

**Anticonvulsants:**  
**Oxcarbazepine extended release (generic Oxtellar XR)**  
**Topiramate extended release (generic Qudexy XR, generic Trokendi XR)**  
**Eprontia (topiramate)**  
**Effective 05/01/2026**

<b>Plan</b>	<input type="checkbox"/> MassHealth UPPL <input checked="" type="checkbox"/> Commercial/Exchange	<b>Program Type</b>	<input checked="" type="checkbox"/> Prior Authorization <input type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
<b>Benefit</b>	<input checked="" type="checkbox"/> Pharmacy Benefit <input type="checkbox"/> Medical Benefit		
<b>Specialty Limitations</b>	N/A		
<b>Contact Information</b>	<b>Medical Benefit</b>	Phone: 833-895-2611	Fax: 888-656-6671
	<b>Pharmacy Benefit</b>	Phone: 800-711-4555	Fax: 844-403-1029
<b>Exceptions</b>	N/A		

### Overview

Prescriptions that meet the initial step therapy requirements will adjudicate automatically at the point of sale. If the prescription does not meet the initial step therapy requirements, the prescription will deny with a message indicating that prior authorization (PA) is required. Refer to the criteria below and submit a PA request for the members who do not meet the initial step therapy requirements at the point of sale.

#### Initial Step-Therapy Requirements:

**First-Line:** Medications listed on first-line are covered without prior-authorization.

**Second-Line:** Second-line medications will pay if the member has filled at least TWO first-line medications or a second-line medication within the past 180 days.

If the member does not meet the automated step therapy requirements, then requests will be reviewed against the prior authorization criteria below.

### Coverage Guidelines

If member is new to the plan (as evidenced by coverage effective date of less than or equal to 90 days), submission of medical records documenting that the member is currently receiving treatment with requested drug, excluding when the product is obtained as samples or via manufacturer's patient assistance programs

**OR**

Authorization may be granted for members when all the following criteria are met:

1. Member meets ONE of the following:
  - a. Inadequate response, adverse reaction, or contraindication to at least two first-line medications\*
  - b. Inadequate response, adverse reaction, or contraindication to at least one second-line medication\*

\*Paid claims in the previous 180 days can be considered as evidence of trial and failure

FIRST-LINE	SECOND-LINE
clobazam (tablet and suspension) clonazepam (tablet) diazepam (rectal gel, tablet) felbamate (tablet and suspension) tiagabine (tablet) vigabatrin (tablet and powder pack) phenytoin (chew tablet, suspension) phenytoin Sodium (extended capsule, injection) ethosuximide (capsule, solution) divalproex Sodium (delayed release capsule sprinkle, delayed release tablet, sustained release 24-hour tablet) valproate Sodium (injection) valproic Acid (capsule) carbamazepine (tablet, chewable tablet, suspension, sustained release 12-hour capsule, sustained release 12-hour tablet) gabapentin (capsule, tablet, oral solution) lamotrigine (tablet, chewable tablet dispersible, orally disintegrating tablet, sustained release 24-hour tablet) levetiracetam (tablet, oral solution, sustained release 24-hour tablet) oxcarbazepine (tablet, suspension) pregabalin (capsule, solution) primidone (tablet) topiramate (tablet, sprinkle capsule,) zonisamide (capsule) fosphenytoin Sodium (injection)	Oxcarbazepine extended-release (generic Oxtellar XR) Topiramate ER sprinkle capsule (generic Trokendi XR) Topiramate ER sprinkle capsule (generic Qudexy XR) Eprontia

**Limitations**

1. Approvals will be granted for 36 months.

**References**

1. Oxtellar XR (oxcarbazepine) [prescribing information]. Rockville, MD: Supernus Pharmaceuticals Inc; December 2018.
2. Trokendi XR (topiramate) extended-release capsules [prescribing information]. Rockville, MD: Supernus Pharmaceuticals; February 2020.
3. Eprontia (topiramate) [prescribing information]. Wilmington, MA: Azurity Pharmaceuticals; November 2021.

**Review History**

11/18/2020—Updated to step therapy criteria, made all generics first line and Oxtellar XR & Trokendi XR second line; removed PA criteria for Oxtellar

05/18/2022 – Updated and Reviewed for May P&T; added new drug Eprontia as second line agent. References updated. Effective 06/01/22.

02/11/2026 – Reviewed and updated at February P&T. Added language for members who are new to the Plan. Clarified step therapy grid to include topiramate ER sprinkle capsules as second-line agents. Added approval criteria for members who do not meet the automated step therapy requirements. Effective 05/01/2026.

