

POLICY NAME	Qudexy XR (topiramate ER) and Trokendi XR	POLICY #	2071P
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Criteria

Coverage Criteria for Seizure Diagnoses

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

Coverage Criteria for Migraine Prophylaxis

- ☐ Diagnosis of chronic migraine
- ☐ 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
- ☐ 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)