POLICY AND PROCEDURE

<table>
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<tr>
<th>DEPARTMENT: Pharmacy</th>
<th>DOCUMENT NAME: Anti-Convulsant Parameters of Coverage and Continuity of Care.</th>
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<td>REPLACES DOCUMENT:</td>
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<tr>
<td>APPROVED DATE: 4/2017</td>
<td>RETIRED:</td>
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<tr>
<td>EFFECTIVE DATE: 4/2017</td>
<td>REVIEWED/REVISED DATE: 4/2018</td>
</tr>
<tr>
<td>PRODUCT TYPE: Medicaid</td>
<td>REFERENCE NUMBER: IN.PHARM.10</td>
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SCOPE:
Centene Corporate Pharmacy Department, MHS Indiana Pharmacy Department, Centene Pharmacy and Therapeutics Committee, MHS Pharmacy and Therapeutics Committee

PURPOSE:
To provide coverage for services that will optimize control of the members’ seizures through the use of effective pharmacologic agents and through following a unified pharmacy benefits policy with FFS and MCE pharmacy programs.

POLICY:
Members with seizure disorders who are newly assigned into a Medicaid program and already stabilized on an antiseizure drug regimen will have their drug regimen grandfathered and supported in the prescription drug benefit. For the duration of the regimen in which the member enters the program and is adherent, the drug therapy will not be changed in favor of a preferred drug regimen.

Members enrolled into a Medicaid program who are newly diagnosed with a seizure disorder requiring pharmacologic treatment will be provided coverage for anticonvulsant medications, in accordance with evidence-based criteria administered by MHS P&T Committee. Criteria for coverage shall emphasizes the effectiveness, appropriateness, safety, and affordability of drug therapy options through clinical edits, step therapy, and prior authorization.

Such criteria may include:
1. Parameters addressing the dosage, quantity, and duration of treatment
2. Parameters addressing drug-drug interactions and adverse drug event risks
3. Parameters addressing age limitations
4. Parameters addressing overutilization or underutilization risks
5. Parameters addressing generic substitution for multi-sourced brand drug products
6. Parameters addressing treatment with medication samples.
7. Parameters for approving non-preferred drug products.
8. Parameters for offering case management personnel when the prescriber determines insufficient efficacy of, or adverse events stemming from, initial preferred antiseizure drug therapy that results in the following:
   a. A decision to add a duplicate antiseizure drug that would result in a claim denial
   b. A decision to prescribe a nonpreferred drug that would result in a claim denial
   c. A decision to prescribe an antiseizure drug outside of its FDA or compendia approved indications that would result in a claim denial

PROCEDURE:

MHS will maintain an independent preferred drug list through the preferred drug list policy and P&T oversight.

Continuity of Care of non-preferred anti-convulsants:
MHS Medicaid members will be permitted to continue their current anti-convulsant drug regimen if they were on stable therapy prior to joining MHS. Stable therapy includes:
- Reduction of symptoms of seizure disorder
- Adherence to drug being requested
- If member was stabilized on drug sample, please refer to CP.PMN.16 Request for Drug Not on the PDL sample criteria (I.A.2)

Grandfathering will be created either through claim and PA file review if available from previous payer, or through manual PA review process.

Approval Duration: Indefinite

Approval of non-preferred anti-convulsants:
For requests for initiation of a non-preferred anti-convulsant, MHS members will only be required to trial and fail or have documented intolerance to one other drug listed on the MHS PDL. All utilization edits, age edits, quantity limits and therapeutic duplication apply.

Approval Criteria:
• Documentation or claim evidence that member has tried 1 PDL anti-convulsant at normal FDA dosing and has not achieved desired therapeutic outcome
• Drug being requested is FDA approved for the documented indication
  ○ This policy does not allow for the off label use of anti-convulsants. For off label use please use CP.PMN.53 Off Label Use of Medication
• Dose of requested medication is FDA approved for the indication

Approval Duration: Indefinite

REFERENCES

ATTACHMENTS

DEFINITIONS:

REVISION LOG

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<tr>
<th>REVISION</th>
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<td>Annual Review – No Changes</td>
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POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Compliance 360, Centene's P&P management software, is considered equivalent to a physical signature.

Director of Pharmacy_________________________ Date: _______________________