Pharmacy Drug Policy Checklist

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)