

<b>Clinical Policy Title:</b>	levetiracetam
<b>Policy Number:</b>	RxA.495
<b>Drug(s) Applied:</b>	Spritam®
<b>Original Policy Date:</b>	03/06/2020
<b>Last Review Date:</b>	12/11/2025
<b>Line of Business Policy Applies to:</b>	All lines of business (except Medicare)

## Criteria

### I. Initial Approval Criteria

#### A. Partial onset Seizures (must meet all):

1. Diagnosis of partial onset seizures;
2. Medical justification supports inability to use generic levetiracetam tablets or solution (e.g., contraindications to the excipients).

#### Approval Duration

**All Lines of Business (except Medicare):** 12 months

#### B. Myoclonic seizures, or primary generalized tonic-clonic seizures (must meet all):

1. Diagnosis of Myoclonic seizures, or primary generalized tonic-clonic seizures;
2. Medical justification supports inability to use generic levetiracetam tablets or solution (e.g., contraindications to the excipients).

#### Approval Duration

**All Lines of Business (except Medicare):** 12 months

### II. Continued Therapy Approval

#### A. All Indications in Section I (must meet all):

1. Auto-approval based on lookback functionality within the past 120 days as a proxy for member responding positively to therapy.

#### Approval Duration

**All Lines of Business (except Medicare):** 12 months

## References

N/A

Review/Revision History	Review/Revision Date	P&T Approval Date
Policy established.	01/2020	03/06/2020

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

<p>Policy was reviewed</p> <ol style="list-style-type: none"> <li>1. Clinical Policy title was updated.</li> <li>2. Line of business policy applies to was updated to ' All lines of business'</li> <li>3. Continued Therapy criteria II.A.1 was rephrased to "Currently receiving medication that has been authorized by RxAdvance..."</li> </ol>	<p>09/16/2020</p>	<p>12/07/2020</p>
<p>Policy was reviewed</p> <ol style="list-style-type: none"> <li>1. Initial Approval Criteria I.A.2 was added to include prescriber criteria.</li> <li>2. Initial Approval Criteria I.A.3 was added to include age criteria.</li> <li>3. Initial Approval Criteria I.A.5 was updated to include dosing criteria.</li> <li>4. Initial Approval Criteria I.B was added for diagnosis "Myoclonic seizures, and primary generalized tonic-clonic seizures"</li> <li>5. Continued Therapy Criteria II.A.1 was rephrased to "Member is currently receiving medication that has been authorized by RxAdvance or member has met initial approval criteria for the covered indications and has received this medication for at least 30 days".</li> <li>6. References were reviewed and updated.</li> </ol>	<p>09/16/2021</p>	<p>12/07/2021</p>
<p>policy was reviewed:</p> <ol style="list-style-type: none"> <li>1. Initial Approval Criteria, I.B.5.b: Updated dosing criteria from Primary generalized tonic-clonic seizures dose does not exceed 3,000 mg per day and 1,500 mg/day for adults and pediatric patients 6 years and older weighing 20 to 40 kg to Primary generalized tonic-clonic seizures: Dose does not exceed 3,000 mg/day for adults and pediatric patients ≥ 6 years and weighing &gt; 40 kg, 1500 mg for pediatric patients ≥ 6 years and weighing 20kg- 40 kg.</li> <li>2. Continued Therapy Approval Criteria, II.A.3.c: Updated dosing criteria from Primary generalized tonic-clonic seizures dose does not exceed 3,000 mg per day and 1,500 mg/day for adults and pediatric patients 6 years and older weighing 20 to</li> </ol>	<p>08/02/2022</p>	<p>10/19/2022</p>

<p>40 kg to Primary generalized tonic-clonic seizures: Dose does not exceed 3,000 mg/day for adults and pediatric patients ≥ 6 years and weighing &gt; 40 kg, 1500 mg for pediatric patients ≥ 6 years and weighing 20kg- 40 kg.</p> <p>3. References were reviewed and updated.</p>		
Policy was reviewed.	10/19/2023	10/19/2023
<p>Policy was reviewed:</p> <ol style="list-style-type: none"> <li>1. Removed age restrictions.</li> <li>2. Removed prescriber restrictions.</li> <li>3. Removed dose restrictions.</li> <li>4. Updated Continued therapy approval with auto-approval based on lookback functionality within the past 120 days.</li> <li>5. Removed reauthorization requirement for positive response to therapy.</li> <li>6. Updated approval duration verbiage.</li> </ol>	08/28/2024	09/13/2024
Policy was reviewed.	12/05/2024	N/A
Policy reviewed	12/11/2025	12/11/2025