Clinical Policy: Perampanel (Fycompa)

Reference Number: CP.PMN.156
Effective Date: 11.16.16
Last Review Date: 08.26
Line of Business: Commercial, HIM/ICHRA, Medicaid Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Perampanel (Fycompa®) is a non-competitive α-amino-3-hydroxy-5-methyl-4-isoxazolepropionic acid (AMPA) glutamate receptor antagonist.

FDA Approved Indication(s)

Fycompa is indicated:

- For the treatment of partial-onset seizures with or without secondarily generalized seizures in patients with epilepsy 4 years of age and older.
- For adjunctive therapy in the treatment of primary generalized tonic-clonic seizures in patients with epilepsy 12 years of age and older.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that perampanel and Fycompa are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Partial-Onset Seizures (must meet all)**:**

1. Diagnosis of partial-onset seizures;
2. Age ≥ 4 years;
3. Member meets one of the following (a or b):
   a. Request is for the treatment of a member in a State with limitations on step therapy in certain settings (*see Appendix D*);
   b. Both of the following (i and ii):
      i. Failure of two preferred alternatives (*see Appendix B for examples*), unless clinically significant adverse effects are experienced or all are contraindicated;
      ii. For Fycompa oral suspension requests, member must use generic perampanel tablets (generic Fycompa), unless contraindicated, clinically significant adverse effects are experienced, or documentation supports inability to use generic perampanel tablets;

   **For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395.*
4. For brand Fycompa tablet requests, member must use generic perampanel tablets (generic Fycompa), unless contraindicated or clinically significant adverse effects are experienced;
5. Request does not exceed health plan-approved quantity limit, if applicable;

6. Dose does not exceed any of the following (a and b):
   a. 12 mg per day;
   b. 1 tablet per day.

Approval duration: 12 months

B. Primary Generalized Tonic-Clonic Seizures (must meet all)**:**
1. Diagnosis of primary generalized tonic-clonic seizures;
2. Age ≥ 12 years;
3. Member meets one of the following (a or b):
   a. Request is for the treatment of a member in a State with limitations on step therapy in certain settings (*see Appendix D*);
   b. Both of the following (i and ii):
      i. Failure of two preferred alternatives (*see Appendix B for examples*), unless clinically significant adverse effects are experienced or all are contraindicated;
      ii. For Fycompa oral suspension requests, member must use generic perampanel tablets (generic Fycompa), unless contraindicated, clinically significant adverse effects are experienced, or documentation supports inability to use generic perampanel tablets;

   **For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395.*
4. Fycompa will be used as adjunctive therapy;
5. For brand Fycompa tablet requests, member must use generic perampanel tablets (generic Fycompa), unless contraindicated or clinically significant adverse effects are experienced;
6. Request does not exceed health plan-approved quantity limit, if applicable;
7. Dose does not exceed any of the following (a and b):
   a. 12 mg per day;
   b. 1 tablet per day.

Approval duration: 12 months

C. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

II. Continued Therapy

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

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Fycompa for seizures and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For Fycompa tablets requests, member must use generic perampanel tablets (generic Fycompa), unless contraindicated or clinically significant adverse effects are experienced;
4. For Fycompa oral suspension requests, member must use generic perampanel tablets (generic Fycompa), unless contraindicated, clinically significant adverse effects are experienced, or documentation supports inability to use generic perampanel tablets;*
   **For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395.*
3. Request does not exceed health plan-approved quantity limit, if applicable;
4. If request is for a dose increase, new dose does not exceed any of the following (a and b):
   a. 12 mg per day;
   b. 1 tablet per day.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
AMPA: α-amino-3-hydroxy-5-methyl-4-isoxazolepropionic acid
FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Class	Examples	Dose Limit/ Maximum Dose
Anticonvulsants for partial seizures	carbamazepine (Tegretol®), felbamate (Felbatol®), gabapentin (Neurontin®), lamotrigine (Lamictal®), levetiracetam (Keppra®), oxcarbazepine (Trileptal®), phenytoin (Dilantin®), tiagabine (Gabitril®), topiramate (Topamax®), valproic acid (Depakene®), divalproex sodium (Depakote®), zonisamide (Zonegran®)	Varies according to the agent used
Anticonvulsants for tonic-clonic seizures	carbamazepine (Tegretol®), lamotrigine (Lamictal®), levetiracetam (Keppra®), phenytoin (Dilantin®), primidone (Mysoline®), topiramate (Topamax®), valproic acid (Depakene®), divalproex sodium (Depakote®)	Varies according to the agent used

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings
- Contraindication(s): none reported
- Boxed warning(s): serious or life-threatening psychiatric and behavioral adverse reactions

Appendix D: States with Limitations against Redirections in Certain Settings

State	Step Therapy Prohibited?	Notes
NV	No	**Applies to Medicaid requests only** Failure of ONE preferred alternative (*see Appendix B for examples*), unless clinically significant adverse effects are experienced or all are contraindicated.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Partial-onset seizures	2 mg PO QHS (4 mg if on CYP3A4 enzyme-inducers). May increase based on clinical response and tolerability by increments of 2 mg QD, no more frequently than at weekly intervals.	12 mg/day

Indication	Dosing Regimen	Maximum Dose
	The recommended maintenance dose range is 8 mg to 12 mg QD, although some patients may respond to a dose of 4 mg QD.	
Primary generalized tonic-clonic seizures	2 mg PO QHS (4 mg if on CYP3A4 enzyme-inducers). May increase based on clinical response and tolerability by increments of 2 mg QD, no more frequently than at weekly intervals. The recommended maintenance dose is 8 mg QHS. Patients who are tolerating Fycompa at 8 mg QD and require further reduction of seizures may benefit from a dose increase up to 12 mg QD if tolerated.	12 mg/day

VI. Product Availability

- Tablets: 2 mg, 4 mg, 6 mg, 8 mg, 10 mg, 12 mg
- Oral suspension: 0.5 mg/mL (340 mL)

VII. References

1. Fycompa Prescribing Information. Coral Gables, FL: Catalyst Pharmaceuticals Inc.; June 2023. Available at: www.fycompa.com. Accessed April 7, 2026.
2. Micromedex® Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed June 5, 2024.
3. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2018. Available at: http://www.clinicalpharmacology-ip.com/. Accessed May 12, 2022.
4. Kanner AM, Ashman E, Gloss D, et al. Practice guideline update summary: Efficacy and tolerability of the new antiepileptic drugs I: Treatment of new-onset epilepsy. Report of the Guideline Development, Dissemination, and Implementation Subcommittee of the American Academy of Neurology and the American Epilepsy Society. Neurology. July 10, 2018; 91(2):74-81.
5. Kanner AM, Ashman E, Gloss D, et al. Practice guideline update summary: Efficacy and tolerability of the new antiepileptic drugs II: Treatment resistant epilepsy. Report of the Guideline Development, Dissemination, and Implementation Subcommittee of the American Academy of Neurology and the American Epilepsy Society. Epilepsy Curr. Jul-Aug 2018;18(4):269-78.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
3Q 2022 annual review: no significant changes; references reviewed and updated.	05.12.22	08.22
Template changes applied to other diagnoses/indications.	10.04.22	
3Q 2023 annual review: no significant changes; references reviewed and updated.	05.18.23	08.23
Added redirection bypass for members in a State with limitations on step therapy in certain settings along with Appendix D, which	08.31.23	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
includes Nevada with requirements for single drug redirection for Medicaid requests.		
3Q 2024 annual review: no significant changes; references reviewed and updated.	05.14.24	08.24
3Q 2025 annual review: no significant changes; added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.	06.06.25	08.25
Per August SDC, revised policy/criteria to also include generic parampanel and added required use of generic perampanel for brand Fycompa requests.	08.21.25	12.25
Clarified required use of generic perampanel tablets for brand tablet and oral solutions requests.	12.03.25	
Clarified oral solutions to oral suspensions.	01.28.26	
3Q 2026 annual review: no significant changes; for Initial Approval Criteria, moved the placement of the redirection from Fycompa oral suspension to generic perampanel tablet such that the Nevada Medicaid redirection bypass would also apply to this redirection; added the requirement that the "Request does not exceed health plan-approved quantity limit, if applicable" since there are strength-differentiated quantity limits on this drug in HIM; added ICHRA line of business; references reviewed and updated.	04.07.26	08.26

Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.