Pharmacy Medical Necessity Guidelines:  
Aptiom® (eslicarbazepine acetate)  

Effective: July 10, 2018

Prior Authorization Required ☑ Type of Review – Care Management
Not Covered Type of Review – Clinical Review ☑
Pharmacy (RX) or Medical (MED) Benefit RX Department to Review RXUM

This Pharmacy Medical Necessity Guideline applies to the following:

Tufts Health Plan Commercial Plans
☒ Tufts Health Plan Commercial Plans – large group plans
☒ Tufts Health Plan Commercial Plans – small group and individual plans

Tufts Health Public Plans
☒ Tufts Health Direct – Health Connector
☐ Tufts Health Together – A MassHealth Plan
☐ Tufts Health RITogether – A RIte Care + Rhody Health Partners Plan

Tufts Health Freedom Plan products
☒ Tufts Health Freedom Plan - large group plans
☒ Tufts Health Freedom Plan - small group plans

Fax Numbers:
RXUM: 617.673.0988

Note: For Tufts Health Plan Medicare Preferred Members, please refer to the Tufts Health Plan Medicare Preferred Prior Authorization Criteria. Background, applicable product and disclaimer information can be found on the last page.

OVERVIEW

FOOD AND DRUG ADMINISTRATION-APPROVED INDICATIONS
Aptiom (eslicarbazepine acetate) tablets are indicated for adjunctive treatment for partial-onset seizures.

COVERAGE GUIDELINES
The plan may authorize coverage of Aptiom (eslicarbazepine acetate) for Members when all of the following criteria are met:

1. Documented diagnosis of partial-onset seizures by a neurologist
   AND

2. One of the following:
   a. The Member is stable on the medication
   OR
   b. The Member has had an insufficient response or intolerance to at least two (2) other medications indicated for adjunct partial seizures (see examples) OR the provider indicates clinical inappropriateness of treatment with the alternative medications.

Examples:
• felbamate
• tiagabine
• lamotrigine
• pregabalin
• levetiracetam
• gabapentin
• topiramate
• oxcarbazepine
• zonisamide

LIMITATIONS
None

CODES
None

REFERENCES

2255479  1  Pharmacy Medical Necessity Guidelines:  
Aptiom® (eslicarbazepine acetate)

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8. LaRoche SM, Helmers SL. The new antiepileptic drugs: scientific review. JAMA. 2004a;291(5);605-14.

APPROVAL HISTORY
June 10, 2014: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:
- July 8, 2014: Changed criteria #2: The Member is stable on the medication OR the Member has had an insufficient response or intolerance to at least two (2) other medication indicated for adjunct partial seizures (see examples), or the provider indicates clinical inappropriateness of treatment with the alternative medications. Removed the brand names for the alternative medications.
- July 14, 2015: No changes
- January 1, 2016: Administrative change to rebranded template applicable to Tufts Health Direct.
- July 12, 2016: No changes
- July 11, 2017: No changes
- July 10, 2018: No changes

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION
Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They are used in conjunction with a Member’s benefit document and in coordination with the Member’s physician(s). The plan makes coverage decisions on a case-by-case basis considering the individual Member’s health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

This Pharmacy Medical Necessity Guideline does not apply to Uniformed Services Family Health Plan Members or to certain delegated service arrangements. Unless otherwise noted in the Member’s benefit document or applicable Pharmacy Medical Necessity Guideline, Pharmacy Medical Necessity Guidelines do not apply to CareLink℠ Members. For self-insured plans, drug coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a coverage guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates will take precedence.

For Tufts Health Plan Medicare Preferred, please refer to Tufts Health Plan Medicare Preferred Prior Authorization Criteria.
Treating providers are solely responsible for the medical advice and treatment of Members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to Member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.