

STEP THERAPY CRITERIA

BRAND NAME (generic)

GRALISE
(gabapentin extended-release tablet)

HORIZANT
(gabapentin enacarbil extended-release tablet)

LYRICA
(pregabalin)

LYRICA CR
(pregabalin extended-release)

Status: CVS Caremark Criteria

Type: Initial Step Therapy; Post Step Therapy Prior Authorization

POLICY

FDA-APPROVED INDICATIONS

Gralise

Gralise is indicated for the management of postherpetic neuralgia.

Gralise is not interchangeable with other gabapentin products because of differing pharmacokinetic profiles that affect the frequency of administration.

Horizant

Treatment of Restless Legs Syndrome

Horizant is indicated for the treatment of moderate-to-severe primary Restless Legs Syndrome (RLS) in adults.

Horizant is not recommended for patients who are required to sleep during the daytime and remain awake at night.

Management of Postherpetic Neuralgia

Horizant is indicated for the management of postherpetic neuralgia (PHN) in adults.

Lyrice

Lyrice is indicated for:

- Management of neuropathic pain associated with diabetic peripheral neuropathy
- Management of postherpetic neuralgia
- Adjunctive therapy for the treatment of partial-onset seizures in patients 1 month of age and older
- Management of fibromyalgia
- Management of neuropathic pain associated with spinal cord injury

Lyrice CR

Lyrice CR is indicated for the management of:

- Neuropathic pain associated with diabetic peripheral neuropathy
- Postherpetic neuralgia

Efficacy of Lyrice CR has not been established for the management of fibromyalgia or as adjunctive therapy for adult patients with partial onset seizures.

Compendial Uses

Lyrica

- Cancer-Related Neuropathic Pain^{10,14}
- Cancer Treatment-Related Neuropathic Pain^{10,14}

INITIAL STEP THERAPY

For Lyrica, Lyrica CR, or Gralise

If the patient has filled a prescription for at least a 30 day supply of gabapentin immediate-release within the past 120 days under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit. If the patient does not meet the initial step therapy criteria, then the system will reject with a message indicating that a prior authorization (PA) is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

For Horizant

If the patient has filled a prescription for at least a 30 day supply of any of the following: pramipexole immediate-release, ropinirole immediate-release, or gabapentin immediate-release within the past 120 days under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit. If the patient does not meet the initial step therapy criteria, then the system will reject with a message indicating that a prior authorization (PA) is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

COVERAGE CRITERIA

The requested drug will be covered with prior authorization when the following criteria are met:

- Lyrica (pregabalin immediate-release) is being prescribed for one of the following: A) Management of fibromyalgia, B) Management of neuropathic pain associated with spinal cord injury, C) Adjunctive therapy for partial-onset seizures (i.e., focal-onset seizures) in a patient 1 month to up to 3 years of age, D) Cancer-related neuropathic pain, E) Cancer treatment-related neuropathic pain **AND**
 - If the request is for Lyrica (pregabalin) oral solution, the patient meets one of the following: A) has difficulty swallowing oral solid dosage forms (e.g., capsules), B) requires a dose that cannot be obtained using the commercially available capsules

OR

- Lyrica (pregabalin immediate-release) is being prescribed for one of the following: A) Adjunctive therapy for partial-onset seizures (i.e., focal-onset seizures) in a patient 3 years of age or older, B) Management of postherpetic neuralgia, C) Management of neuropathic pain associated with diabetic peripheral neuropathy **AND**
 - The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to gabapentin immediate-release **AND**
 - If the request is for Lyrica (pregabalin) oral solution, the patient meets one of the following: A) has difficulty swallowing oral solid dosage forms (e.g., capsules), B) requires a dose that cannot be obtained using the commercially available capsules

OR

- Lyrica CR (pregabalin extended-release), Gralise (gabapentin extended-release), or Horizant (gabapentin enacarbil extended-release) is being prescribed for the management of postherpetic neuralgia **AND**
 - The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to gabapentin immediate-release

OR

- Lyrica CR (pregabalin extended-release) is being prescribed for the management of neuropathic pain associated with diabetic peripheral neuropathy **AND**
 - The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to TWO of the following: A) gabapentin immediate-release, B) pregabalin immediate-release, C) duloxetine, D) venlafaxine, E) a tricyclic antidepressant

OR

- Horizant (gabapentin enacarbil extended-release) is being prescribed for the treatment of Restless Legs Syndrome **AND**

- The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to ANY of the following: A) pramipexole immediate-release, B) ropinirole immediate-release

REFERENCES

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