Clinical Policy Title:	gabapentin
Policy Number:	RxA.147
Drug(s) Applied:	Gralise®
Original Policy Date:	02/07/2020
Last Review Date:	01/01/2024
Line of Business Policy Applies to:	All lines of Business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Postherpetic Neuralgia (must meet all)**:**

1. Diagnosis of PHN;
2. Trial and failure of more than a 30-day supply, unless contraindicated or clinically significant adverse effects are experienced (must meet a, b, and c):
   a. Gabapentin immediate release
   b. Pregabalin immediate release or extended release
   c. Tricyclic antidepressant (e.g., amitriptyline, nortriptyline, imipramine)

Approval Duration

All Lines of Business (except Medicare): 12 months

II. Continued Therapy Approval

A. Postherpetic Neuralgia

1. Member is currently receiving or has been treated with this medication within the past 90 days, excluding manufacturer samples.

Approval Duration

All Lines of Business (except Medicare): 12 months

References

1. Rowbotham M, Harden N, Stacey B, Bernstein P, Magnus-Miller L. Gabapentin for the treatment of postherpetic neuralgia: a randomized controlled trial. JAMA 1998; 280:1837-42. Available at: https://jamanetwork.com/journals/jama/fullarticle/188226. Accessed November 21, 2023.
2. Rice ACS, Maton S. Gabapentin in postherpetic neuralgia: a randomised, double blind, placebo-controlled study. Pain 2001; 94:215–224. Available at: https://journals.lww.com/pain/Abstract/2001/11000/Gabapentin_in_postherpetic_neuralgia__a.13.aspx . Accessed November 21, 2023.

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy established.	1/2020	02/07/2020
Policy was reviewed: 1. Clinical Policy Title was updated. 2. Drug(s) Applied was updated.	6/22/2020	09/14/2020

3. Line of Business Policy Applies to was updated. 4. Continued Therapy criteria II.A.1 was rephrased to "Currently receiving medication that has been authorized by RxAdvance..." 5. Initial and Continued Therapy Approval criteria: Commercial approval duration was updated from length of benefit to 12 months; Medicaid approval duration was included. 6. References were updated.		
Policy was reviewed: 1. Last review date was updated. 2. Continued Therapy criteria II.A.1 was rephrased from Currently receiving medication that has been authorized by RxAdvance..." 3. References were reviewed and updated.	02/18/2021	06/10/2021
Policy was reviewed: 1. References were reviewed and updated.	01/12/2022	04/18/2022
Policy was reviewed: 1. Initial Approval Criteria I.A.4: Trial and failure of generic pregabalin immediate-release (at doses up to 450 mg/day) and controlled-release (at doses up to 660 mg/day) each used for ≥ 30-days, unless clinically significant adverse effects are experienced, or both are contraindicated. 2. Trial and failure of a ≥ 30-day trial of a tricyclic antidepressant (TCA) (e.g., amitriptyline, nortriptyline, imipramine), unless clinically significant adverse effects are experienced, member's age is ≥ 65, or all are contraindicated. 3. References were reviewed and updated.	01/18/2023	04/13/2023
Policy was reviewed: 1. Removed prior age criteria. 2. Removed prior dosing criteria. 3. Restructured try/fail criteria. 4. Updated approval duration. 5. Removed reauthorization requirement for positive response to therapy. 6. References were reviewed and updated.	11/21/2023	01/01/2024
Policy was reviewed.	02/28/2024	02/28/2024