Mass General Brigham
Health Plan

Benzodiazepines and Antianxiety Agents:
alprazolam ODT
Byfavo® (remimazolam)
clonazepam ODT
chlordiazepoxide/amitriptyline
Doral® (quazepam)
estazolam
flurazepam
Halcion® (triazolam)
Librax® (chlordiazepoxide/clidinium)
Loreev XR® (lorazepam extended release)
meprobamate
oxazepam
Restoril® (temazepam)
Tranxene® (clorazepate)
Xanax® XR (alprazolam extended release)
Effective 10/02/2023

Plan	☒ MassHealth UPPL ☐Commercial/Exchange	**Program Type**	☒ Prior Authorization ☒ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☒ Medical Benefit (NLX)		
Specialty Limitations	N/A		
Contact Information	**Specialty Medications**		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	Non-Specialty Medications		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	Medical Specialty Medications (NLX)		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
Exceptions	Byfavo is available through the medical benefit only.		

Overview

No PA	Require PA
Ativan® # (lorazepam solution, tablet)	alprazolam orally disintegrating tablet
Ativan® # (lorazepam injection)	Byfavo® (remimazolam)[MB]
buspirone	clonazepam ODT 0.125 mg, 0.25 mg, 0.5 mg, 1 mg > 3 units/day
chlordiazepoxide	clonazepam ODT 2 mg > 2 units/day
diazepam injection	chlordiazepoxide/amitriptyline
Klonopin® # (clonazepam tablet)	Doral® (quazepam)± ‡
lorazepam 1 mg/0.5 mL oral concentrate**	

midazolam injection midazolam syrup Valium® # † (diazepam solution, tablet) Xanax® # (alprazolam)	estazolam > 1 unit/day‡
	flurazepam > 1 unit/day‡
	Halcion® # (triazolam) > 1 unit/day * ‡
	Librax® (chlordiazepoxide/clidinium)*
	Loreev XR® (lorazepam) extended-release capsules
	meprobamate
	oxazepam
	Restoril® (temazepam 22.5 mg)* ‡
	Restoril® # (temazepam 7.5 mg, 15 mg, 30 mg) > 1 unit/day* ‡
	Tranxene® (clorazepate)*
	Xanax® XR # (alprazolam extended-release) > 2 units/day*

#This designates a brand-name drug with FDA "A"-rated generic equivalents. PA is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.
*A-rated generic available. Both brand and A-rated generic require PA.
†Brand name is non-rebate, review using Non-Rebate guideline and the Brand Name and Non-Preferred Generic Drugs guideline
‡Use of antianxiety agents in members less than 18 years of age is discussed in the Pediatric Behavioral Health Medication Initiative guideline. Please note clobazam and rectal diazepam, diazepam nasal spray, and midazolam nasal spray formulations are not included in the initiative.
±Authorized generic available. Both brand and authorized generic require PA and do not participate in federal rebate.
§All benzodiazepines (with the exception of clobazam, diazepam rectal gel, diazepam nasal spray, midazolam nasal spray and injectable products) will require prior authorization if used concomitantly with an opioid for 60 out of the past 90 days under the Concomitant Opioid and Benzodiazepine Initiative.
**Agent does not participate in the federal rebate program. Please see the Non-FDA and Non-rebate products guideline for more information.
MB – Medical Benefit
¶ Use of clobazam, diazepam nasal spray, midazolam nasal spray, and rectal diazepam is discussed in the Anticonvulsants guideline.
‡ For requests for Duplicate Therapy with Multiple Hypnotic Agents (including hypnotic benzodiazepines), please refer to the Hypnotics guideline appendix.

The **Pediatric Behavioral Health Medication Initiative** may apply to MassHealth members <18 years of age due to polypharmacy, age, and/or drug restrictions. As indicated within this guideline, please refer to the **Pediatric Behavioral Health Medication Initiative** guideline to assess appropriateness of therapy.

Coverage Guidelines
Authorization may be reviewed on a case by case basis for members who are new to the plan currently receiving treatment with requested medication excluding when the product is obtained as samples or via manufacturer's patient assistance programs.
OR
Authorization will be granted when all the following criteria has been met, and documentation has been submitted:

Alprazolam orally disintegrating tablets
ALL of the following:
1. Diagnosis of ONE of the following:
    a. Anxiety
    b. Panic disorder

c. Skeletal muscle spasms
2. Medical necessity for ODT formulation as indicated by BOTH of the following:
    a. Member has a G-tube, dysphagia, or swallowing difficulties
    b. Member is currently not using other oral medications
3. Dose requested cannot be consolidated

Byfavo® (remimazolam)
ALL of the following:
1. Agent will be used for induction and maintenance of procedural sedation
2. Physician attestation of inadequate response, adverse reaction, or contraindication to intravenous midazolam
3. Appropriate dosing

Chlordiazepoxide/amitriptyline
ALL of the following:
1. Diagnosis of moderate to severe depression associated with moderate to severe anxiety
2. Medical necessity for the use of the combination product instead of the commercially available separate agents

Doral® (quazepam)
ALL of the following:
1. Diagnosis of insomnia
2. Medical records documenting an inadequate response or adverse reaction to **ALL** of the following hypnotic benzodiazepines:
    a. estazolam
    b. flurazepam
    c. temazepam 7.5, 15 or 30 mg
    d. triazolam

Librax® (chlordiazepoxide/clidinium)
ALL of the following:
1. Diagnosis of ONE of the following:
    a. Acute enterocolitis
    b. irritable bowel syndrome
    c. peptic ulcer
2. Member is ≥ 18 years of age
3. Quantity limit of 8 units/day (See Appendix A)
4. Prescriber is a gastrointestinal specialist or consult notes from a gastroenterology office are provided
5. Requested medication will be used as an adjunctive therapy
6. Inadequate response or adverse reaction to **TWO** anticholinergic/antispasmodics or contraindication to all antispasmodics
7. Inadequate response, adverse reaction to an SSRI or contraindication to **ALL** SSRIs
8. Inadequate response or adverse reaction to a non-benzodiazepine anxiolytic or contraindication to **ALL** non-benzodiazepine anxiolytics
9. Inadequate response or adverse reaction to **ONE** other benzodiazepine
10. For a diagnosis of peptic ulcer, **ALL** of the following:
    a. Inadequate response (defined as at least 4 weeks of therapy) or adverse reaction to **TWO** proton pump inhibitors or contraindication to **ALL** proton pump inhibitors

b. For H. pylori-positive peptic ulcer, an inadequate response to one 4 week course of appropriate combination therapy
c. Requested treatment duration does not exceed 12 weeks

11. For a diagnosis of irritable bowel syndrome with constipation, **ALL** of the following:
    a. Inadequate response, adverse reaction or contraindication to **ONE** agent from **three** of the four traditional laxative therapy classes:
        i. Bulk forming laxatives
        ii. Osmotic laxatives
        iii. Saline laxatives
        iv. Stimulant laxatives
    b. Inadequate response or adverse reaction to **TWO** of the following or contraindication to **ALL** of the following:
        i. lubiprostone
        ii. Linzess® (linaclotide)
        iii. Trulance® (plecanatide)
12. For a diagnosis of irritable bowel syndrome with diarrhea, inadequate response or adverse reaction to **FIVE** of the following or contraindication to **ALL** of the following:
    a. loperamide
    b. bile acid sequestrants
    c. diphenoxylate/atropine
    d. bismuth subsalicylate
    e. bulk-forming laxatives
    f. Xifaxan® (rifaximin)
13. For a diagnosis of acute enterocolitis, **ALL** of the following:
    a. Inadequate response, adverse reaction or contraindication to **BOTH** of the following:
        i. loperamide
        ii. bismuth subsalicylate
    b. Requested treatment duration of therapy does not exceed 3 days

Loreev XR® (lorazepam) capsules
ALL of the following:

1. Diagnosis of anxiety
2. Medical records documenting stability with lorazepam tablets in three evenly divided daily doses
3. **ONE** of the following:
    a. Medical records documenting inadequate response or adverse reaction to **TWO** intermediate/long- or long-acting benzodiazepines (See Appendix B)
    b. Contraindication to **ALL** other long-acting benzodiazepines
4. Request does not exceed 1 unit/day

Meprobamate
ALL of the following:

1. Diagnosis of anxiety
2. Physician attestation of inadequate response or adverse reaction to the use of at least **TWO** or contraindication to **ALL** benzodiazepine agents

Oxazepam
Tranxene (clorazepate)

ALL of the following:

1. Diagnosis of ONE of the following:
    a. Alcohol withdrawal syndrome
    b. Anxiety disorder
    c. Panic disorder
    d. Seizure disorder
2. **ONE** of the following:
    a. Physician attestation of inadequate response or adverse reaction to **TWO** of the following benzodiazepines:
        i. alprazolam
        ii. chlordiazepoxide
        iii. clonazepam
        iv. diazepam
        v. lorazepam
    b. Contraindication to the use of **ALL** other benzodiazepine agents

Restoril® (temazepam 22.5 mg)
ALL of the following:

1. Diagnosis of insomnia
2. Medical records documenting an inadequate response or adverse reaction to **ALL** of the following hypnotic benzodiazepines
    a. estazolam
    b. flurazepam
    c. temazepam 7.5, 15 or 30 mg
    d. triazolam
3. **ONE** of the following:
    a. Requested quantity is ≤ 1 unit/day
    b. For requested quantity of 2 units/day, **ALL** of the following:
        i. Inadequate response to 30 mg/day
        ii. Medical records documenting titration of medication up to current dose
        iii. Clinical rationale for dosing higher than the FDA approved limits *
4. Dose requested cannot be consolidated

**See Appendix for FDA-approved maximum doses of hypnotics*

Brand Name Agents with A-rated generics:
Ativan® (lorazepam)
Klonopin® (clonazepam)
Xanax® (alprazolam)
ALL of the following:

1. Diagnosis of ONE of the following:
    a. Alcohol withdrawal syndrome
    b. Anxiety disorder
    c. Panic disorder
    d. Seizure disorder
    e. Skeletal muscle spasm
2. Medical records of an inadequate response or adverse reaction to the generic equivalent (as per the Brand Name guideline).

3. Paid claims or physician attestation of inadequate response (a 30-day trial) or adverse reaction to one other non-hypnotic benzodiazepine (e.g., alprazolam, chlordiazepoxide, clonazepam, clorazepate, diazepam, lorazepam)
4. Dose requested cannot be consolidated

>3 units/day of: clonazepam orally disintegrating tablets 0.125 mg, 0.25 mg, 0.5 mg, 1 mg
>2 units/day of: clonazepam orally disintegrating tablets 2 mg
ALL of the following:

1. Diagnosis of ONE of the following:
    a. Anxiety disorder
    b. Panic disorder
    c. Skeletal muscle spasm
    d. Seizure disorder
    e. Alcohol withdrawal syndrome
2. **ONE** of the following (See Appendix A)
    a. For 0.125 mg, 0.25 mg, 0.5 mg, 1 mg ODT > 3 units/day, **BOTH** of the following:
        i. Medical records documenting titration of medication up to current dose
        ii. Clinical rationale for dosing higher than the FDA approved limits
    b. For 2 mg ODT > 2 units/day, **BOTH** of the following:
        i. Medical records documenting titration of medication up to current dose
        ii. Clinical rationale for dosing higher than the FDA approved limits
3. Prescriber is a neurologist or psychiatrist, or consult notes from a neurology or psychiatry office are provided
4. Dose requested cannot be consolidated

Hypnotic benzodiazepine requests > 1 unit/day: estazolam, flurazepam, triazolam, temazepam 7.5 mg, 15 mg, 30 mg

<u>triazolam 0.25 mg</u>
ALL of the following:

1. Diagnosis of insomnia
2. For requested quantity of 2 units/day, inadequate response to 0.25 mg/day

<u>estazolam, flurazepam, temazepam 7.5 mg, 15 mg, 30 mg *</u>
ALL of the following:

1. Diagnosis of insomnia
2. Inadequate response to 1 unit/day
3. Higher dose was effective in alleviating symptoms
4. Requested dose cannot be consolidated
5. For requests exceeding the FDA-approved maximum dose, inadequate response, or adverse reaction to TWO alternatives for sleep (one must be a non-benzodiazepine hypnotic)
    a. Non-benzodiazepine hypnotics
        i. eszopiclone
        ii. zaleplon
        iii. zolpidem, zolpidem ER
    b. Other alternatives
        i. Belsomra®(suvorexant), Dayvigo®(lemborexant), or Quviviq®(daridorexant)
        ii. diphenhydramine

iii. Rozerem®(ramelteon), melatonin
iv. silenor®(doxepin), doxepin capsules
v. trazodone

*See Appendix for FDA-approved maximum doses of hypnotics

>2 units/day of: Xanax XR® (alprazolam ER)
ALL of the following:

1. Diagnosis of ONE of the following:
    a. Alcohol withdrawal syndrome
    b. Anxiety disorder
    c. Panic disorder
    d. Seizure disorder
    e. Skeletal muscle spasm
2. Dose requested cannot be consolidated
3. Medical records documenting titration of medication up to current dose
4. Clinical rationale for dosing higher than the FDA approved limits

Benzodiazepine Polypharmacy* for members ≥ 18 years of age:
Individual drug PA criteria must be met first if applicable.

1. Member had a recent psychiatric hospitalization (within the last three months) **OR** member has a history of severe risk of harm to self or others.

OR

2. **ALL** of the following:
    a. Clinically appropriate diagnosis (e.g., anxiety, panic disorder, insomnia, agitation, skeletal muscle pain, seizures)‡
    b. Documentation of treatment plan including names of current benzodiazepine agents and corresponding diagnoses
    c. **ONE** of the following:
        i. Cross-titration/taper of benzodiazepine therapy
        ii. Clinical rationale for use of ≥2 benzodiazepines of different chemical entities (e.g., lorazepam and clonazepam) (****Please see appendix regarding criteria for clinical rationale****)

**Provisional approvals may be granted for different reasons – see Limitations*
‡ Please see appendix for additional diagnosis-specific criteria

Concomitant opioids and benzodiazepines*
Individual drug PA criteria must be met first if applicable.

1. Member had a recent psychiatric hospitalization (within the last three months) **OR** member has a history of severe risk of harm to self or others.

OR

2. **ALL** of the following:
    a. Appropriate diagnosis for the benzodiazepine (e.g., anxiety disorder, panic disorder, musculoskeletal disorder)
    b. Appropriate diagnosis for the opioid (e.g., acute pain, chronic pain, cancer pain)
    c. Prescriber provides documentation of **ONE** of the following:
        i. Member's treatment is currently managed by palliative care
        ii. Member currently in hospice or is transitioning to hospice

iii. If the benzodiazepine is being used for a psychiatric diagnosis (e.g., anxiety, panic disorder, PTSD), documentation of an inadequate response or adverse reaction to **THREE** antidepressants, or contraindication to **ALL** antidepressants
iv. If the benzodiazepine is being used for a musculoskeletal diagnosis (e.g., musculoskeletal pain, skeletal muscle spasm), documentation of an inadequate response or adverse reaction to **THREE** skeletal muscle relaxants (e.g., cyclobenzaprine, chlorzoxazone, metaxalone, methocarbamol, orphenadrine), or a contraindication to **ALL** skeletal muscle relaxants
v. If the benzodiazepine is being used for a sleep disorder (e.g., insomnia), documentation of an inadequate response or adverse reaction to **THREE** non-benzodiazepine sleep medications, or a contraindication to **ALL** non-benzodiazepine sleep medications
vi. If the benzodiazepine is being used for a seizure disorder (e.g., epilepsy, akinetic seizures, myoclonic seizures), documentation that the member is stable on a non-benzodiazepine anticonvulsant
vii. Treatment plan to taper off or taper down from benzodiazepine therapy
viii. Treatment plan to taper off opioid therapy
ix. Clinical rationale for the concomitant use of opioids and benzodiazepines

d. Member will be co-prescribed naloxone

**An initial approval and reauthorization approval of 3 months may be granted provisionally if criteria not met.*

Continuation of Therapy

Alprazolam ODT: Reauthorization require physician attestation of **ALL** of the following:

- Dose requested cannot be consolidated
- Continued medical necessity for use

All other agents: Reauthorization by physician will infer a positive response to therapy.

Meprobamate: Reauthorization require physician attestation of **ALL** of the following:

1. Inadequate response (a 30-day trial), adverse reaction to **THREE** or contraindication to **ALL** anxiolytic agents:
    a. SSRI
    b. SNRI
    c. TCA
    d. Buspirone
2. Clinical rationale for continued therapy with meprobamate

Agents exceeding the quantity limit (QL): Reauthorization require physician attestation of continued medical necessity for exceeding the QL.

Limitations

1. Initial approvals will be granted:
    a. Brand names for seizure disorder 12 months; other indications 6 months
    b. Alprazolam ER, Clonazepam ODT exceeding QL: 12 months
    c. Alprazolam ODT, chlordiazepoxide/amitriptyline, clorazepate, Loreev XR®, oxazepam
        i. Seizure disorder: 12 months
        ii. Other indications: 6 months
    d. Byfavo®: 1 month or until procedure date, if provided

e. Librax® (chlordiazepoxide/clidinium)
    i. Peptic ulcer: 3 months
    ii. Acute Enterocolitis: 3 days
    iii. Irritable bowel syndrome: 6 months
f. Meprobamate: 2 months
g. Hypnotic Benzodiazepine Agents (quazepam, temazepam 22.5 mg and agents exceeding QL [estazolam, flurazepam, triazolam, and temazepam 7.5, 15, 30 mg]): 12 months
h. Adult Benzodiazepine Polypharmacy:
    i. All criteria met: 12 months
    ii. Criteria not met: 3 months provisional
i. Concomitant Opioid and Benzodiazepine:
    i. All criteria met: 12 months
    ii. Criteria not met: 3 months provisional

2. Reauthorizations will be granted for:
    a. Alprazolam ODT:
        i. Seizure disorder: 12 months
        ii. Other indications: 6 months
    b. Byfavo® (remimazolam) treated as a new request: 1 month or until procedure date, if provided
    c. Librax® (chlordiazepoxide/clidinium) for irritable bowel disease: 6 months
    d. Meprobamate: 4 months
    e. Benzodiazepines excluding Librax® (chlordiazepoxide/clidinium): 12 months
    f. All agents exceeding the QL: 12 months
    g. Adult Benzodiazepine Polypharmacy: 12 months (for all listed above)
    h. Concomitant Opioid and Benzodiazepine:
        i. All criteria met: 12 months
        ii. Criteria not met: 3 months provisional
3. **Requests for Brand Name when generic is preferred:** In addition to any prior authorization requirements that may be listed above, if an A-rated generic equivalent is available, such prior authorization requests require medical records documenting an allergic response, adverse reaction, or inadequate response to the generic equivalent drug (history of allergic reaction to the inactive ingredients used in the manufacturing process of a certain drug is acceptable).
4. **Requests for generic when Brand Name is preferred:** There are some drugs for which the Plan has determined it will be cost effective to prefer the use of the Brand Name formulation. In this case, the generic equivalent formulation is considered non-preferred and requires prior authorization. These requests require medical records documenting an allergic response, adverse reaction, or inadequate response to the Brand Name formulation. For the most up to date list of drugs where the Brand Name formulation is preferred, see the MassHealth Brand Name Preferred Over Generic Drug List (BOGL) at www.mass.gov/druglist.
5. The following quantity limits apply:

Librax	240 capsules per 30 days
clonazepam ODT 0.125 mg, 0.25 mg, 0.5 mg, 1 mg	90 tablets per 30 days
clonazepam ODT 2 mg, Xanax® XR (alprazolam extended-release)	60 tablets per 30 days
estazolam, flurazepam, Halcion® (triazolam), Restoril® (temazepam 7.5 mg, 15 mg, 30 mg), Loreev XR	30 units per 30 days

Appendix
FDA-approved maximum doses of hypnotics

Agent	FDA-Approved Max Daily Dose
estazolam (1, 2 mg)	2 mg
flurazepam (15, 30 mg)	30 mg
temazepam (7.5, 15, 22.5, 30 mg)	30 mg
triazolam (0.125, 0.25 mg)	0.5 mg

A. Benzodiazepine Agents Duration of Action

Generic Name	Brand Name	Duration of Action
Alprazolam	Xanax®, Niravam®	Short
Alprazolam XR	Xanax XR®	Intermediate/Long
Chlordiazepoxide	Librium®	Long
Chlordiazepoxide/clidinium	Librax®	Long
Clonazepam	Klonopin®	Intermediate/Long
Clorazepate	Tranxene-T®	Long
Diazepam	Valium®, Diastat®, Valtoco®	Long
Estazolam	ProSom®	Short
Flurazepam	Dalmane®	Long
Lorazepam	Ativan®	Short
Lorazepam ER	Loreev XR®	Long
Midazolam	Versed®, Nayzilam®	Short
Oxazepam	Serax®	Short/Intermediate
Quazepam	Doral®	Long
Remimazolam	Byfavo®	Short
Temazepam	Restoril®	Short
Triazolam	Halcion®	Short

B. Benzodiazepine Polypharmacy
Requests should be reviewed based on the member's primary diagnosis (or diagnoses) and member is **≥ 18 years of age** utilizing the criteria outlined below:

Sleep Diagnosis
ALL of the following:

1. Clear treatment plan (diagnosis intended to treat, medication name(s), dose, frequency)
2. Severity of sleep diagnosis outlined (e.g., symptoms, recent hospitalizations, risk of harm to self or others, etc)
3. Intended treatment duration and prescriber follow-up plan noted
4. Documentation of **ONE** of the following:
    a. Paid claims or physician attestation of inadequate response or adverse reaction to **THREE** of the following (trials must include at least one non-benzodiazepine hypnotic if not contraindicated):
        i. Non-benzodiazepine hypnotics
            1. eszopiclone
            2. zaleplon
            3. zolpidem, zolpidem ER

ii. Other alternatives
1. Belsomra® (suvorexant), Dayvigo® (lemborexant), or Quviviq® (daridorexant)
2. diphenhydramine
3. Rozerem® (ramelteon), melatonin
4. Silenor® (doxepin), doxepin capsules
5. trazodone

b. A contraindication to ALL of the trials listed above

5. The benzodiazepine regimen includes one short acting benzodiazepine agent and one long-acting benzodiazepine agent

Psychiatric Diagnosis
ALL of the following:

1. Clear treatment plan (diagnosis intended to treat, medication name(s), dose, frequency)
2. Severity of psychiatric condition outlined (e.g., symptoms, recent hospitalizations, risk of harm to self or others, etc)
3. Intended treatment duration and prescriber follow-up plan noted
4. Documentation of **ONE** of the following:
    a. Paid claims or physician attestation of inadequate response or adverse reaction to three of the following (trials must include at least one SSRI and one SNRI, unless classes are contraindicated):
        i. SSRI
        ii. SNRI
        iii. TCA
        iv. mirtazapine
        v. buspirone (for the diagnosis of GAD only)
        vi. Viibryd (vilazodone HCl)
        vii. Trintellix® (vortioxetine)
    b. Contraindication to **ALL** of the trials listed above*
5. The benzodiazepine regimen includes one short acting benzodiazepine agent and one long-acting benzodiazepine agent

* For members with a diagnosis of bipolar disorder requiring treatment for anxiety, standard treatment with an antidepressant may not be appropriate.

Musculoskeletal Diagnosis
ALL of the following:

1. Clear treatment plan (diagnosis intended to treat, medication name(s), dose, frequency)
2. Severity of musculoskeletal condition outlined (e.g., symptoms, functional status, impact on ADLs, recent hospitalization, etc.)
3. Intended treatment duration and prescriber follow-up plan noted
4. Documentation of **ONE** of the following:
    a. Paid claims or physician attestation of inadequate response or adverse reaction to **THREE** skeletal muscle relaxants (e.g., cyclobenzaprine, chlorzoxazone, metaxalone, methocarbamol, orphenadrine)
    b. Contraindication to **ALL** of the trials listed above
5. The benzodiazepine regimen includes one short acting benzodiazepine agent and one long-acting benzodiazepine agent

Seizure Diagnosis
ALL of the following:

1. Diagnosis of epilepsy or any other seizure type
2. Clear treatment plan (diagnosis intended to treat, medication name(s), dose, frequency)
3. Intended treatment duration and prescriber follow-up plan
4. **ONE** of the following:
    a. Documentation of stability on the requested regimen
    b. Cross-titration/taper of benzodiazepine therapy
    c. BOTH of the following:
        i. Paid claims or physician attestation of inadequate response or adverse reaction to any three anticonvulsants
        ii. Benzodiazepine regimen includes one short acting and one long acting benzodiazepine agent

Psychiatric and Seizure Diagnoses
ONE of the following:

1. If the prescriber notes the primary diagnosis being treated is either a psychiatric diagnosis **OR** a seizure diagnosis utilize the corresponding criteria above
2. If the prescriber documents the primary diagnoses being treated are both a psychiatric diagnosis **AND** a seizure diagnosis, the prescriber must provide **ALL** of the following:
    a. Clear treatment plan (diagnosis intended to treat, medication name(s), dose, frequency)
    b. Severity of condition outlined (e.g., symptoms, recent hospitalizations, risk of harm to self or others, etc)
    c. Intended treatment duration and prescriber follow-up plan
    d. Documentation of **ONE** of the following:
        i. Stability on the requested regimen
        ii. Paid claims or physician attestation of inadequate response or adverse reaction to any three anticonvulsants
        iii. Paid claims or physician attestation of inadequate response or adverse reaction to three of the following (trials must include at least one SSRI and one SNRI, unless classes are contraindicated)*:
            1. SSRI
            2. SNRI
            3. TCA
            4. mirtazapine
            5. buspirone (for the diagnosis of GAD only)
            6. Viibryd® (vilazodone HCl)
            7. Trintellix® (vortioxetine)
        iv. Contraindication to **ALL** of the trials listed above*

* For members with a diagnosis of bipolar disorder requiring treatment for anxiety, standard treatment with an antidepressant may not be appropriate.

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Review History

02/08/2023 - Reviewed and created for Feb P&T; matched MH UPPL to be in compliance with Masshealth unified formulary requirements. Effective 4/1/23.
04/12/23 – Reviewed and updated for Apr P&T. Clarified diagnoses throughout policy. Added QL criteria for triazolam 0.25 mg. Guideline update to reflect inclusion of hospice/palliative care in the COBI clinical criteria as rationales for using combination therapy. Benzodiazepine polypharmacy criteria was clarified to only apply to adult member reviews. Effective 6/5/23
05/10/23 – Reviewed and updated for P&T. Added provisional approvals for various circumstances. Updated polypharmacy criteria for seizure diagnosis to include taper therapy plan and one short acting and long acting benzodiazepine agent regimen. Effective 7/1/23.
07/12/23 – Reviewed and updated for P&T. Brand preferred and mandatory generic language was added under Limitations. Added diagnosis of seizure disorder as acceptable for approval of oxazepam and clorazepate. Updated approvable diagnoses for alprazolam ER. Moved Hypnotic benzodiazepine requests > 1 unit/day from Appendix. Formatting updates made to drug table. Effective 7/31/23.
09/13/23 – Reviewed and updated for P&T. Clarified Tranxene (clorazepate) criteria. Effective 10/2/23