

POLICY NAME

Qudexy XR (topiramate ER) and Trokendi XR

POLICY #

2071P

Criteria

Coverage Criteria for Seizure Diagnoses

- ☐ 1.1 Diagnosis of Partial-Onset Seizures, Primary Generalized Tonic-Clonic Seizures, or Lennox-Gastaut Syndrome
- ☐ 1.2 Documented failure after 90 days, intolerance, or contraindication to topiramate

Coverage Criteria for Migraine Prophylaxis

- ☐ 2.1 Diagnosis of chronic migraine
- ☐ 2.2 Documented failure, intolerance, or contraindication to topiramate IR with claims history to support member compliance with filling at least a 90-day supply within a 120-day time frame
- ☐ 2.3 Documented failure, intolerance or contraindication to at least 1 additional supported migraine preventative medication (such as metoprolol, propranolol, timolol, atenolol, nadolol, amitriptyline, nortriptyline, duloxetine, venlafaxine, divalproex or valproic acid)