

**Sabril (vigabatrin)  
Effective 07/01/2021**

<b>Plan</b>	<input type="checkbox"/> MassHealth <input checked="" type="checkbox"/> MH UPPL <input 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 (NLX)		
<b>Specialty Limitations</b>	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
<b>Contact Information</b>	<b>Specialty Medications</b>		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	<b>Non-Specialty Medications</b>		
	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
	<b>Medical Specialty Medications (NLX)</b>		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
<b>Exceptions</b>	N/A		

### Overview

Sabril (vigabatrin) is FDA approved for the following indications:

- Monotherapy for pediatric patients 1 month to 2 years of age with infantile spasms for whom the potential benefits outweigh the potential risk of vision loss.
- Adjunctive therapy for adults and pediatric patients  $\geq 2$  years of age with refractory complex partial seizures who have inadequately responded to several alternative treatments and for whom the potential benefits outweigh the risk of vision loss.

No PA	Drugs that require PA
	Sabril <sup>®</sup> (vigabatrin) <sup>* †</sup>

\* Available as an A-rated generic, both brand and A-rated generic require a PA

† Brand Preferred over generic equivalents. In general, a trial of the preferred drug or clinical rationale for prescribing the non-preferred drug generic equivalent

§ Use of anticonvulsants in members less than 18 years of age is discussed in the **MassHealth Pediatric Behavioral Health Medication Initiative guideline**.

### Coverage Guidelines

Authorization may be reviewed on a case by case basis for members who are currently receiving treatment with Sabril excluding when the product is obtained as samples or via manufacturer's patient assistance programs

**OR**

Authorization may be granted if prescriber provides documentation that the member meets **ALL** following criteria and documentation has been submitted:

1. The member has a diagnosis of infantile spasms, epilepsy, or a seizure disorder
2. Prescriber is a neurologist or consult notes from a neurology office are provided

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3. For a diagnosis of infantile spasms: member is < 2 years of age
4. For a diagnosis of epilepsy or a seizure disorder: **ALL** of the following:
  - a. Member is  $\geq$  2 years of age
  - b. Member will be using the requested agent as adjunctive therapy
  - c. Paid claims or physician documented inadequate response or adverse reaction to any 2 anticonvulsants indicated for seizures (e.g., clobazam, phenobarbital, quinidine, Afinitor<sup>®</sup> [everolimus])
5. For **vigabatrin**, a trial of Sabril is required or a clinical rationale for prescribing the generic equivalent.

Please refer to the **MassHealth Pediatric Behavioral Health Medication Initiative** guideline regarding the review of requests for members <18 years of age.

### **Continuation of Therapy**

Reauthorization requires physician attestation of continuation of therapy

### **Limitations**

Initial approvals and reauthorizations will be granted for 12 months

### **References**

1. Sabril (vigabatrin) [prescribing information]. Deerfield, IL: Lundbeck; February 2020.

### **Review History**

05/19/2021: Created and Reviewed at May P&T to be in compliance with MH UPPL for 7/1/21. Effective 07/01/2021.

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