Clinical Policy: Neuropathic Pain Agents

Reference Number: PHW.PDL.232
Effective Date: 01/01/2020
Last Review Date: 11/2025

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 PA Health and Wellness® that Neuropathic Pain Agents are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Neuropathic Pain Agents

A. Prescriptions That Require Prior Authorization

Prescriptions for Neuropathic Pain Agents that meet any of the following conditions must be prior authorized:

1. A non-preferred Neuropathic Pain Agent.

2. A Neuropathic Pain Agent 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).

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Neuropathic Pain Agent, the determination of whether the requested prescription is medically necessary will take into account whether the member:

1. 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; **AND**

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

3. For gabapentin extended-release for the treatment of postherpetic neuralgia, has a history of **both** of the following:

a. Therapeutic failure of the maximum tolerated dose of a tricyclic antidepressant or a contraindication or an intolerance to tricyclic antidepressants
b. Therapeutic failure of the maximum tolerated dose of immediate-release gabapentin or a contraindication or an intolerance to immediate-release gabapentin that would not be expected to occur with the requested drug;

AND

4. For gabapentin enacarbil extended-release, **one** of the following:

   a. For a diagnosis of postherpetic neuralgia, has a history of **both** of the following:

      i. Therapeutic failure of the maximum tolerated dose of a tricyclic antidepressant or a contraindication or an intolerance to tricyclic antidepressants
      ii. Regular Therapeutic failure of the maximum tolerated dose of immediate-release gabapentin or a contraindication or an intolerance to immediate-release gabapentin that would not be expected to occur with the requested drug;
   b. For a diagnosis of moderate to severe primary restless leg syndrome (RLS), has a history of therapeutic failure of the maximum tolerated dose of immediate-release gabapentin or an intolerance, or a contraindication to immediate-release gabapentin that would not be expected to occur with the requested drug;

   AND

5. For all other non-preferred Neuropathic Pain Agents, has a history of therapeutic failure, contraindication, or intolerance of the preferred Neuropathic Pain Agents approved or medically accepted for the member's diagnosis; **AND**

6. 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 drugs that is supported by peer-reviewed literature or national treatment guidelines;

   AND

7. If a prescription for a Neuropathic Pain Agent 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 member 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 member, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR NEUROPATHIC PAIN AGENTS: The determination of medical necessity of a request for renewal of a prior authorization for a Neuropathic Pain Agent that was previously approved will take into account whether the member:

1. Has documentation of positive clinical response to the drug; **AND**

2. For a non-preferred Neuropathic Pain Agent except gabapentin extended-release and gabapentin enacarbil extended-release, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Neuropathic Pain Agents approved or medically accepted for the member's diagnosis; 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 drugs that is supported by peer-reviewed medical literature or national treatment guidelines;

AND

4. If a prescription for a Neuropathic Pain Agent 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 member 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 member, the request for prior authorization will be approved.

C. 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 a Neuropathic Pain Agent. 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 member.

D. **Approval Duration:**
   - **New Request: 6 months**
   - **Renewal Request: 12 months**

E. References

1. Gralise [package insert]. Depomed, Inc. Newark, CA. September 2015. Morristown, NJ: Almatica Pharma LLC; April 2023.
2. Horizant [package insert]. Atlanta, GA: Arbor Pharmaceuticals, LLC; October 2016. April 2020.
3. Shefner JM. Postherpetic neuralgia. In: UpToDate [internet database]. Swanson JW, Goddeau RP, eds. Waltham, MA: UpToDate Inc. Updated August 2, 2024. Accessed August 16, 2024.
4. Silber MH. Management of restless legs syndrome and periodic limb movement disorder in adults. In: UpToDate [internet database]. Hurtig HI, Avidan AY, Eichler AF, eds. Waltham, MA: UpToDate Inc. Updated June 14, 2024. Accessed August 16, 2024.

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Q3 2020 annual review: no changes.	07/2020
Q1 2021 annual review: no changes.	01/2021
Q1 2022 annual review: no changes.	11/2021
Q1 2023 annual review: no changes.	11/2022
Q1 2024 annual review: no changes.	11/2023
Q1 2025: policy revised according to DHS revisions effective 01/06/2025	11/2024
Q1 2026 annual review: no changes.	11/2025