BOSTON MEDICAL CENTER HEALTHNet PLAN

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Pharmacy Policy

Step Therapy Policy – Anticonvulsant Agents

Policy Number: 9.214
Version Number: 2.1
Version Effective Date: 07/01/2021

Product Applicability	☐ **All Plan[+] Products**
Well Sense Health Plan	**Boston Medical Center Healthnet Plan**
☐ New Hampshire Medicaid	☒ Masshealth - MCO
	☒ Masshealth - ACO
	☐ Qualified Health Plans
	☐ Senior Care Options

Note: Disclaimer And Audit Information Is Located At The End Of This Document.

Prior Authorization Policy

POLICY STATEMENT:
A step therapy program has been developed to encourage the use of generic Step-1 products prior to the use of a Step-2 product, without interrupting existing therapy. If the step therapy rule is not met for a Step-2 agent at the point of service, coverage will be determined by the step therapy criteria below. All approvals are provided for 1 year in duration.

Standard Criteria:
The plan may authorize coverage of the products in the appendix for all FDA approved indications not otherwise excluded and for members meeting the following criteria when step therapy is not met at point of sale from claims history.

1. Prescribers must provide documentation (including dates of trial and outcome) that the member has tried and failed the appropriate number of Step 1 agents as indicated in Appendix A and in the coverage criteria requirements. **OR**

[+] *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

2. Prescriber must provide documentation that the member has had a contraindication to or other clinical rationale preventing the use of **ALL** Step 1 agents indicated in Appendix

Appendix A: Step Therapy Details

Anticonvulsants-General		
Step 1	**Step 2**	**Coverage Criteria**
Carbamazepine Divalproex Epitol Ethosuximide Felbamate Gabapentin Lamotrigine Levetiracetam Oxcarbazepine Phenytoin Primidone Tiagabine Topiramate IR Valproic Acid Zonisamide	Aptiom Clobazam Banzel Briviact Fycompa Vimpat Vigabatrin Oral Pkt	Pharmacy Claims Indicating The Use of at least two (2) Step 1 Agents in the last 130 days.

Anticonvulsants-Lam		
Step 1	**Step 2**	**Coverage Criteria**
Lamotrigine IR	Lamotrigine ODT Lamotrigine XR	Pharmacy Claims Indicating The Use of Lamotrigine IR In The Previous 130 Days

Anticonvulsants-Spritam		
Step 1	**Step 2**	**Coverage Criteria**

Levetiracetem Sol	Spritam	Pharmacy Claims Indicating The Use Of Levetiracetem Sol In The Previous 130 Days

Anticonvulsants – Topiramate		
Step 1	**Step 2**	**Coverage Criteria**
Topiramate IR	Topiramate ER	Pharmacy Claims Indicating The Use Of Topiramate IR In The Previous 130 Days

Original Approval Date	Original Effective Date	Policy Owner	Approved By
12/10/2020	1/1/2021	Pharmacy Services	Pharmacy & Therapeutics (P&T) Committee

Policy Revisions History			
Review Date	**Summary Of Revisions**	**Revision Effective Date**	**Approved By**
12/10/2020	Created separate policies per applicable line of business. Coverage duration changed to 1 year. Addition of policy statement and standard criteria. Changed trial look back to 130 days from 120 days.	1/1/2021	Pharmacy & Therapeutics (P&T) Committee
02/11/2021	P & T annual review. No formulary or criteria changes. Minor language changes to standard criteria to clarify intent of policy.	06/01/2021	P&T Committee
6/25/2021	Sabril removed from Step Therapy. As of 7/1/21 Sabril is managed by the MH UPPL policy MA9.230	7/1/2021	P&T Committee

Next Review Date

February 2022

Other Applicable Policies

Reference To Applicable Laws And Regulations, If Any

Disclaimer Information

Medical Policies Are the Plan's Guidelines For Determining The Medical Necessity Of Certain Services Or Supplies For Purposes Of Determining Coverage. These Policies May Also Describe When A Service Or Supply Is Considered Experimental Or Investigational, Or Cosmetic. In Making Coverage Decisions, The Plan Uses These Guidelines And Other Plan Policies, As Well As The Member's Benefit Document, And When Appropriate, Coordinates With The Member's Health Care Providers To Consider The Individual Member's Health Care Needs.

Plan Policies Are Developed In Accordance With Applicable State And Federal Laws And Regulations, And Accrediting Organization Standards (Including NCQA). Medical Policies Are Also Developed, As Appropriate, With Consideration of the Medical Necessity Definitions in Various Plan Products, Review of Current Literature, Consultation with Practicing Providers in the Plan's Service Area Who Are Medical Experts In The Particular Field, And Adherence To FDA And Other Government Agency Policies. Applicable State Or Federal Mandates, As Well As The Member's Benefit Document, Take Precedence Over These Guidelines. Policies Are Reviewed And Updated On An Annual Basis, Or More Frequently As Needed. Treating Providers Are Solely Responsible For The Medical Advice And Treatment Of Members.

The Use Of This Policy Is Neither A Guarantee Of Payment Nor A Final Prediction Of How A Specific Claim(S) Will Be Adjudicated. Reimbursement Is Based On Many Factors, Including Member Eligibility And Benefits On The Date Of Service; Medical Necessity; Utilization Management Guidelines (When Applicable); Coordination Of Benefits; Adherence With Applicable Plan Policies And Procedures; Clinical Coding Criteria; Claim Editing Logic; And The Applicable Plan – Provider Agreement.