past 90 days) of being prescribed the same non-preferred Anticonvulsant (does not apply to non-preferred brands when the therapeutically equivalent generic is preferred or to non-preferred generics when the therapeutically equivalent brand is preferred)

    b. **All** of the following:

        i. Has a documented history of therapeutic failure, contraindication, or intolerance of the preferred Anticonvulsants approved or medically accepted for the beneficiary's diagnosis (therapeutic failure of preferred Anticonvulsants must include the generic equivalent when the generic equivalent is designated as preferred)

        ii. Is being treated for a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication,

        iii. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,

        iv. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature;

    AND

2. For clonazepam, **all** of the following:

    a. For a beneficiary under 21 years of age, **one** of the following:

        i. Has a diagnosis of **one** of the following:

            a) Seizure disorder,
            b) Chemotherapy induced nausea and vomiting,
            c) Cerebral palsy,
            d) Spastic disorder,
            e) Dystonia,
            f) Catatonia

        ii. Is receiving palliative care,

b. For a beneficiary with a concurrent prescription for a buprenorphine agent indicated for the treatment of opioid use disorder, **both** of the following:

   i. Is prescribed the buprenorphine agent and clonazepam by the same prescriber or, if prescribed by different prescribers, all prescribers are aware of the other prescription(s)
   ii. Has an acute need for therapy with clonazepam,

c. For therapeutic duplication of clonazepam with another benzodiazepine, **one** of the following:

   i. Is being titrated to or tapered from another benzodiazepine
   ii. Has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines,

d. When there is a record of 2 or more paid claims for any benzodiazepine, **both** of the following:

   i. The multiple prescriptions are consistent with medically accepted prescribing practices and standards of care, including support from peer-reviewed literature or national treatment guidelines
   ii. The multiple prescriptions are written by the same prescriber or, if written by different prescribers, all prescribers are aware of the other prescription(s),

e. **One** of the following:

   i. Meets the guidelines in B.2.a.
   ii. Has documentation that the prescriber or the prescriber's delegate conducted a search of the Pennsylvania Prescription Drug Monitoring Program (PDMP) for the beneficiary's controlled substance prescription history;

AND

3. For therapeutic duplication of a gabapentinoid, **one** of the following:

   a. Is being titrated to or tapered from another gabapentinoid
   b. Has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines;

AND

4. If a prescription for an Anticonvulsant is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override.

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

B. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an Anticonvulsant. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

C. **Approval Duration: 12 months**

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Q3 2020 annual review: no changes.	07/2020
Q1 2021: policy revised according to DHS revisions effective 01/05/2021.	11/2020
Q1 2022: policy revised according to DHS revisions effective 01/03/2022.	10/2021