May 1, 2005

MEDICAID INFORMATION RELEASE 2005-14

TO: Prescribing Providers, Pharmacists, Pharmacies, Hospitals, and Long-Term Care Facilities

FROM: Randy May, Deputy Administrator

SUBJECT: NEW PRIOR AUTHORIZATION CRITERIA FOR ANTIEPILEPTIC DRUG CLASS

Drug/Drug Class: **ANTIEPILEPTIC**

Implementation Date: **Effective for dates of service on or after June 1, 2005**

Idaho Medicaid is not designating preferred agents for the Antiepileptic therapeutic drug class. Instead, the focus will be placed on **indication**. Use of antiepileptic drugs will require an **FDA approved indication** or an **indication supported by evidenced-based research**. For a list of antiepileptic agents and their approved indications please see the table below.

The Enhanced Prior Authorization Program (EPAP) is designed to provide Medicaid participants the most effective drug at the right price. **Beginning June 1, 2005**, the following Antiepileptic agents will require Prior Authorization for all indications ***NOT*** listed below:

EPAP Drug Class	DRUG NAME	APPROVED INDICATIONS^
ANTIEPILEPTIC	• Keppra® • Lamictal® • Neurontin® • Topamax® • Trileptal® • Zonegran®	• Seizures only • Seizures and Bipolar Disorder • Seizures and Neuropathic Pain • Seizures and Migraines • Seizures and Bipolar Disorder • Seizures

^All other indications for these six (6) agents will require prior authorization.

Point-of-service pharmacy claims will be routed through an automated computer system to apply PA criteria specifically designed to assure effective drug utilization. Through this process, therapy will automatically and transparently be approved for those patients who meet the system approval criteria. For those patients who do not meet the system approval criteria, it will be necessary for you to contact the Medicaid Drug Prior Authorization help desk at (208) 364-1829 or fax a PA request form to (208) 364-1864 to initiate a review and potentially authorize claims.

To assist in managing patients affected by these changes, Medicaid will be sending in a separate mailing to prescribing providers, a list of their patients currently receiving therapy whose drug claims will be affected.

The Enhanced PA Program and drug class specific PA criteria are based on evidence-based clinical criteria and available nationally recognized peer-reviewed information. The determination of medications to be considered preferred within a drug class is based primarily on objective evaluations of their relative safety, effectiveness, and clinical outcomes in comparison with other therapeutically interchangeable alternative drugs and secondarily on cost.

Additional therapeutic drug classes will be added in the coming months to the Enhanced Prior Authorization (EPAP) program. Please watch for further information releases on the Medicaid Pharmacy website at www.medicaidpharmacy.idaho.gov .

A current listing of all the preferred agents by drug class and prior authorization criteria is also available online at www.medicaidpharmacy.idaho.gov.

As always, your support is critical to the success of this Medicaid Pharmacy initiative. It is our goal to partner with you in the provision of quality, cost-effective health care to your patients. Questions regarding the Prior Authorization program may be referred to Medicaid Pharmacy at (208) 364-1829.

RM/cb