oscar

Clinical Guideline

Guideline Number: PG055, Ver. 1

lamotrigine ER

Disclaimer

Clinical guidelines are developed and adopted to establish evidence-based clinical criteria for utilization management decisions. Oscar may delegate utilization management decisions of certain services to third-party delegates who may develop and adopt their own clinical criteria.

The clinical guidelines are applicable to all commercial plans. Services are subject to the terms, conditions, limitations of a member's plan contracts, state laws, and federal laws. Please reference the member's plan contracts (e.g., Certificate/Evidence of Coverage, Summary/Schedule of Benefits) or contact Oscar at 855-672-2755 to confirm coverage and benefit conditions.

Summary

Lamotrigine is an oral anticonvulsant agent. It is FDA labeled for use in bipolar disorder, Lennox - Gastaut syndrome, partial seizures, tonic-clonic seizures. The exact mechanism of anticonvulsant activity is not known but studies suggest lamotrigine may stabilize neuronal membranes by acting at voltage-sensitive sodium channels.

Lamotrigine comes in an oral formulation including an extended-release formulation and immediate-release formulation.

Definitions

"Epilepsy" is the syndrome of two or more unprovoked seizures that occur more than 24 hours apart.

"Bipolar Disorder" is a disorder associated with episodes of mood swings ranging from depressive lows to manic highs.

Medical Necessity Criteria for Initial Authorization

Oscar covers Lamotrigine ER when ALL the criteria for ONE of the following diagnoses below::

1. The member has a diagnosis of epilepsy
    a. The member is 13 years of age or older; *and*
    b. The member had an inadequate treatment response, intolerance or contraindication to any of the following generic formulary agents for at least a 1 month duration:
        i. Carbamazepine

ii. Divalproex
iii. Ethosuximide
iv. Lamotrigine immediate release
v. Levetiracetam
vi. Oxcarbazepine
vii. Topiramate
viii. Valproate
ix. Valproic acid

2. The member has a diagnosis of bipolar disorder
    a. The member is 12 years of age or older; *and*
    b. The member had an inadequate treatment response, intolerance or contraindication to lamotrigine immediate release tablet for at least a 1 month duration

<u>If the above prior authorization criteria are met, Lamotrigine ER will be approved for 36 months.</u>

Medical Necessity Criteria for Reauthorization:

Reauthorization for 36 months will be granted if there is chart documentation:

A. Epilepsy: stating the member has demonstrated a reduction in severity and/or frequency of seizures for epilepsy.
B. Bipolar disorder: stating that the member's condition has been improved or maintained based upon the prescriber's assessment while on therapy.

Experimental or Investigational / Not Medically Necessary

Lamotrigine ER for any other indication is not covered by Oscar as it is considered experimental, investigational, or unproven.

References

1. Fisher RS, Acevedo C, Arzimanoglou A, et al. ILAE official report: a practical clinical definition of epilepsy. Epilepsia 2014; 55:475.
2. Bipolar disorder in adults: Choosing maintenance treatment. Up To Date [Online]. November 2019
3. Lamictal XR (lamotrigine) [prescribing information]. Research Triangle Park, NC: GlaxoSmithKline; September 2019.

Clinical Guideline Revision / History Information

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